

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION
OF THE ESSENCE OF THE EXPERIENCE

By

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ABSTRACT

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION OF THE ESSENCE OF THE EXPERIENCE

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It is estimated that one in four of all clinically recognized pregnancies will end in miscarriage (Lerner, 2003; Rai & Regan, 2006). The medical community considers miscarriage to be the most common complication of pregnancy (Rai & Regan, 2006). Today, more women are choosing to delay childbearing (Mathews & Hamilton, 2009) and the risk of miscarriage increases with maternal age (Balasch & Gratacos, 2011; Garmel, 2002). Although it has been well documented that miscarriage is a relatively common pregnancy outcome and more likely to happen among women aged 35 years and older, very little research has been conducted on the quality of such a lived experience. Given that, this qualitative study explores the essence of the experience of miscarriage among women aged 35 years and older. Concepts from Ambiguous Loss Theory and Feminist Theory guide this study, with the Human Ecological Model situating the experience within various levels of context. A Transcendental Phenomenological approach, as specified by Moustakas (1994) is utilized to analyze the content of 10 in-depth participant interviews. The salient themes identified suggest that women experience miscarriage from a physical, emotional, temporal and social context. From these themes of experience, the essence of miscarriage for the participants in this study were found to be 1) physically experiencing intense loss and grief, 2) having a sense of otherness, 3) a continuous search for meaning and 4) feelings of regret and self-blame. Clinical implications are provided, as well as future research directions as pertaining to the phenomena and limitations to this study.

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DEDICATION

This dissertation is dedicated to my two sons,
Elliott and Phillip,
and to my husband, Jason.

ACKNOWLEDGEMENTS

Leaving a successful career in the biotech industry to pursue a career in family science and family therapy, while at that same time starting my own family, has been the biggest challenge of my life. Coming from the east coast, Michigan State University seemed the most unlikely of options, yet proved to be the best choice. The Human Development and Family Studies department provided me an exemplary academic environment and a strong system of support, for which I am very grateful. I would like to acknowledge and to thank all of those who have influenced me and my challenging academic journey.

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I must thank my sister, Michelle Auffarth, for her sustained influence for all my life. She served as my grief therapist during my own miscarriage experience. I can sometimes get mired

down in the grim realities of my research and clinical interests, but my sister and her family of six wonderful children is the face of hope. My sister has modeled for me family resilience and cohesion, the meaning of “good mothering,” and together we have set the highest standard of sibling love and friendship. Her encouragement of my academic pursuits has meant the world to me. I also want to thank my mother-in-law, Ruth Anderson for her endless encouragement and tireless efforts to support me by providing the best quality childcare available! Without her provision of care for my children when I had to be away, none of this would have been possible. To Amy Maffeo and Dr. Kayla Katterman, thanks for the years of friendship and for all the spirit lifting.

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Chapter One: Introduction

It is estimated that one in four of all clinically recognized pregnancies will end in miscarriage (Lerner, 2003; Rai & Regan, 2006). With women having a 25% risk of experiencing a miscarriage, the medical community considers miscarriage to be the most common complication of pregnancy (Rai & Regan, 2006). The overall rate of miscarriage is influenced by biological factors but also by the changing reproductive behaviors in our society. Increasingly, women are choosing to delay childbearing (Dobrzykowski & Stern, 2003), and the risk of miscarriage increases with maternal age (Garmel, 2002). With the risk of miscarriage increasing with age and the increasing trend of delayed childbearing, there is a growing segment of the population who will likely experience a miscarriage. The many contextual issues characteristic of miscarriage make it a distinctive loss experience. Furthermore, women of advanced maternal age (AMA) who miscarry confront challenges unique to their maternal age. Thus, the population of women over 35 years of age who have suffered a miscarriage is ripe for the qualitative exploration of their experience. The experience of miscarriage in the later maternal years has important family life and clinical implications.

Significance

Miscarriage and Women 35+

Although the trend of delayed childbearing and the general risks and rates of miscarriage have been studied extensively, the lived experience of women who miscarry at an AMA has yet to be well studied. There is research from the medical community from the perspective of a miscarriage being a bodily, biological issue. Yet the context of the loss(es) intrinsic to miscarriage at an AMA is missing from the literature. With more and more women choosing

later motherhood, this phenomenon is on the rise. Thus, a more complete and qualitative consideration of woman's experience of miscarriage at an AMA is appropriate.

Among many other studies highlighting the increased risks of miscarriage with increasing age, Liu and Case (2011) sought to improve awareness of the natural age-related decline in fertility and increased risk of miscarriage. Liu and Case quantitatively documented the reality of ovarian reserve decline and reduced fertility over the reproductive years. The Liu and Case study documents the risks of miscarriage and lowered fertility from a biological standpoint but does not explore the qualitative and personal experience of running out of biologically optimal reproductive years with the increasing risk of miscarriage. Beyond making women aware of these stark clinical findings regarding fertility and miscarriage, there is a necessity to explore the nature of women's experience of becoming keenly aware of the natural age-related experience of lowered fertility and increased risk of miscarriage.

Shreffler, Greil and McQuillan (2011) published a quantitative study in *Family Relations* reporting on women's general distress level following pregnancy loss. The Shreffler et al. study gives voice to the distress women experience following a miscarriage, but the study takes a very broad look at distress following miscarriage, using only quantitative grief scales to measure level of distress. Further, with a wide participant age range (25-45 years), the study lacks distress differentiation based on the participants' fertility context, including age. This study reinforces the necessity for age-specific, qualitative exploration of the experience of miscarriage.

One recent qualitative inquiry into perinatal loss, parental grief, ambiguity and disenfranchisement of such grief gave visibility to parental grief after a perinatal loss (Lang, Fleiszer, Duhamel, Sword, Gilbert & Corsini-Munt, 2011). This study is not particularly differentiated by the form of loss (i.e. includes perinatal death and stillbirth, along with

miscarriage), nor gender or age of participants. A qualitative study of miscarriage with an emphasis on participant age and other contextual factors could inform a more comprehensive approach for medical and mental health clinicians who treat women of advance maternal age who experience a miscarriage.

Purpose of Study

The purpose of this qualitative study is to contribute to the body of literature on miscarriage. Particularly, this study addresses some of the missing aspects of the current body of literature on miscarriage, including AMA, the ambiguity in loss, and the contextual experience of women, with a feminist informed critical lens of that experience. This study seeks to capture the lived experience of miscarriage at an AMA.

Background of Theoretical Constructs Regarding Motherhood and Miscarriage

Clarifying Motherhood

Significant attention has been paid to mothers by social researchers in an attempt to gain some insight into the complexities of motherhood and mothering (Arendell, 2000). Mothers, of varying demographic backgrounds, have been studied in a multitude of settings, circumstances and contexts (Arendell, 2000). A great deal of the scholarship devoted to the study of mothering presents motherhood as a normative, female role. However, to classify motherhood as a role sparks some controversy from feminist scholars who feel that defining motherhood as a role minimizes and narrows motherhood (Chrisler, 2004; Osmond & Thorne, 2009). Some scholars prefer the notion of motherhood as an experience or an activity (Osmond & Thorne, 2009). For the purposes of this study, motherhood will be considered as a social role, a social and personal status and a component of women's development.

Motherhood as a Developmental Stage and Social Role

From a developmental standpoint, entering into motherhood and being successful at mothering can represent competency in meeting the core tasks associated with what Erik Erikson (1994) termed the *generativity phase* of adult development. Motherhood also can represent a separation and individuation from one's own mother and ultimately marks entrance into adulthood (Erikson, 1994). For many women, passage through and into each new developmental stage is a driving force for becoming a mother, at various chronological (Erikson, 1994; Leon, 1990). For those women desiring biological children, pregnancy is vital to entering into the developmental stage of motherhood (Low, Hazel, Parker, and Welch, 2008; McGoldrick, 1999). Becoming a mother and caring for others is a major life transition that causes a shift and an enhancement in the set of beliefs and knowledge we have about ourselves. (Lemme, 2006). Bandura (1997) suggested that success in the role of nurturing others and various other problem-solving roles promotes self-esteem and self-efficiency, creating an enrichment of the self.

A social role is defined as a set of activities and relationships expected of an individual who holds a particular social position, and expectations of others in relation to the individual (Lemme, 2006). Social roles change over the course of life, and are especially influenced by age (Neugarten & Neugarten, 1996). There is a time to be a child, a time to be a student, a time to be a wife. Motherhood is also a social role. With it, the role of motherhood brings expectations regarding women's behavior, attitude and feelings towards themselves as mother and towards their child(ren) (Chodorow, 1978; Lemme, 2006). Motherhood as a social role creates a sense of belonging and engaging in similar behaviors and sharing similar attitudes and feelings with those within the group (Arendell, 2000). Inclusion into the normative social role of motherhood engenders a sense of belonging to a socially accepted and glorified positionality (Chrisler, 2004,

Lemme, 2006). The experience of what it means to be female is shaped by gendered and social roles, such as motherhood (Osmond & Thorne, 2009; McGoldrick, Anderson, and Walsh, 1991).

Delayed Motherhood

Women's choosing to delay motherhood is a family trend which has been on the rise since the late 1970's (Hamilton, Martin, and Ventura, 2011; Hewlett, 2002). Two decades ago, there were more mothers of newborns in their teens than mothers of newborns who were aged 35 years and older. Today, the trend is reversed (Hamilton, Mathews, and Ventura, 2013). The birth rate for women aged 35-39 years was 45.9 births per 1,000 women in 2010, an increase of 15.6% since 2000. In 2010, the birth rate for women aged 40-44 years was 10.2 births per 1,000 women, an increase of 27.5% since 2000. The rate for women aged 45-49 years (which includes births to women aged 50 years and over) was 0.7 births per 1,000 women in 2010, an increase of 40% since 2000. To give these birth rates by age group perspective, consider that the general birth rate (GBR) for 2010 was 64.1 births per 1,000 women age 15-44 years (Hamilton et al., 2011). The average age of first-time mothers increased 3.6 years from 1970 to 2006, from 21.4 to 25.0 years (Mathews & Hamilton, 2009). Although more women are choosing to delay motherhood until 35 years of age and older, most Americans today consider a normative and ideal time to start a family as occurring sometime within a women's twenties (Dobrzykowski & Stern, 2003; Tough, Benzies, Fraser-Lee, and Newburn-Cook, 2007).

The increase in births to older mothers has been linked to the rising level of women's education attainment and the confounding effect of those women subsequently postponing marriage. Therefore, it is often suggested that postponement of motherhood is correlated to socioeconomic status (Wu & Macneill, 2002). Although the broad trend of later motherhood is characteristic of all major U.S. racial and ethnic groups, Caucasian women and women of Asian

and/or Pacific Islander descent represent the largest proportion of women delaying entrance into motherhood (Livingston & Cohn, 2010). The data that indicate the increased proportion of Caucasian and Asian and/or Pacific Islander representing those women choosing to delay motherhood are shown in tabular form below:

Table 1.1 Distribution of Births by Maternal Age and Race/Ethnicity

Distribution of Births by Maternal Age and Race/Ethnicity, 2009							
Race/Ethnicity	Percent of Births: Under 18 Years	Percent of Births: 18-19 Years	Percent of Births: 20-24 Years	Percent of Births: 25-29 Years	Percent of Births: 30-34 Years	Percent of Births: 35-39 Years	Percent of Births: 40 Years and Older
Total	3.1	6.9	24.4	28.2	23.1	11.5	2.8
Non-Hispanic White	1.9	5.4	22.2	29.7	25.5	12.3	3
Non-Hispanic Black	5.5	11	31.8	25.1	16.2	8.2	2.2
Hispanic	5	8.8	27.5	27.1	19.6	9.7	2.3
American Indian/Alaska Native**	5.7	11.6	33.4	26	15.2	6.6	1.6
Asian or Pacific Islander***†	0.8	2	11.7	28.1	34	19.2	4.2
**May include Hispanics. †Separate estimates were not available for Asians and Native Hawaiians and Other Pacific Islanders.							
Martin, J., Hamilton, B., Ventura, S., Osterman, M., Kirmeyer, S., Mathews, T., & Wilson, E. (2011). Births: Final data for 2009. <i>National Vital Statistics Reports</i> , 60(1), 1-42.							

During Bernice Neugarten's many years of studying adult development and the timing of life events, she developed several terms and concepts which can be applied to the phenomenon of delayed motherhood. Terms such as: *the fluid life cycle* – a blurring of the traditional age divisions in the life cycle, *the social age clock* – an internalized social calendar which informs us

of when in our lives we should be doing things, and the concept of an *on-time or off-time life event* – events happening at the expected time or events happening earlier or later than normally expected, are phrases used to describe adult development (Neugarten & Neugarten, 1996). Currently, age 25 is the average age of first birth, such that those women choosing to delay motherhood until age 35 years of age and older are mothering at an *off-time* age (Martinez, Daniels, & Chandra, 2012)

The timing of the transition into motherhood is influenced by a variety of ontogenetic factors (Bergston & Allen, 2009). Bergston and Allen define ontogenetic factors as those influences affecting individuals over the course of their lifetime. Those most widely noted ontogenetic factors influencing women's delay of motherhood are career and economic development, along with a delay in timing of first marriage (Gangl & Ziefle, 2009; Garrison, Blalock, Zarski, and Marritt, 1997). Considering the concept of the social clock and the importance of timing transitional life events with the fluidity of the life cycle along with an age-irrelevant attitude, various contextual factors influence women's choices regarding entrance into motherhood (Arendell, 2000; Gregory, 2007; Hewlett, 2002).

Pregnancy and Miscarriage

Before further discussion regarding AMA and the experience of miscarriage, it is helpful to review the statistics for the overall rates of pregnancy, estimated rates of miscarriage, and definitional information regarding miscarriage typology and general risk factors associated with miscarriage. Also necessary is a cautionary word about the difference between rates and risks, as the terms are often used interchangeably. A rate is the measured occurrence of some phenomenon or event over a defined time period. Rates are sometimes more challenging to establish since a rate measurement requires data regarding some larger "total" population. For

example, a true rate of miscarriage would require data gathering of the total number of women who experience a miscarriage as compared to the total population of pregnant women, at various time intervals, e.g. woman's age or weeks of gestation. In contrast, the term "risk" is a statement of probability; the chance a woman has of experiencing a miscarriage during all of her reproductive years. Risks can be stated more generally, while rates often inform factors of risk.

Pregnancy Rates

The National Survey of Family Growth (NSFG) is a databank that is part of the National Center for Health Statistics (NCHS) which provides statistical information regarding the health of the general U.S. population. The NCHS operates within the Centers for Disease Control (CDC), which is an organization within the larger governmental agency, the U.S. Department of Health and Human Services (DHHS). The NSFG gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. The NSFG survey results are used by the U.S. Department of Health and Human Services (and others) to plan health services and health education programs and to do statistical studies of families, fertility, and health. The NSFG obtains information specific to factors affecting birth and pregnancy rates, adoptions, and maternal and infant health, and supplements the information obtained on birth certificates collected through the National Vital Statistics System. Using the NSFG data, some general statements about the estimated rates at which women become pregnant and the rate at which women subsequently miscarry can be made.

Based on the NSFG report of fertility, the pregnancy rate for women aged 35-39 was 78.5 per 1,000 women in the U.S. in 2008. The pregnancy rate for the oldest women in the report, those aged 40-44, was 18.8 per 1,000 women in 2008, and the rate for this age group has steadily increased since 1991 (Martinez et al., 2012; Ventura, Curtin, and Abma, 2012). All estimates in

the NSFG report were weighted to reflect the approximate 62 million men and women aged 15-44 in the household population of the U.S. These estimates represent fertility rates and differ from birth rates.

Overall, 65% of reported pregnancies ended in a live birth in 2008, 18 % in elective (or induced) abortion, and 17% in fetal loss (Martinez et al., 2012). These patterns in pregnancy outcomes have changed only slightly since 1990. The proportion of pregnancies ending in fetal loss was 17% in 2008 compared with 15% in 1990 (Martinez et al., 2012; Ventura et al., 2012). Pregnancies among women in their late 20's and early 30's are more likely to end in live birth (about 70%) than for younger and older women (Martinez et al., 2012). These statistical estimates of U.S. women's fertility lend support to the generally accepted notion that reproductive behavior has changed over the past several decades. Motherhood, as a choice, is still very popular, and the trend of delaying motherhood into the later reproductive years (i.e. mid 30's and beyond) continues to be on the rise (Garrison et al., 1997).

Miscarriage Types

A presentation of some basic information regarding definitions, rates and risks of miscarriage is requisite for understanding miscarriage as a common complication of pregnancy. As previously mentioned, miscarriage is the most common complication of pregnancy (Garmel, 2002; Rai & Regan, 2006). Miscarriage, generally, is defined as any pregnancy loss that ends of its own doing, within the first 20 weeks of gestation (Lerner, 2003). The vast majority of miscarriages are thought to be due to chromosomal abnormalities with the fertilized egg (Garmel, 2002; Lerner, 2003).

Miscarriages are termed early (within the first 13 weeks of gestation) or late (occurring between the 13th and 20th week of gestation) (Garmel, 2002). When considering biological

causes of miscarriage, the terms chemical pregnancy, molar pregnancy, ectopic pregnancy and a blighted ovum are grouped as some of the typical forms of miscarriage (Garmel, 2002; Lerner, 2003).

A chemical pregnancy is a pregnancy lost shortly after implantation when there is barely enough pregnancy hormone (hCG human chorionic gonadotropin) generated by the fertilized egg to register a positive result on a pregnancy test. In this case the pregnancy quickly ends and is followed by heavy bleeding near or around the time of the expected menstrual cycle (Garmel, 2002; Lerner, 2003). Chemical pregnancies sometimes account for the inflated estimates of miscarriage, those projected estimates which include the non-clinically recognized pregnancies (Lerner, 2003).

A molar pregnancy is categorized as either a complete or a partial molar pregnancy (Garmel, 2002; Lerner, 2003). A complete molar pregnancy is the result of a genetic error during fertilization of the egg and results in abnormal tissue development (Garmel, 2002; Lerner, 2003). With a complete molar pregnancy only the placental parts (no embryo) develop from a fertilized but empty egg. The placenta grows and produces hCG but ultimately the pregnancy will end on its own and the uterus will spontaneously expel the tissue. A partial molar pregnancy occurs when the fertilized egg contains abnormal cells as well as a defective embryo (Garmel, 2002; Lerner, 2003). With a partial molar pregnancy the defective embryo will eventually be engulfed by the abnormal mass of cells and the pregnancy will terminate (Garmel, 2002; Lerner, 2003).

An ectopic pregnancy occurs when a fertilized egg attaches in any place other than inside the uterus, most commonly inside the fallopian tube. As the pregnancy develops, the fallopian tube is not able to support the developing embryo and usually ruptures if the tubal pregnancy is not first detected by a physician and terminated with drug therapy (Lerner, 2003).

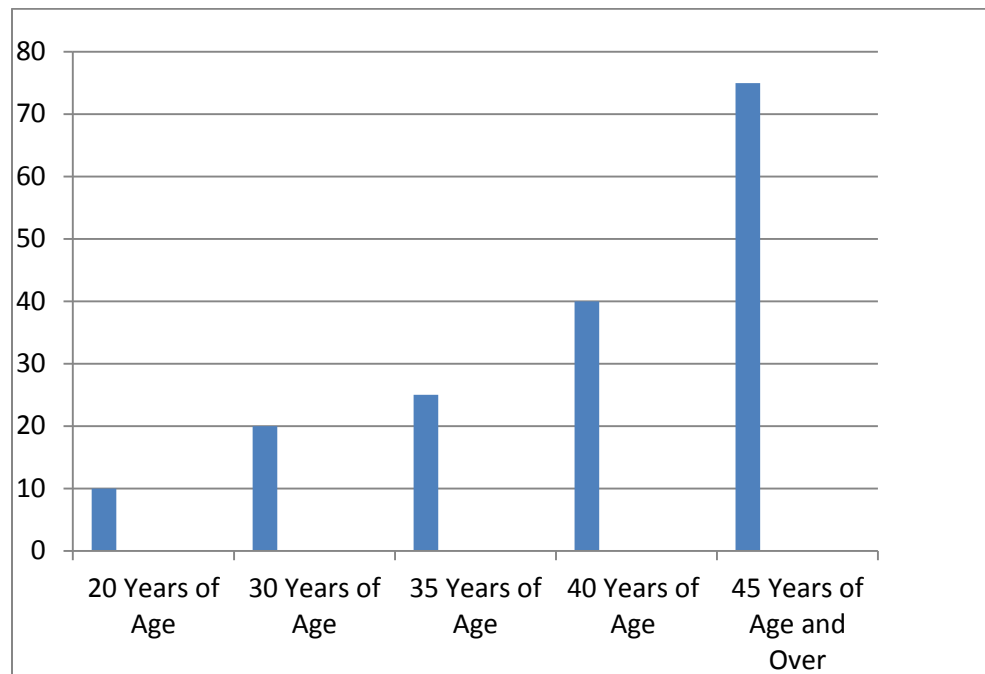
Finally, a blighted ovum is a form of miscarriage characterized by a fertilized egg attaching to the uterine wall without an embryo developing (Garmel, 2002; Lerner, 2003). Only an empty fetal sac develops. A blighted ovum typically presents much like a chemical pregnancy, it is short lived and the woman's body naturally miscarries and expels the materials in the form of a heavy, and sometimes slightly delayed menstrual cycle (Garmel, 2002).

Miscarriage Rates and Risks

Miscarriages are spontaneous, frequent and normative reproductive events – though extremely disappointing and sad events (Lerner, 2003). The rate of miscarriage is sometimes categorized as an overall rate for all clinically recognized pregnancies or delineated by age cohort and various other pregnancy contexts (e.g. rate of recurrent miscarriage, rate of miscarriage with the use of artificial reproductive technologies). When taken by age group, women 20 years of age have a 10% risk of miscarrying, whereas women 35 years of age have an approximate 25% risk of miscarrying, and the rate increases dramatically after age 40, whereby women 45 years of age and older have a 75% risk of miscarrying (Anderson, Wohlfahrt, Christens, Olsen, and Melbye, 2000; Heffner, 2004). These data depicted in the table below (Table 1.2) show the enormous jump and disparity in the risk for miscarriage among women aged 40 years and over.

Table 1.2 Risk of Miscarriage by Age

For interpretation of the references to color in this and all other figures, the reader is referred to the electronic version of this dissertation.



The risk factors associated with miscarriage are varied (Garmel, 2002). There is general consensus within the medical community that the majority of miscarriages are due to a chromosomal abnormality, i.e. a chromosomal mis-combination (Lerner, 2003). Just as motherhood is complex, reproductive biology is extraordinarily complex. If any of the thousands of steps in genetic recombination do not occur correctly, the developing embryo cannot continue to develop, and a miscarriage will ensue (Lerner, 2003). There are various other biological risks for miscarrying such as pregnancy interval (the time between previous pregnancy and subsequent pregnancy), uterus and other anatomical malformations, hormonal imbalances during early pregnancy, infectious diseases, overall maternal health problems such as diabetes, thyroid disease, epilepsy, and obesity, as well as many other chronic illnesses which can and do increase the risks for miscarriage (Lerner, 2003).

There are several physiological reasons why women of AMA are more likely to experience a miscarriage (Benzies, 2008; de La Rochebrochard & Thonneau, 2002). As women grow older they simply run out of eggs, and it is thought that the “healthiest” eggs are ovulated early in a woman’s reproductive years (Lerner, 2003). The longer a woman’s eggs remain in her body, the more her eggs are exposed to the possibility of damage (Lerner, 2003). Similarly, the uterus incurs an increased possibility of damage with the passage of time, making it less optimal to support pregnancy (Lerner, 2003). As women age, they become less adept at providing adequate hormonal support for a pregnancy. Finally, with age women are at an increased risk of developing various medical problems (thyroid disease, lupus, diabetes) which can decrease fertility and increase the risk of miscarriage (de La Rochebrochard & Thonneau, 2002; Lerner, 2003).

With AMA comes lowered fertility, a higher rate of fetal chromosomal abnormalities, most notably Trisomy 21 (or Down’s Syndrome), and an increased risk of miscarriage (Anderson et al., 2000). The lowered fertility of women at an AMA can necessitate the use of artificial reproductive technologies to aid in conception (Grainger, Frazier, and Rowland, 2006; Heffner, 2004). The use of artificial reproductive technologies adds an additional factor of risk for miscarriage among women of all ages (Gerodetti & Mottier, 2009). This compounding of risk factors produces a double burden of miscarriage risk for women over 35 years of age who utilize artificial reproductive technologies (Lerner, 2003). Although researchers have explored the value of new reproductive technologies during the last decade, the analysis has not been extended to include the influence that these technologies are having on the experience of those whose pregnancies end with a miscarriage (Brin, 2004; Layne, 2003b; Keane, 2009).

Theoretical Frameworks

Ambiguous Loss Theory

Ambiguous loss theory is a framework based on a family stress model and is particularly useful for conceptualizing the losses inherent with miscarriage at an AMA. One of the primary assertions that inform ambiguous loss theory is the principle that it is more difficult to cope with losses that involve a degree of ambiguity (Boss, 2003). In the case of women who miscarry, there is a recognized and real loss of the wished-for and wanted child, but at the same time, there are many ambiguous, ambivalent and unclear losses which may lead to unresolved losses (Lang et al., 2011). Ambiguity worsens the normal response to loss, stress, and grief (Boss, 2006; 2007). Recovery from a loss which is ambiguous is difficult and often leads to complicated grief, post-traumatic stress disorder, depression and despair (Abrams, 2001; Boss, 2006; 2007).

Ambiguous loss theory has been applied to several loss scenarios. As the theory's developer, Pauline Boss has applied ambiguous loss theory to the experience of families affected by missing in action soldiers, family members who have gone missing during catastrophic natural disasters, those affected by Alzheimer's disease, addictions and other chronic illnesses. Understanding the ambiguous loss experience for women who had their child abducted by the child's father was explored in the early nineties (Holiday-McGrady, 1992). Katherine Allen (2007) explored the ambiguity of mothers' losses while going through a same-sex break-up in which non-biological children are no longer present in the non-biological mother's life. Additionally, ambiguous loss theory has been applied to a variety of family forms which include children who are mentally disabled or physically ill, exploring mothers' losses in the realm of their child's physical presence and psychological absence (Berge & Holm, 2007; O'Brien, 2007; Roper & Jackson, 2007). The aforementioned studies lay the ground work for a more liberal

extension of ambiguous loss theory to women of AMA and miscarriage. Experiencing a miscarriage can create ambiguity in a woman's identity, social role and social status. Thus, a study of miscarriage among women 35 years of age and older through the lens of ambiguous loss theory adds to the literature regarding women's experience of miscarriage.

Women who miscarry may experience ambiguous loss due to the uncontrollable nature of the loss itself and the reality that meaning making in light of their loss is especially challenging (Lang et al., 2011). As previously mentioned, one of the primary tenets of ambiguous loss theory is that a loss which is unclear in nature is more stressful to tolerate and more difficult from which to recover than a more definitive, normative form of loss (Boss, 1999). Ambiguity is a significant aspect of the loss experience and can affect how some women conceptualize the loss of their wished-for and wanted baby. With an ambiguous loss experience, the grief process gets frozen (Boss, 2007). The ambiguous, unclear nature of miscarriage makes it especially traumatizing. Thus, ambiguous loss theory is a fitting framework for conceptualizing the experience of miscarriage at an AMA.

Feminist Theory

Gender, which is a social category assigned to each of us at birth, affects nearly every aspect of our lives and results in different expectations, roles, behaviors, and statuses for men and women (Knudson-Martin, 1997). Gender is different than our biological sex which is the physiological characteristics that define us as males or females. Gender is a basic organizing concept regarding individual experience (Osmond & Thorne, 2009), and we experience life very differently based on our gender alone. The concept of gender is a useful tool for analyzing experience as a means of gaining insight into how we act, feel, and think about experiences (Chodorow, 1978; McGoldrick, 1999). Feminist theory originated from a social movement with

the purpose of exposing women's gendered experience of subordination and oppression and with the goal of ending such unfair subjugation (Osmond & Thorne, 2009). Feminist theory is empirical, evaluative and ideological in nature. Feminist scholarship begins by observing, assessing and conceptualizing women and their varied, lived experiences (White & Klein, 2002).

The politics of gendered roles and statuses are at the core of most feminist literature. A general theme in feminist literature on the topic of miscarriage or pregnancy loss is the would-be mother's role in grieving the loss of her baby as well as her loss of the role and status of mother-to-be. The title or status of motherhood brings with it many expectations, assumptions, and values (Gerodetti & Mottier, 2009). Mothers and mothers-to-be are expected to adhere to the socially constructed notions of behaving in a certain way and desiring certain things for themselves and their child(ren) (Gerodetti & Mottier, 2009; Layne, 1997). Miscarriage has a way of dislocating women from their socially constructed role of would-be-motherhood. A feminist perspective is a useful lens for viewing the oppressive experience of miscarriage at an AMA.

Human Ecological Theory

Human ecology is the study of humans interacting with their natural, human-built and social environments (Griffore & Phenice, 2001). Natural environments in the context of human ecological theory relate to the organic or earthly environments (e.g. vegetation, animals, hills, oceans, all living and nonliving things). Griffore and Phenice (2001) use the example of the prenatal environment within the womb as the earliest natural environment for humans. Human-built environments include all of the architectural, man-made. Some examples of human constructed environments could include buildings, ceiling fans, a kitchen table, lighting, and office equipment. The social environment as applied to human ecological theory relates to the

cultural aspect of experience (White & Klein, 2002). The social environment includes the interactions with others, family members, teachers, civic leaders, store clerks (Griffore & Phenice, 2001).

Human ecological theory is not one defining, uniform theoretical proposition (White & Klein, 2002). Though there are various ecological theories and propositions, core to all is the concept of the ecosystem (White & Klein, 2002). Bubolz, Eicher and Sontag (1979) define the ecosystem as the basic unit of organism-environment interaction. Bronfenbrenner (1979) described individual development within the ecosystem as an individual's process of growth and adaptation through interchanges with the immediate ecosystem (the family) and the more distant environments (such as school or work).

Bronfenbrenner (1979), expounding on Lewin's (1935) earlier work regarding the dynamics of psychological development, suggested conceptualizing the human ecosystem as nested levels within which an individual develops and interacts. Bronfenbrenner (1979) proposed four nested levels of analysis within the scope of the human ecosystem: the microsystem, the mesosystem, the exosystem and the macrosystem. Later he added a fifth dimension of analysis called the chronosystem (1989). The microsystem consists of the face-to-face and concrete interactions of the individual and others. The mesosystem comprises the interrelations of two or more microsystems (systems directly involved with the individual self), such as work and home. The exosystem is defined as systems that are ancillary with relation to the individual, though have an indirect effect on the individual's microsystem or mesosystem, such as a social network or a spouses' place of employment, as it affects the other spouse. The micro-, meso- and exosystems are embedded within the individual's macrosystem, which creates the overarching and ever changing cultural context of individual development. Finally, the chronosystem gives

consideration to time and how the temporal passage of time influences development and environments (Bronfenbrenner, 1979).

Human ecological theory is qualitative in essence, and seeks to describe and explain (Bubolz & Sontag, 2009). Thus, it is well fitting to apply human ecological theory to a qualitative inquiry of women of AMA and their experience of miscarriage.

Combined Conceptual and Theoretical Map

Ambiguous loss theory is the guiding theoretical model informing this appraisal of women and their experience of miscarriage at an AMA. In a recently published (2013) literary account of pregnancy loss, *How to Expect What You're Not Expecting*, essayists describe the unforeseen nature of pregnancy losses and their own personal account of unhappy endings. The book's title is a play on words as compared to the very popular book, *What to Expect When You're Expecting*, (2008) which devotes very little attention and content to the possibility and experience of miscarriage. The unexpected, unresolved losses associated with being pregnant and then suddenly not pregnant, creates a scenario of paradox and unrest (Anderson et al., 2000). These conflicting aspects of miscarriage at an AMA make ambiguous loss theory an appropriate tool to conceptualize the often unexpected and unclear losses women experience when suffering a miscarriage.

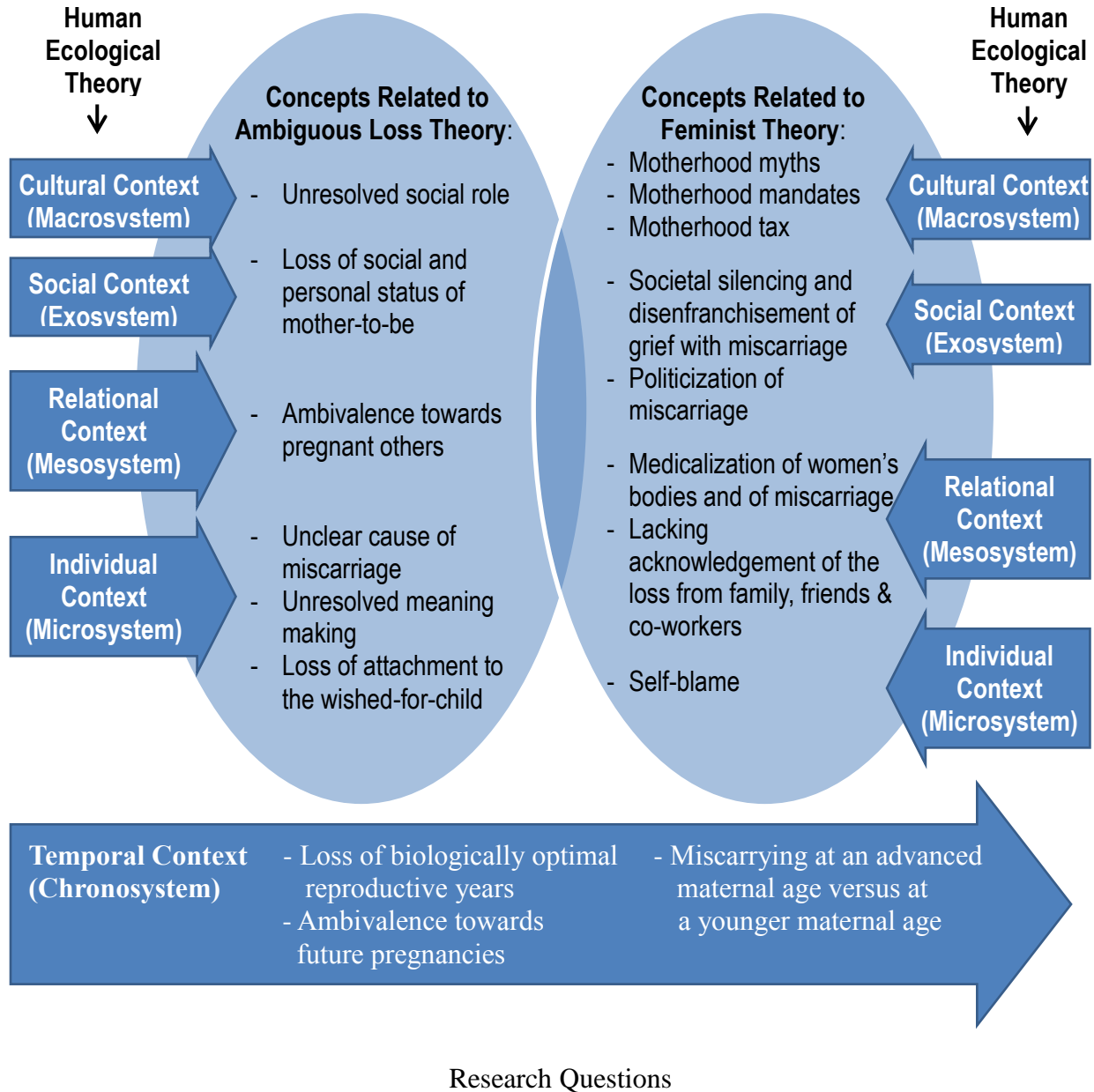
Feminist theory acknowledges that individual experiences are embedded in context (Osmond and Thorne, 2009; White & Klein, 2002). Additionally, feminist theory attends to the notion of separate spheres, traditionally conceptualized as the public sphere for men and the private sphere for women, as contexts of experience (Osmond and Thorne, 2009). Feminist scholars argue that the idea of separate spheres of public and private experiences for men and women are related to one another, rather than separate from one another (McGoldrick et al.,

1991; Osmond and Thorne, 2009). Power imbalances exist and are experienced in women's public life as well as in their private life or institution (that being family life) (Osmond and Thorne, 2009). Therefore, when considering a woman of AMA experiencing a miscarriage, it is imperative to identify the various environmental factors associated with that loss experience. Feminist theory and human ecological theory complement each other well. Feminist theory draws upon major tenets of human ecological theory regarding the importance of context, making their blended application a very fitting theoretical framework for addressing environmental contexts related to women and their experience of miscarriage at an AMA.

Concepts from ambiguous loss and of feminist theory applied to the experience of miscarriage at an AMA will be delineated along with the human ecological model contexts of environmental influences as applied to the individual. Concepts related to ambiguous loss theory and feminism tell the story of *what* and contexts related to human ecological theory tell the story of *how*, with respect to women of AMA and their experience of miscarriage.

The five ecosystems of Bronfenbrenner's ecological theory serve as organizing levels or brackets for categorizing specific concepts regarding women of AMA and their experience of miscarriage. Women of AMA and their experience of miscarriage were conceptualized as having experienced an ambiguous form of loss and were viewed through a feminist lens. The conceptual map created and utilized to guide this study reflects the context of the woman and miscarriage at the microsystem level (individual), the mesosystem level (relational), the exosystem level (social), the macrosystem (cultural) and the chronosystem level (temporal).

Figure 1.1 Combined Conceptual and Theoretical Map



The primary research question that guides this study is: 1) How do women of advanced maternal age perceive and describe their experience of miscarriage? The word “how” denotes a stance of not knowing and an openness to whatever may emerge from each participant’s telling of her experience of miscarriage. The word “perceive” relates to the relativity, difference, and uniqueness of each participant’s experience, and the word “describe” relates to what a miscarriage

is and means to each participant. The use of the word “experience” in the research question simply speaks to the fact that each participant has had, at some point in time, a miscarriage in her everyday lived experience. Table 1.3 (shown below), depicts the general conceptualization of this study. The contents of Table 1.3 illustrate how the conceptualization of this study began broad, in terms of the scope from a theoretical perspective. The research question and research goals lead toward a more defined research paradigm which established the basis of the relationship between the more specific elements and assumptions regarding miscarriage at an AMA, those elements and assumptions being expressed in contextual factors of experience.

Table 1.3 Research Question, Goals and Concepts

Theory	Research Question	Research Goals	Human Ecological Contextual Factors	Concepts of Experience
Ambiguous Loss	How do women of AMA perceive and describe their experience of miscarriage?	<p>Aim is to determine what experiencing a miscarriage at an AMA means for those who have had the experience and are able to give a comprehensive description of it.</p> <p>From individual descriptions general meanings can be derived, i.e. the essence of the experience of miscarriage at an AMA.</p>	Cultural Context	Unresolved Social role
			Social Context	Loss of social and personal status
			Relational Context	Ambivalence towards pregnant others
			Individual Context	Unclear cause of miscarriage
				Unresolved meaning making
				Loss of attachment to wished-for-child
			Temporal Context	Loss of biologically optimal reproductive years
				Ambivalence towards future pregnancies
Feminist Theory	How do women of AMA perceive and describe their experience of miscarriage?	<p>Uncover qualitative factors of behavior regarding the experience of miscarriage.</p> <p>Gain insight (knowledge) into the nature, quality, meaning and essence of experience of miscarriage at an AMA.</p>	Cultural Context	Motherhood myths
				Motherhood mandates
				Motherhood tax
				Medicalization of women's bodies and of miscarriage
			Social Context	Societal silencing and disenfranchisement of grief
				Politicalization of miscarriage
			Relational Context	Lacking acknowledgement of the loss from family, friends & co-workers
			Individual Context	Self-blame
			Temporal Context	Miscarrying at an AMA versus at a younger maternal age

Chapter Two: Literature Review

As previously stated, miscarriage is a common complication of pregnancy, with nearly 25% of all clinically recognized pregnancies ending in miscarriage (Lerner, 2003; Rai & Regan, 2006). Additionally, women over 40 years of age have an increased risk of miscarriage (de La Rochebrochard & Thonneau, 2002). Despite their heightened risk for miscarriage, women of AMA who have suffered a loss have not been highly represented in the current body of literature regarding miscarriage. This may be due in part to the often ambiguous, unclear biological causes of miscarriage, whereby the medical literature tends to lump miscarriages all together, typically differentiated only by type of miscarriage or length of gestation. There is a sense of having to play catch up, since women of AMA were historically not representative of those women actually getting pregnant and then subsequently miscarrying. Only in the last several decades have we seen the dramatic shift in reproductive behavior, which includes delayed motherhood (Hamilton et al., 2011). With that, this qualitative study of the ambiguous nature of the losses inherent to miscarriage at an AMA is well-timed research.

Ambiguous Losses with Miscarriage

One of the primary tenants of ambiguous loss theory is that a loss which is unclear in nature is more stressful to tolerate and more difficult from which to recover than a more definitive, normative form of loss (Boss, 1999). Ambiguous loss theory is a fitting framework for conceptualizing the experience of miscarriage at an AMA. Using Bronfenbrenner's Human Ecological Theory, concepts related to ambiguous loss theory will be delineated along contextual subsystems (cultural, social, relational, individual and temporal) associated with miscarriage at an AMA.

Cultural Context

Unresolved Social Role

As previously noted, motherhood is a complex social role. When a woman experiences a miscarriage, the loss experience is defined not only by the loss of her baby, but also by the ambiguous losses endured. After a miscarriage, the loss of the social role “mother-to-be” is real and significant, though ambiguous in nature (Shreffler et al., 2011). A sense of role ambiguity comes from the abrupt ending of the “mother-to-be” identity (Boss, 2006). In the case of miscarriage, the loss of what was anticipated or expected with the role of mother-to-be is not entirely certain, it can be unclear, but it is still considered and wanted.

As a society, we have moved away from the “children are to be seen and not heard” culture toward a more child-centered culture (McGoldrick, 1999). Badinter (1981) wrote extensively about the changing landscape of family, and the role of mother, in particular. When traced over the past several centuries, it has been noticed that mothers tend to adhere to what the prevailing culture dictates (Badinter, 1981). When the culture espoused wet nurses and boarding schools, mothers relegated the care of their newborns to nursemaids and sent their children away to be raised by others. As the pendulum has now shifted, the culture of today places an emphasis on embracing full responsibility for children in the role of mothering (Arendell, 2000; Meyers, 2001). With such emphasis being placed on children and the quality of mothering, society can impose a sense of “otherness” upon those struggling to gain acceptance into the role of motherhood (Blades & Rowe-Finkbeiner, 2006).

The social role of motherhood, as a position, encompasses particular social activities of mothering, which begin with experiencing a healthy, full-term pregnancy, delivering a live child, and caring for a newborn. Pregnancy and entrance into motherhood is a rite of passage.

Pregnancy loss disrupts the rite of passage into motherhood and interrupts the expected unfolding of the activities of mothering, creating an ambiguity and a loss in fulfillment of the socially constructed role of carrying and birthing a child. With such value placed on fulfilling the role of motherhood, the extent of loss when that role is disrupted due to miscarriage is difficult to measure (Cosgrove, 2004).

Social Context

Loss of Social and Personal Status of Mother-to-Be

Motherhood as a social role has to do with the actual position and activities of mothering; motherhood as a status has to do with the honor and prestige assigned to that role (Osmond & Thorne, 2009). The social ranking or status of mother-to-be leads to a sense of either inclusion or exclusion of being among the ranks of one's peers (Arendell, 2000; Osmond & Thorne, 2009). The miscarriage experience is marked by the loss of title, "mother-to-be," and with the loss of that title so too is the status that comes with it.

In addition to the developmentally appropriate desire to become a mother in *social role*, most women desire the *social status* of motherhood (Lemme, 2006). The concept of role versus status may initially seem nuanced, but there is a true distinction in the act of doing and the status of having. The status of mother-to-be is a way of meeting the social world, so to speak, as an expectant mother. Mother-to-be status tells the social world that one is well on her way to becoming a mother and meeting that developmental task (Mathews & Hamilton, 2009). The status of "expectant mother" has a profoundly personal meaning to pregnant women (Hare-Muston & Broderick, 1979; Mercer, 2004). The social and personal status of mother-to-be can command a degree of prestige and a sense of being insider to a group (Boucai & Karniol, 2008). Gaining access to a normative and appropriate social status provides women with a desired social

integration with peers; hence, soon-to-be motherhood status locates women (Neugarten & Neugarten, 1996; Mercer, 2004). With all there is to gain in becoming a mother, there is a significant loss associated with identifying as would-be-mother only to miscarry and lose the identity that comes with that role and status. Women who miscarry are excluded from their social role and status abruptly and are left to feel excluded from their cohort of reproductively active peers (Layne, 2003b).

Relational Context

Ambivalence Towards Pregnant Others

Ambivalence towards pregnant others is a kinder, more thoughtful way of describing pregnancy envy among women who have miscarried. Although there is some scholarship devoted to the psychological sequelae of miscarriage such as depression and anxiety, little attention is paid to other problematic emotions of grief following a miscarriage, such as jealousy and resentment (Layne, 2003a; Swanson, 1999). Although the notion of being resentful of another woman's pregnancy is rarely mentioned in the scholarly literature, pregnancy envy and resentment towards other women who are pregnant are common reactions following a pregnancy loss and are frequently mentioned feelings on miscarriage blogs and grief support message boards. There is a cohort effect for women who have miscarried and have peers enter into the motherhood role at the time that they had expected to do so. News of family members,' friends' and co-workers' pregnancies bombard women of a certain age. Layne (2006) described the silencing and minimization of women's miscarriage via the shutting down of those undesirable emotions of jealousy, which can occur following a miscarriage.

Individual Context

Unclear Cause of Miscarriage

Of the many ambiguous burdens of miscarriage, not knowing the cause of the loss may be the most difficult. It is standard procedure for medical insurance companies and thus obstetrician/gynecologists (OB/GYN's) to preclude any form of causation testing following a miscarriage unless the woman has had two or three consecutive miscarriages (Garmel, 2002). Thus, the vast majority of women never have a definitive answer as to why their pregnancy ended (Lee, Slade, and Lygo, 1996; Lerner, 2003). The findings from a study by Nikcevic, Kuczmierczyk, Tunkel and Nicolaides (2000) regarding distress following a miscarriage and knowledge of the cause suggest that decreased distress level following a miscarriage was associated more with the provision of follow-up care than with whether the cause of the miscarriage was identified or not. However, it may be that the unclear cause of the miscarriage is not increasing post miscarriage distress but rather, a woman's own internal beliefs about the cause which moderates distress following a miscarriage (Nikcevic et al., 2000).

Unresolved Meaning Making

Some theorists argue that the unclear nature of losing some entity never held, and possibly never seen, makes miscarriage more tormenting than other forms of loss (Robinson, Baker & Nackerud, 1999). Although the use of sonogram and ultrasound technologies can project an image of an early fetus inside the womb, naturally occurring miscarriages typically present like a very heavy menstrual bleeding. Without the presence of an actual, viewable by the naked eye fetus, miscarriages are often unacknowledged losses (Paton, Wood, Bor, and Nitsun, 1999; McCreight, 2008). When what was lost in miscarriage is unacknowledged and thus not validated, meaning making becomes difficult. Meaning making is an essential piece of grief and

loss resolution work (Leon, 1990; Wordon, 2002). Adding to the unresolved meaning making of miscarriage is the few memories, if any, women who miscarry have of what was lost (Layne, 2003a).

There is a lack of generally accepted death rituals following a miscarriage. When there are no accepted loss rituals following a miscarriage, there is a sense that a miscarriage should not be perceived as a death to be mourned (Layne, 2003a; Keefe-Cooperman, 2005). With most forms of grief, the healing process often begins with rituals or rites around the death experience, such as a funeral, a wake, or a memorial service (Keefe-Cooperman, 2005). If there is no place for mourning, then there is no place for giving consideration to the meaning associated with a woman's experience of miscarriage. Women who miscarry often can experience a disenfranchised form of grief due to minimization of their loss and unresolved meaning making of their loss (Doka, 2002; Lang et al., 2011).

Loss of Attachment to Wished-for-Child

Mother-child attachment can begin as early as the time when a woman decides to try to conceive and continues throughout pregnancy (Armstrong, 2002; Van Bussel, Spitz, and Demyttenaere, 2010). Miscarriage brings about the loss of that early mother-child attachment. The use of sonogram technologies increases the sense of attachment to the wished-for-child by creating an early image of the child (Layne, 2003a; O'Leary, 2004). There are losses related to what could have been, expectancies and hopes for the wished-for-child's future as well as a loss of hopes for the mother's own future (Keane, 2009; Lang et al., 2011). Peppers and Knapp (1980) stated in their study of prenatal attachment that maternal love reaches deeply into the earliest stages of pregnancy and attaches itself firmly to the growing fetus. As described by Peppers and Knapp (1980) the majority of events that influence maternal attachment occur

prenatally, not after giving birth. Gaffney (1988) reviewed the literature on perinatal attachment in an attempt to make recommendations for facilitating mother-child attachment and validated the claim that attachment begins prenatally. In a concept paper related to clinical practice with perinatal loss as viewed through the lens of attachment theory, Robinson et al. (1999) discuss the various and individualized levels of maternal attachment and the importance of accurate assessment of the degree of attachment and loss for women who have miscarried. The broken attachment bond in miscarriage speaks to the paradox of grief, having to bear the unbearable, having to let go of what was never held.

Temporal Contexts

Loss of Biologically Optimal Reproductive Years

Especially among women of AMA, the feeling that the time for becoming a mother is running out can provoke a heightened sense of urgency and longing for entrance into motherhood (Lemme, 2006; McGoldrick, 1999). Layne (2003a) found that ambiguity of what could have been lingers in the mind of many older women who begin to feel that they may have waited too long to begin a family. Boss (1999) describes ambiguity in loss as an absurdity of not knowing, the indefinitely unclear. That same absurdity can be applied to a women's pondering the what if's of the years gone by...would child bearing have been more biologically suitable with better pregnancy outcomes ten years earlier? From a historical perspective, Herz (1984) reported that the loss of biologically optimal reproductive years, infertility and miscarriage is especially difficult for the woman who has postponed pregnancy until the establishment of a career because it contradicts the goal setting nature of most career oriented women. More contemporary examination of women's experience of delayed childbearing for career pursuits

reflects similar findings of emotional distress and anxiety regarding the loss of fertility with AMA (Edwards, 2002; Wu & Macneill, 2002).

Ambivalence toward Future Pregnancies (Hope – No Hope)

Another loss which has been noted in qualitative interviews with women who have miscarried is the loss of bliss and optimism in subsequent pregnancy (Armstrong, 2002; Shreffler et al., 2011). Some reproductive scholars talk about the “hope – no hope” roller coaster many women experience during subsequent pregnancies after suffering a miscarriage (Wojnar, Swanson & Adolfsson, 2011). Distress and detachment from subsequent pregnancies have been reported by both women and men who had previously experienced an early pregnancy loss (Leon, 1990). In Layne’s (2006) interviews with women who had experienced a miscarriage she found participants describe a “luxury” or blissfulness many other women get to experience when they have never had a miscarriage, the aloof and somewhat lacking awareness of the real possibility of miscarriage. After one or more pregnancy losses, some women “dehumanize, minimize, and medicalize” their experience of a subsequent pregnancy as a kind of anticipatory grief (Swanson, 1999; Zucker, 1999).

In a study of the internal and external attributions following miscarriage, Madden (1988) found that every participant had some degree of anxiety and fear towards the idea of a future pregnancy. Herz (1984) notes the dichotomy in response to miscarriage whereby some women felt that the thought of another pregnancy is anxiety-provoking and therefore rejected it, while others would obsessively try to conceive again immediately following a miscarriage, to replace the lost child. Herz noted that both the “never again” approach and the “right away” approach are equally undesirable. O’Leary’s (2004) paper regarding grief from a previous perinatal loss and the influence on prenatal attachment in subsequent pregnancies noted the necessity for parents to

acknowledge their fears of future losses while also finding ways to slowly regain trust in the world and in their future with their children born after a loss.

Feminist Perspectives and Miscarriage

Using a feminist critical lens to view women's experience of miscarriage at an AMA raises several points related to gender and power. Feminist ideology applied to the experience of miscarriage provides a strong base for considering how best to understand women who experience the loss of a wanted child. The feminist perspective brought to miscarriage suggests giving equal consideration to both the child who was lost and the woman's experience of that loss (Layne, 1997). Further, feminist thought explores the realms of the positionality of women who are labeled "failed mothers" in our socially constructed view of those who cannot reproduce successfully (Afek, 1990; Forrest & Gilbert, 1992). Using Bronfenbrenner's Human Ecological Theory, concepts related to feminist theory will be delineated along contextual subsystems (cultural, social, relational, individual and temporal) associated with miscarriage at an AMA.

Cultural Contexts

Motherhood Myths

Feminist scholars have long written about the myths of motherhood (Hare-Mustin & Broderick, 1979; Hare-Mustin, Bennett, and Broderick, 1983). Myths of motherhood include notions that motherhood provides the quintessential and ideal form of self-fulfillment, rewards and personal happiness for women. The caveat of this myth is that motherhood, though mythically rewarding, is held in lower esteem than male occupations (Crittenden, 2010). Although feminist scholars challenge these notions of motherhood as central to women's personhood, society still places women's worth squarely on their ability to bear children (Layne,

2003b; Zucker, 1999). An awareness of the myth and rallying against the myth does not remove the myth from societal consciousness (Crittenden, 2010). Completing or fulfilling the ideals of the motherhood myth and the satisfaction which comes from doing so are part of what keeps the myth perpetuated (McGoldrick et al., 1991; Douglas & Michaels, 2005).

Motherhood Mandates

Feminist scholars have noted the centrality of motherhood to women's identities, as noted by Russo's (1976) work regarding the motherhood mandate. The motherhood mandate exists as an internalized force within women to bear children, at least two children, and to raise them well. This force comes from a pervasive societal pressure regarding women's primary role and function being that of mother (Arendell, 2000). The motherhood mandate involves a socially sanctioned belief that all women should become "good" mothers in order to be successful in their female role (Mottarella, Fritzsche, Whitten & Bedsole, 2009).

According to the aforementioned NSFG report, the most commonly reported number of children *expected* among young women in 2006-2010 in the U.S. was two children. Roughly two out of five women surveyed *expect* to have a total of two children. About one in four women expects to have a total three children (Martinez et al., 2012). This is an example of the internalized force many women feel regarding having children as well as the expectation to have a certain number of children. Some scholars suggest that the role of motherhood is salient to woman's development (Douglas & Michaels, 2005). From a feminist perspective, the notion that women's worth and sense of self-concept is or should be based on one's ability to produce a live, biological child is steeped in oppressive subordination (Osmond & Thorne, 2009). However, the mandate and expectation to become a mother, as Russo (1976) describes, is socially prescribed and socially reinforced. Liss, Schiffrin and Rizzo (2012) examined self-reported levels of

maternal guilt and shame and confirmed Rotkirch's earlier findings (2009) which reported that internalized notions of ideal mothering and the mandate to become a mother were implicated as major sources of guilt and shame for mothers.

Motherhood Tax

These motherhood myths and mandates factor into the context of women of AMA and miscarriage on many levels and resonate with the idea of the “motherhood tax,” or the total economic and career advancement losses endured for leaving the workforce, even briefly, to raise children (Blades & Rowe-Finkbeiner, 2006). Some social scientists have pointed out that the gendered wage penalty has declined over recent decades and have suggested that wage gaps exist primarily between those people who have children versus those who remain childfree (Polachek, 2006). Though there may be plenty of research to support the notion of the “family wage gap” it is necessary to note that women, by in large, are still tasked with the majority of childcare, even those women employed outside of the home (Gangl & Ziefle, 2009). Gangl and Ziefle (2009) reported in their study of motherhood and the wage penalty in Britain, Germany and the U.S., that mothers who are employed in the public sector experience a 9% to 18% per child wage loss when compared to their childfree male and female counterparts. Women are still being taxed for completing their traditional caregiving role as mothers (Crittenden, 2010). The American economic culture needs to shift away from a “mother taxing” employment structure and must stop penalizing women for having babies during their younger, more optimal childbearing years, when the risk of miscarriage is lower (Hewlett, 2002).

Medicalization of Women's Bodies and of Miscarriage

When a woman experiences a miscarriage, traditional medicalization of the experience may minimize the miscarriage or in some cases create a climate of blame, in which the woman

may feel responsible for the fetal outcome (Reagan, 2003). In many ways the terms used by the medical field when describing conception and subsequent loss categorize miscarriage as a *less than* form of loss. A culture of silence, dismissal and minimization within the medical field is evident by the way in which “what is” and “what is no longer” is conceptualized (Layne, 2003b). Some commonly used terms within the medical field relating to conception and subsequent miscarriage are: spontaneous abortion, missed abortion, habitual aborters, late abortion or premature fetus, evacuation of the remaining products of conception (ERPC), dilation and curettage (D&C), threatened miscarriage, recurrent miscarriage, and chemical pregnancy. Nowhere in the medical jargon is there ever mention of *the baby* which was expected. Even the term miscarriage, which is presumably less stigmatizing than the term spontaneous abortion, propagates a sense of mother blaming. To mis-carry implies a mother’s failing to carry a baby to term and live birth (Cosgrove, 2004). Feminist scholars have long seen the medicalization of miscarriage as a means of disparaging women (Gerodetti & Mottier, 2009; Layne, 2006; McCreight, 2008; Paton et al., 1999; Zucker, 1999). Miscarriage is desensitized and minimized, as it is often viewed as medically boring since it cannot be fixed and is rarely life threatening for the woman (Layne, 1997).

Social Contexts

Societal Silencing and Disenfranchisement of Grief with Miscarriage

October is annually observed as Pregnancy and Infant Loss Awareness Month in the United States since October 25, 1988 when then-President Ronald Reagan signed proclamation 5890, acknowledging the losses so many experience during pregnancy and shortly after birth. October 15th is recognized as National Pregnancy and Infant Loss Remembrance Day (PAILRD), since congress passed H. CON. RES. 222 on September 28, 2006. To date, all 50 states have

yearly proclamations of the October 15th PAILRD, symbolized by the 7:00 PM candle lighting by those who honor and recognize the babies who have died during pregnancy or shortly after birth.

Despite these recognition efforts, there is still a noticeable silence around the issue of miscarriage, as people simply do not want to discuss it (Lang et al., 2011). There is a dubious cultural exclusivity among those who have suffered a miscarriage, stillbirth or neonatal death. There exists a notable distinction among women; those who are within the group of women who have experienced a pregnancy loss and those who are not within that group. Capitulo (2004) conducted a qualitative study of the culture of an online perinatal loss group. She described the participants as having a shared metamorphosis, with their loss having forever changed them and their grief connecting them to others who have had a perinatal loss, although they otherwise would likely have never met. In her book *Motherhood Lost*, Layne (2003a) references Marty Heilberg's (2001) experience of an ectopic pregnancy and her sense of being out of place, with the pregnancy literally being out of place (e.g. not within the uterus) and the feeling of being out of place within a culture which loves pregnant women, though only when the pregnancy works.

Until recently, there were no sympathy cards regarding miscarriage or stillbirth in the greeting card aisle in retail stores. Few, if any employers would recognize days off from work after a miscarriage as bereavement days, but rather as sick days (Geller, Psaros & Kornfield, 2010; Layne, 2003a). Essentially, the silencing of miscarriage at the public or societal level comes down to a nonexistent social script for how to discuss and behave in such situations (Layne, 2003a). Society has not been told adequately how to adjust to and meet women where they are in their experience of miscarriage. As a result of the absent social script for

acknowledging loss and grief with miscarriage, it goes largely unattended, as though it never happened (Walsh & McGoldrick, 2004).

The social denial of miscarriage and the psychological sequelae of grief, depression and despair many women feel after a miscarriage have a profound effect on those who experience such a loss (Lang et al., 2011). There is general consensus in the scientific, empirical literature about the frequency of depressive symptoms following miscarriage (Barr & Cacciatore, 2008; Neugebauer et al., 1992; Shreffler et al., 2011; Woods-Giscombé, Lobel & Crandell, 2010). In an analysis of the quantitative data regarding psychological distress following miscarriage, Slade (1994) reported that between 20-50% of women experience “significant depressive symptoms within the first month after a miscarriage.” In a more recent study, Klier, Geller and Ritsher (2002) found that in the first six months after a miscarriage, women are at increased risk for depressive symptoms.

Depressive symptoms as they relate to grief and bereavement were among the highly contested topics in the sometimes controversial Diagnostic and Statistical Manual of Mental Disorders (DSM) V debate. The current DSM is in its fifth edition, and there was considerable debate regarding the elimination of the “bereavement exclusion” for the diagnosis of a major depressive episode in the DSM IV. In the previous edition of the DSM, depressive symptoms persisting beyond two months after a loss event was deemed consistent with a major depressive episode, rather than as a normal grief response. Some work groups associated with the revision of the DSM IV had proposed extending the duration of depressed mood following a loss to six months rather than removing the “bereavement exclusion” all together (Zisook et al., 2012). Others suggested the addition of complicated grief as a diagnosis (Rando et al., 2012). The DSM debate regarding grief and depression following a loss serves as a social indicator of society’s

shift in thinking and talking about grief (Zisook et al., 2012). Although there is a slow shift toward a more socially acceptable dialogue around grief and loss, some forms of loss still remain relatively silenced, including miscarriage. When a miscarriage is silenced, so is the grief that follows. When the grieving individual is made to feel there is nothing to grieve, since it is socially unrecognized, the griever is then left feeling disenfranchised, stigmatized or alienated with her grief (Doka, 2002; Dubose, 1997; Lang et al., 2011).

Slade's (1994) research on the psychological effect of miscarriage found that over two-thirds of the women interviewed would have liked some form of follow-up care after being discharged from their doctor's care following a miscarriage. Despite this need, most hospitals and doctors' offices report no such follow-up care provisions following a miscarriage (Prettyman, Cordle & Cook, 2011). This is an unmet need for many women who experience a miscarriage and could address the link between miscarriage and disenfranchised grief.

Politicization of Miscarriage

Miscarriage is political (Layne, 2003b). Women's reproductive behaviors and the experience of miscarriage follows that old feminist adage of the "personal is political." That is, issues personal to women, topics regarding our reproduction, experiences of miscarriage and our bodies, all fall into categories of the political realm, the public realm. Issues personal to women must be negotiated within the oppressive structure of power relationships which women face in their everyday lives (Firestone & Koedt, 1970; Hanisch, 1970, 2009).

Feminist scholars face the dilemma of granting personhood to an embryo in the case of miscarriage and denying personhood in the case of elective abortion (Kevin, 2011; Rapp & Ritchie, 1997; Zucker, 1999). Perhaps the acknowledgement that there was something of value lost, and something worth grieving in a miscarriage, would thereby automatically grant

personhood to all embryos and fetuses (Parsons, 2010; Rapp & Ritchie, 1997). This is not the case, however, unless one accepts the anti-abortion view of personhood beginning at the moment of conception. If, on the other hand, one accepts the view that personhood is culturally constructed, and personally constructed, then one can see that the process of constructing personhood may be undertaken with some embryos and not with others (Layne, 1997; Parsons, 2010). The cultural construction of personhood is an iterative process, one which continues through the course of a lifetime. During the course of a pregnancy (and even before conception occurs) one may begin to establish a relationship with a wished-for child. For many women the child *begins* when the decision is made to bear it. When a woman decides to become pregnant, her wanted child begins to exist. Of course, this is not always the case even for desired pregnancies (Layne, 2003b; Peel & Cain, 2012; Zucker, 1999). This heated, societal politicization of miscarriage in no way attends to the needs of women who suffer a miscarriage.

Relational Contexts

Lacking Acknowledgement of the Loss from Family, Friends and Co-workers

There is a public or societal silencing and minimization of women's experience of miscarriage (Hazen, 2006). The existing literature, from various disciplines, indicates that there is a general lack of formal procedures for medical care providers when tending to women who have experienced a miscarriage (Layne, 2006; Paton et al, 1999). That does not however explain the silencing and minimization of a women's miscarriage from family, friends and co-workers.

Researchers who have examined the emotional response of women following a miscarriage found that participants consistently reported the need to have someone to talk to about their loss (Callister, 2006; Côté-Arsenault, 2003; Engelhard, van den Hout & Vlaeyen, 2003; Geller et al., 2010). Additionally, Layne (2003b) reported in her research of miscarriage

support groups that one of the primary complaints voiced by women who had experienced a miscarriage was their family, friend and co-workers' dismissive behavior toward their loss. Layne (2003b) reported that miscarriage support group participants often described family, friends and co-workers who pretended that nothing had ever happened following their miscarriage. Most women who suffer a miscarriage report feeling minimized in their miscarriage experience, while simultaneously being inundated with news of others' pregnancies (Hazen, 2003). The idea of having just miscarried one's own baby only to hear endlessly about someone else's pregnancy can create a degree of pregnancy envy and resentment towards pregnant others (Layne, 2003a).

Individual Contexts

Self-blaming

Inherent to the experience of miscarriage is the reminder of the lack in control over one's body and ability to carry a pregnancy to live birth. As previously noted, in the majority of cases, the cause of miscarriage can only be speculated at best, and is typically not definitive. Without a clear answer as to why the miscarriage occurred, many women fill in the unclear causation with self-blame (Barr & Cacciatore, 2008). As previously mentioned, it is generally understood within the medical community that the majority of miscarriages are the result of random chromosomal abnormalities, a non-inherited, non-disjunctional event (Rai & Regan, 2006). Most miscarriages are due to a genetic abnormality from within the fertilized egg itself; due to a failure of chromosome pairs to separate during meiosis, and not that of an inherited sort, contributed by either parent (Garmel, 2002). Yet many women when interviewed admit to feeling some degree of self-blame for their miscarriage and believe the loss could be related to something ingested such as caffeine, tobacco, early pregnancy alcohol consumption, over-the-counter pain

medications, or over-exertion from exercise or sexual activity (Stirtzinger, Robinson, Stewart & Ralevski, 1999). A pregnancy that ends in miscarriage can be perceived as a woman's failing in her primary role, to produce a child. This sense of failure and self-blame following a miscarriage results in a lowered self-image (Cosgrove, 2004; Janssen, Cuisinier, Hoogduin & de Graauw, 1996; Layne, 2006).

Temporal Contexts

Miscarrying at an Advanced Maternal Age versus at a Younger Maternal Age

As previously noted, there is a trend among U.S. women aged 35 and older to choose to delay motherhood (Arendell, 2000). Medical literature generally considers women 35 years of age and older to be of advanced maternal age. Though much has been written in the medical community regarding delayed motherhood and the rates and risk factors for miscarriage at various maternal ages, very little research has been conducted on the specific age-related experience for women who miscarry at an AMA (Anderson et al., 2000; Lerner, 2003). Many feminist scholars have examined women's experience of miscarriage, though little attention has been paid exclusively to women of AMA and their unique circumstance (Heffner, 2004).

Although motherhood at an AMA is on the rise (Anderson et al., 2000; Byrom, 2004) age cohort centrism should not be assumed. Overall, there are still far fewer women engaging in reproductive activities at an AMA than those at younger reproductive ages, which means there are fewer age specific cohort supports for women who miscarry at an AMA. Therefore, those women of AMA who do miscarry are likely to suffer their loss in isolation due to the relatively small percentage of procreating women in their age group (Garrison et al., 1997; Kazaryants, 2009; Layne, 2003b; Schardt, 2005).

Though it has been noted that the socially constructed notion of the idealized status of motherhood as a role full of endless rewards is in essence a myth, one cannot dismiss the developmental appropriateness of desiring motherhood. Among women of AMA, the feeling that the time for becoming a parent is running out can engender a heightened sense of urgency and longing for entrance into motherhood (Kazaryants, 2009; Lemme, 2006; McGoldrick, 1999; Schardt, 2005). There is something of a biological self-esteem associated with meeting the developmental task of entering into adulthood via motherhood (Bergston & Allen, 2009).

Summary

Gaps persist within the current literature on the experience of miscarriage among women of AMA. It is important to conduct research that is relevant. It is equally important to conduct research that is qualitative in nature in order to gain understanding of the experience and essence of miscarriage at an AMA. Gaining a better understanding of the ambiguous losses that women experience with miscarriage at an AMA, the oppressive and silenced nature of women's experience, and the contextual factors that situate the miscarriage experience can aid professionals in better addressing the needs of women.

Chapter Three: Research Methods

Rationale for Qualitative Methodology

Quantitative research is based, in part, on testing hypotheses through the use of statistical data analysis, and evaluating variable change as measured by assessments. The quantitative research paradigm falls within the realm of the positivist tradition, assuming that knowledge derived from a sensory experience produces one valid truth, often substantiated by scientific and mathematical evidence (Kazdin, 2003). Among many scholars and scientists, quantitative research is the dominant research paradigm and is largely associated with the rise of evidence-based practices (EBP). The burgeoning literature on evidence-based practice and the reliance on randomized clinical trials is the gold standard of EBP inquiry (Haverkamp & Young, 2007; Sandelowski, 2004). However, excluding qualitative evidence completely ignores certain forms and sources of evidence, failing to present a complete picture of the experience (Sandelowski, 2004).

It is important to note that qualitative research is an empirical approach in its own right; and though it is not a new paradigm, it is gaining more support and attention by various scientific disciplines (Kazdin, 2003). The qualitative researcher pursues a constructivist approach or research paradigm wherein multiple meanings and multiple truths exist, and interpretations and subjective experiences exist within a shared phenomenon (Denzin & Lincoln, 1998, 2005; Greenstein, 2006). Following from the notion of a constructivist approach, qualitative studies value context and meaning (Marshall & Rossman, 2010). Understanding the meanings that women assign to their experience is the primary rationale for using a qualitative means of inquiry to address the research questions of this study. Because deep, thick, and rich descriptions of thoughts, feelings, beliefs, values, meanings, and assumptions are involved with women's

experience of miscarriage, the researcher must understand the deeper perspectives that can be captured through in-depth, one-on-one qualitative interviews.

Phenomenology

The theoretical background or rooting of phenomenology is based in the discipline of philosophy. Edmund Husserl, the late 19th century philosopher, wrote about the issues of how objects, actions and events appear in the consciousness of the observer (Moustakas, 1994). Consciousness is a core concept of phenomenology and relates to how experiences are consciously perceived (Daly, 2007; Moustakas, 1994). Phenomenology is a *science of science*, rooted in an epistemology of how individuals subjectively assign meaning to objects of their consciousness (Moustakas, 1994). Phenomenology is concerned with the conscious, though often taken-for granted, ways of knowing and experiencing everyday life (Creswell, 2007).

Given the philosophical focus and interest in understanding the mind, awareness and consciousness, phenomenology as a specific qualitative method of inquiry is well suited for psychological research (Giorgi & Giorgi, 2003; Starks & Trinidad, 2007). Phenomenology is also well suited for family therapy research (Daly, 2007). Phenomenology privileges individuals' lived experience. Increased understanding of the experience of women of AMA who suffer a miscarriage is essential to establishing higher standards of care as helping professionals, in both medical and mental health care. As already noted, the medical community has brought forth a great deal of research regarding the biological aspects, risks and rates related to miscarriage. However, our culture of silencing women's voices, particularly regarding the loss experience with miscarriage, has contributed to the dearth of literature on the true essence of the experience. To address the lack of understanding of women's experience of miscarriage at an AMA, a transcendental phenomenological approach is appropriate to narrate the structure and essence of

the shared experience of participants who have suffered a miscarriage. An advantage of transcendental phenomenology, as a qualitative method, is that it takes into consideration the researcher's own personal experience combined with the experience of the participants (Marshall & Rossman, 2010; Moustakas, 1994; Starks & Trinidad, 2007).

Sampling Procedures

In phenomenological research it is essential that all participants have experience of the phenomenon being studied (Creswell, 2007). With "criterion sampling," the essential participant criteria include: the participant has experienced the phenomenon, is intensely interested in understanding its nature and meaning, is willing to participate in a lengthy interview and grants the researcher the right to audio or video record the interview and to publish the data in a dissertation or other publication (Moustakas, 1994).

Participant Recruitment and Selection Criteria

A site-based, purposeful, criterion sampling method of recruitment was utilized; sites of recruitment and participants were selected based on the idea that they could purposefully inform an understanding of the research question and the phenomenon in this study. I made use of the snowball sampling method, whereby existing participants acted as key informants and assisted in recruiting additional participants. This "word of mouth" form of recruitment accounted for the majority of participants enrolled in this study. In addition, recruitment flyers (see Appendix B) were placed in local obstetrical and gynecological medical offices and reproductive/fertility specialists offices in the Northeast Ohio region. An additional method of recruitment included provision of my recruitment flyer to a local grief counseling center, to a local hospital based pregnancy loss support group facilitator, and to a local infertility support group facilitator. One final method of recruitment entailed uploading my electronic recruitment flyer onto an on-line,

closed (private, members only) group or message board page on the Facebook social networking site for women who have experienced a miscarriage, stillbirth, or neonatal loss. Being a member of the closed Facebook group for women who have experienced a miscarriage, stillbirth or neonatal loss afforded me a degree of site entry and researcher trustworthiness while at the same time blurred the social media networking boundaries. I was always cognizant of the benefits as well as the complications of being an insider to a group to which the potential participants belonged. The ethical obligation for me was to make clear my role as a researcher within the context of soliciting participants from a group to which I am an insider. Additionally, it was of paramount concern for me to make sure that each participant recruited from the closed Facebook group be assured of the confidentiality which would be maintained during and after their participation in this study.

Potential participants made contact with me through my contact information made available on the recruitment flyer. Once potential participants expressed an interest in participating in the study, I responded to the interested party through the same means by which they had contacted me. Potential participants were provided information regarding the purpose of the study, information regarding the confidential nature of the study, and information regarding the types of probing questions that may be asked by me in order to meet the goals for this study. Potential participants were informed of the possibility of an emotional response following the telling of their story of miscarriage. Potential participants were informed that should they request it, I would provide a list of local therapeutic support resources. Potential participants also were informed of the necessity for audio recording the interview and were provided with general information regarding the informed consent requirement for participation in the study. Potential participants were made aware of the rights and protections afforded to them under the laws

governing the Michigan State University Institutional Review Board (IRB). Potential participants were informed of the voluntary nature of the study and their right to withdraw from the study at any time without penalty. Finally, potential participants were made aware of the measures that would be taken to ensure their privacy and confidentiality. These measures were maintained at all times and will continue to be maintained through the use of a locked filing cabinet in my home, the use of participant code numbers and fictive participant names in place of real names, and the use of password protected electronic files of the transcribed interviews.

After the full disclosure of the nature and purpose of this study to each potential participant, I screened each potential participant for goodness of fit for participation in the study. The general considerations for selecting the research participants included: research participant was English speaking, had experienced a miscarriage within the past two years, the loss occurred at age 35 years of age or older, the participant was interested in understanding the nature and meaning of her miscarriage experience, was willing to participate in a lengthy interview, and granted me the right to audio record the interview and publish the data in a dissertation and other publications. Once the participant was selected for inclusion in the study, the interview was scheduled and took place at a mutually agreed upon location.

The goal for this study was to obtain 10 participants to engage in an in-depth interview, an ecomap activity and to complete a brief demographic questionnaire. Prior to the start of the interview, I explained in greater detail the logistics of the interview process. Participants were provided with the informed consent form (see Appendix C). The informed consent form was explained and each participant was reminded of the voluntary nature of their participation. Upon signing consent to participate the interview began. Following the interview, ecomap activity and

demographic questionnaire completion, the participant was given a \$25 gift card as a token of appreciation.

Sample Description

The participants included 10 women who fit the aforementioned criteria. General demographic information was gathered from each participant through the use of a basic demographic questionnaire (see Appendix D). The participant demographic overview shown below (Table 3.1) provides an overall description of the study participants as a group. The average age of the women in this study was 40.8 years old, with the participants ranging in age from 35 – 47 years. All of the participants were married, with an average length of marriage for these women being 10.1 years. The participants years married ranged from 1.75 – 20 years.

In terms of participant educational attainment, the participants were all well educated women. Each participant had completed a college degree, while four of the participants in this study also held graduate degrees.

In terms of participant income level, over half of the participants reported that their annual family income was over \$100,000. Three of the participants reported that their annual family income was from \$70,000 to \$100,000, and one participant reported her annual family income ranged from \$60,000 to \$69,000.

As for work status, five of the participants in this study reported not currently working outside of the home. One participant indicated working part-time. Four of the participants reported working full-time.

Nine of the participants in this study were Caucasian with one participant being Mexican American.

Table 3.1 Participant Demographic Overview

Participant	Age	Marital Status	Years Married	Highest Level of Education Completed	Total Annual Family Income	Work Status	Race/Ethnicity
001	40	Married	3	Graduate school	Over \$100,000	Full-time	Caucasian
002	40	Married	16	College degree completion	Over \$100,000	Not employed outside of the home	Caucasian
003	38	Married	13	Graduate school	Over \$100,000	Not employed outside of the home	Caucasian
004	43	Married	13	Graduate school	Over \$100,000	Not employed outside of the home	Caucasian
005	43	Married	16	College degree completion	\$70,000-\$100,000	Full-time	Caucasian
006	35	Married	5	College degree completion	\$70,000-\$100,000	Part-time	Caucasian
007	39	Married	8	Graduate school	Over \$100,000	Not employed outside of the home	Caucasian
008	45	Married	20	College degree completion	\$70,000-\$100,000	Full-time	Caucasian
009	47	Married	1.75	College degree completion	Over \$100,000	Full-time	Caucasian
010	38	Married	6	Graduate school	\$60,000-\$69,000	Not employed outside of the home	Mexican American

Method of Inquiry

Phenomenological Researcher as Instrument and the Use of Epoche

In qualitative research, specifically with phenomenological research, evidence is derived from first-person reports of lived experiences (Moustakas, 1994). According to transcendental phenomenological principles, a scientific investigation is considered valid when the knowledge pursued is reached through descriptions that make possible an understanding of the absolute meaning and essences of an experience. In order to derive new knowledge, it is imperative that the researcher, as the research instrument, embrace the process of bracketing, or what Husserl (1931, 1970) calls *epoche*. Epoche refers to the researcher's very disciplined and systematic process of setting aside prejudices regarding the phenomenon being investigated, and meeting the participant and the research interview with an unbiased, fresh, receptive presence (Moustakas, 1994). Prior to engaging in the participant interview, I engaged in epoche by attempting to balance the notions of myself as the research instrument and myself as having a personal connection to and passion for exploring miscarriage. Many of the personal attributes to which the phenomenological researcher is seeking to bracket are the same attributes that pique the researcher's interest and passion for the phenomenon of interest. The negotiation of the self of the researcher and epoche efforts are balanced by what Moustakas (1994) describes as the researcher's "brief creative close," setting down the personal connection to the phenomenon in order to receive the participant's description of the phenomenon.

Feminist Fieldworker

Feminist analysis, generally, seeks to give voice to the experience of individuals and/or groups who have been historically silenced and oppressed (Kleinman, 2007). As a feminist field

worker, an overarching objective for this study was to strike a balance between reporting the participant's voices without exploiting the participant or her experience. It was imperative then to avoid attempting to derive a coherent or unified voice – as women and their experiences are all different (Lather, 1991; Olesen, 2005). Rather, it was my goal to find commonalities and address issues of epistemology and women's ways of knowing about their experience of miscarriage (Marshall & Rossman, 2010). A feminist informed phenomenological approach acknowledges that grief and loss with miscarriage are universally experienced, though *how* the grief, loss and miscarriage are experienced is deeply personal and unique to each woman.

In-depth Interviews

The nature of this study was to address the research question; “How do women of advanced maternal age perceive and describe their experience of miscarriage?” Thus in-depth, one-on-one interviews were conducted as a means of collecting data on that topic. The phenomenological interview involved an informal, interactive process, utilizing open-ended comments and questions. An interview guide (see Appendix E) was constructed and aimed to evoke a comprehensive account of each participant's experience of the phenomenon of miscarriage in the event that the participant was lacking thick description and/or depth when sharing her full story.

Interview Process

The phenomenological interview process begins with epoche; my own bracketing, or suspending (setting aside) any and all prejudgments about reality and consciousness in order to prepare for seeing and experiencing reality as the participant described it to me. My epoche or bracketing efforts began by engaging in pre-interview memo writing as a means of revealing my thoughts and feelings going into each interview. I spent 10-20 minutes before each participant

interview writing down my thoughts, feelings, and assumptions about the impending interview as a method of releasing these thoughts, feelings and assumptions. As previously mentioned, specific to phenomenology, this preparatory step of blocking all researcher biases and assumptions in order to describe and explain a phenomenon in terms of the participant is known as epoche (Creswell, 2007; Matthews, 2005). In this way, I attempted to set aside my own personal experiences (which cannot be done entirely) so that the focus could be drawn to the participants in the study.

Six of the 10 participant interviews were conducted at a mutually agreed upon, casual dining establishment. The other four participant interviews were conducted in the participant's home. The phenomenological interview began with an engaging social conversation aimed at creating a relaxed and trusting atmosphere (Creswell, 2007; Groenewald, 2004). Following this relaxed opening, I explained the rationale and direction for completing the ecomap activity as it pertained to her experience of miscarriage. I asked each participant to think about her miscarriage experience and to complete the ecomap activity. The ecomap provided an opening for a conversation about each participant's experience. Following the completion of the ecomap activity I asked each participant to take a few moments to focus on her experience of miscarriage, moments of particular awareness, and then to describe the experience of miscarriage fully. The researcher is responsible for creating the climate for which the participant will feel comfortable to respond honestly and comprehensively (Moustakas, 1994). Each interview continued until the participant felt she had shared all that she wanted. Table 3.2 (shown below) illustrates the theory informed areas of inquiry that were sought for the interview process. Once the interview had ended and the participant and I had parted ways, I again engaged in a 10-20 minute memo writing session to release my thoughts, feelings, and any assumptions I held about

the interview, and the participant. The participant interviews averaged a length of 63 minutes, with the interviews ranging from 39 – 108 minutes in length. Each audio-taped interview file was sent to a professional transcription service company to be transcribed into an electronic, verbatim MS WORD document.

Table 3.2 Interview Areas of Inquiry

Topical Context	Conceptual Areas of Inquiry
Cultural Context (Macrosystem)	○ Dimensions, incidents and people intimately connected with the experience which stand out for the participant
Social Context (Exosystem)	○ How the experience affected significant others in the participant's life
Relational Context (Mesosystem)	○ How did significant others affect the participant relative to the experience
Individual Context (Microsystem)	○ Feelings generated by the experience ○ Cognitions (thoughts) generated by the experience
Temporal Context (Chronosystem)	○ Changes in bodily state of participant during experience
○ Anything else the participant feels is significant related to the experience	

Ecomap

As previously mentioned, I asked each participant to complete an ecomap activity, as an additional source of data gathering (see Appendix F). Following the overarching Human Ecological Theory framework for this study, an ecomap is a graphic representation of all of the systems affecting an individual's life and experience (Hartman, 1995). Developed by Hartman in 1978, the concept of an ecomap was introduced as a therapeutic tool for diagramming different systems operating on and within an individual's life and for evaluating systemic relationship qualities. The aim of the ecomap activity was to open up the discourse regarding the unique qualities of each participant's miscarriage experience, and to reveal sources of support and

sources of stress to the participant surrounding the time of her miscarriage experience. All of the information gathered from each participant ecomap was used to further develop the themes of the study and to inform the individual textural and structural descriptions of each participant. In this study, the ecomap activity had limited usefulness, serving primarily as a researcher – participant joining activity and as a tool for opening up the dialogue at the start of the participant interview.

Demographic Questionnaire

A basic demographic questionnaire (see Appendix D) was given after the in-depth, one-on-one interview in order to gather data pertaining to age, marital status, educational attainment, income, work status, and race/ethnicity. The qualitative demographic information was gathered in an attempt to gain greater understanding of the context of the individuals and follows the basic assumptions of the human ecological theoretical underpinnings, which help to guide this study. Taken as a whole, the sample demographic data helps to provide an overall description of the study participants as a group, those who have had a shared experience of miscarriage at an AMA. In a qualitative study, demographic data places an emphasis on social representativeness rather than statistical representativeness (Gobo, 2004). Participant demographic data lends itself to the transferability of the results of the study to other similar situations or settings (Lincoln & Guba, 1985).

Data Analysis

In phenomenology, there is a specific, structured method of analysis advanced by Moustakas (1994) which is a modification of the Stevick-Colaizzi-Keen method of phenomenological data analysis (Creswell, 2007). Just as I had done before and after each interview, prior to engaging in any data analysis activities, I engaged in a brief reflective moment, attempting to reach a place of unbiased, receptive presence.

The combined participant interviews resulted in 630 minutes of audio-recorded researcher and participant dialogue. The 10 audio-recorded interviews were transcribed verbatim and resulted in 227 single-spaced MS WORD document pages. Those interview transcripts were uploaded into the *NVivo* qualitative research computer software platform (version 8.0; QSR International Propriety Limited, 2010). *NVivo* was used to handle and reduce the data extracted from the 10 interview transcripts. As each participant interview transcript was read and re-read along with data gleaned from each participant ecomap, significant statements were considered for relevance with respect to description of the experience of miscarriage and were grouped in a list and were identified as invariant horizons. Included in the list were those statements that were thick with descriptive verbiage about how the participant experienced her miscarriage. Next, a recursive process of screening each horizon for containment of a descriptor of experience was conducted as well as a check for the ability to name or label the descriptor of experience. Any repetitive, over-lapping horizon was removed from the list. Each of the non-repetitive, non-overlapping significant statements were treated as having equal worth and value; these statements were categorized as the final list of invariant horizons of the experience of miscarriage. A total of 376 invariant horizons of experience were identified from the 10 interview transcripts. While reducing the data into invariant horizons, similar participant attributes of experience were noted across all 10 participant interviews, thus data saturation was achieved.

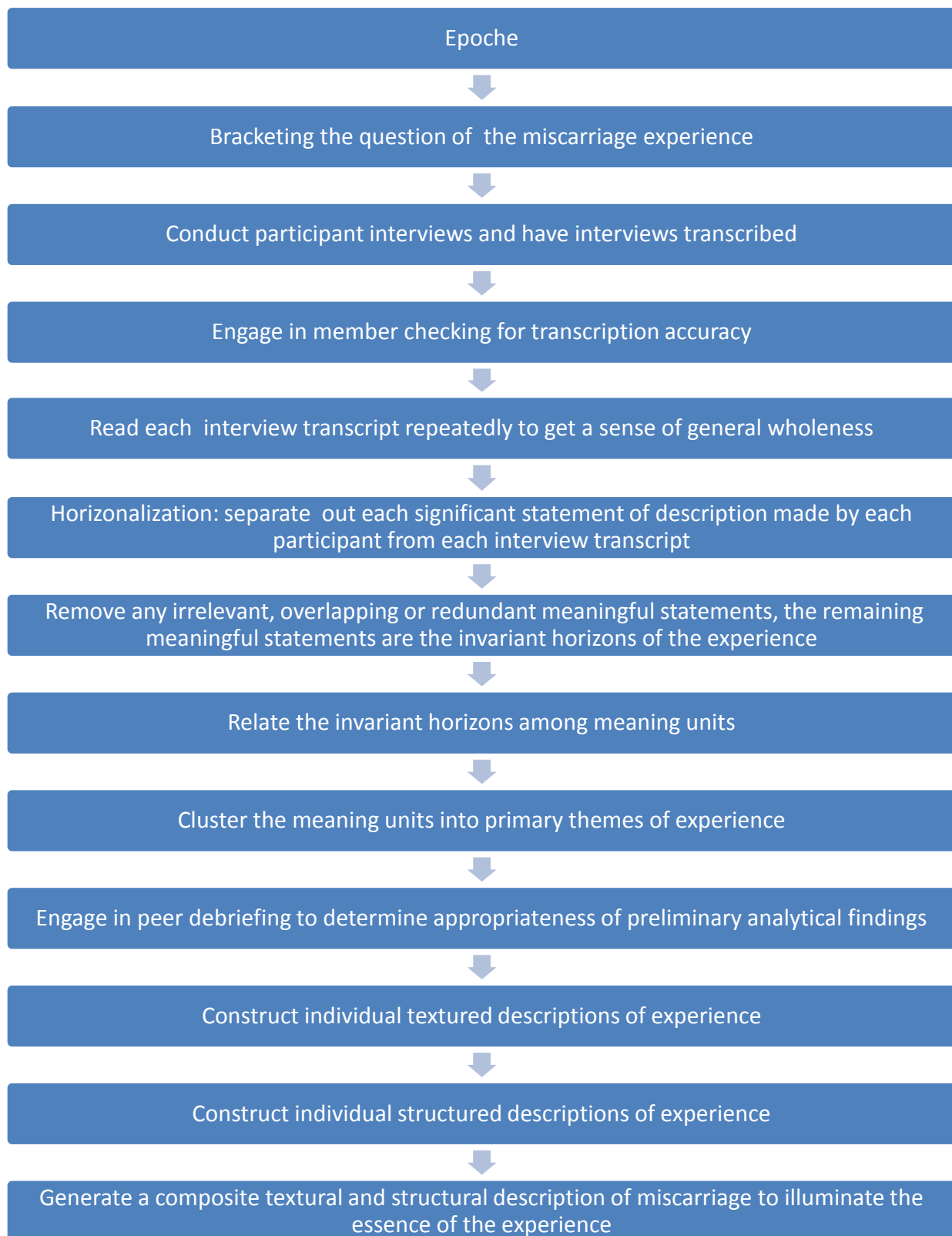
To engage in further phenomenological reduction, the invariant horizons across all 10 participant transcripts were related and categorized into 24 meaning units. The meaning units represent the highlights of the experience of miscarriage among women of AMA. Four primary themes were derived from the 24 meaning units. A synthesis of meaning units and themes was

used to create a textural description of the experience of miscarriage for each participant.

Verbatim participant quotes and examples describing the texture of the experience illustrated the “what” of the experience, i.e. the physical aspect of what happened.

Based on my personal experience with miscarriage, using imaginative variation along with the textured description of each participant’s experience, a structural description of the experience of miscarriage was developed for each participant. Imaginative variation is generally regarded as a process of abstraction; attempting to make the invisible visible. The process of imaginative variation involves contemplating and considering every possible, imagined aspect (time, space, bodily concern, materiality, causality, and relationship to self and to others) of experience and of the feelings associated with the experience. For example, through the process of imaginative variation, I imagined the possible positive aspects of miscarrying, having the pregnancy end sooner, rather than later. Does having to cope with the loss of one’s pregnancy early on change the grief experience? Systematically, all varying possibilities of the meaning associated with each participant’s experience were considered for additional structural and descriptive verbiage of the experience of miscarriage. The structural description of experience tells the “how” of the experience, i.e. the feelings and beliefs about what happened. A combining of each participant’s textural and structural descriptions together develops a group or composite description of the experience and represents the essence of the experience of miscarriage at an AMA. The flow chart below (Figure 3.1) gives a pictorial representation of the data analysis procedures.

Figure 3.1 Data Analysis Flow Chart



Trustworthiness

The soundness or validity of any qualitative study is of paramount concern given that some scientific disciplines privilege positivist, quantitative research paradigms. There are various ways of establishing the validity, or trustworthiness, of a qualitative study. Some terms regarding credibility have been borrowed from the world of quantitative research such as validity, reliability, and generalizability and have been replaced in qualitative research by terms such as credibility, dependability, and transferability. Lincoln and Guba (1985) established ways to ensure that standards of trustworthiness are met within the realm of qualitative research. To ensure the trustworthiness of this study I enlisted the following procedures of qualitative research rigor: triangulation, development of an audit trail, searching for alternative explanations, peer debriefing, member checking, and researcher reflexivity.

Data collected for this study were triangulated by the use of multiple theoretical perspectives rather than just one theoretical model. For this study, the phenomenon of miscarriage at an AMA is conceptualized through the lens of human ecological theory, ambiguous loss theory, and feminist theory. Additionally, having 10 participants or informants report on the same phenomenon (i.e. miscarriage at an advance maternal age) is another form of triangulation. Finally, an added measure of triangulation was accomplished through the use of multiple data sources. Data were collected through the use of in-depth, one-on-one interviews as well as through the use of demographic questionnaires and participant ecomaps. Triangulation enhances the research finding's generalizability or transferability (Creswell, 2007; Marshall & Rossman, 2010).

An audit trail was maintained and kept up-to-date at all times throughout this study. An audit trail consists of a transparent way to show how the data were collected and managed. The

purpose of this method of tracking data collecting through the use of an audit trail is to account for all of the data collected and for all study design decisions made in the field, as a means of tracing the logic of the study (Lincoln & Guba, 1985; Marshall & Rossman, 2010). The audit trail outlines the research process as well as the evolution of transcript data codes, invariant horizons, meaning units, themes, and essences (Creswell, 2007; Matthews, 2005). The audit trail for this study consists of chronological entries of research activities regarding my participant recruitment activities, my entry into the field, the interviewing process, data reduction activities, and the final description of essence.

Peer review or debriefing in qualitative research is used as a means of external review and challenging of the research process. Peer debriefing forces the researcher to justify her study methods, and the meanings and interpretations assigned to the collected data (Creswell, 2007). For this study, Dr. Marsha Carolan acted as a peer reviewer with debriefing sessions at the point in time when I was engaged in data analysis activities. The goal of the late stage analysis debriefing sessions is to assess researcher and peer agreement or congruence of interpretation when viewing the analytic methods and findings (Lincoln & Guba, 1985). Dr. Carolan and I engaged in extended communications regarding my organization and reduction of the data. She read through raw transcript data and initial and revised significant statement grouping charts. Dr. Carolan's peer debriefing efforts helped me to better develop connections between the themes and essences derived from the data. She questioned some aspects of my approach to data reduction and offered her own reflections regarding my analysis and final reporting.

I also employed member (or participant) checking. This also operates on the notion of confirming credibility of the study findings and interpretations by soliciting participants' views of the accuracy of the researcher's account of the data (Creswell, 2007; Lincoln & Guba, 1985). I

provided each of the 10 participants with a 2-3 page transcript excerpt as a means of soliciting participant feedback regarding transcription accuracy and any additional participant insights. Five of the 10 participants responded to the request for transcript accuracy. Of those five who responded to the request for transcription checking, all five responded positively to the accuracy of the transcription of our interview.

Finally, throughout this study I engaged in ongoing efforts to monitor my own biases, assumptions, preferences, prejudices, and values by taking part in a conscious reflexive effort. Researcher reflexivity is critical and is at the center of qualitative research (Daly, 2007). Since qualitative research relies on the self of the researcher as the instrument of the research, reflexive efforts are of great importance in attending to the ethics of doing good qualitative research (Lincoln & Guba, 1985). It is through researcher reflexive actions that the qualitative researcher acknowledges and attempts to manage her own voice, own position of power and all of the self of the researcher attributes (researcher's own biases, assumptions, personal opinions and values, etc.) which can influence the overall study design and planned execution along with the participants and their experience of being interviewed (i.e. interview setting, interview questions asked) (Moustakas, 1990). Additionally, researcher reflexivity attends to the study's overall degree of trustworthiness, as reflexive practices create the space for the researcher to actively consider how her own age, race, gender, life experiences, biases, and ways of knowing influence how she hears, experiences, analyzes, understands and explains the participant interview data and study findings (Daly, 2007). Given the importance placed on researcher reflexivity activities, I actively paid attention to my own inner voice throughout all of the study activities. As previously noted, I created handwritten reflexive notes before and immediately after each

participant interview. Reflexive activities such as note taking complemented the bracketing or epoche activities which are requisite of this sort of phenomenological research.

Initial Researcher Reflexivity

As previously stated, researcher reflexivity requires the researcher to acknowledge and manage her personal biases, assumptions and values garnered through life experience.

Researcher biases are likely to influence the aims, direction and conclusions of a qualitative study (Matthews, 2005). In an attempt to manage biases, researchers must attempt to demonstrate that their life experiences do not bias the study by clearly stating their own personal biases as pertaining to the study constructs (Starks & Trinidad, 2007). Given the importance of researcher reflexivity, I will provide my personal reflexivity and biases.

My personal journey into motherhood has been shaped by my having had a miscarriage at age 35. Ironically, just six months before experiencing a miscarriage, I had become interested in the topic and had explored miscarriage and Ambiguous Loss Theory for my master's degree thesis. Between the births of my two sons, I became pregnant and had 8 weeks to fully attach to the idea of being pregnant again before learning through the use of a routine sonogram at my 10 week OB/GYN appointment that my baby had stopped growing at about 9 weeks gestation. I had had a "missed miscarriage" and endured a D&C procedure to remove the "products of conception," as it was termed on the hospital forms. As it happens, I became insider to the mother's group to which nobody wants to belong.

The emotionally painful experience of having gone through my own loss has fueled my passion and desire to explore other women's experience of miscarriage. After my miscarriage, all I wanted to do was to talk about it, but I found few people who wanted to discuss it with me. The silencing of women's loss experience and grief with miscarriage comes from society's general

discomfort with discussing death and dying in a meaningful way. The death of a baby is especially distressing because it goes against the natural course of life. As it is often referred, the death of an older person represents the loss of one's history with that person, but the loss of a baby represents the loss of one's future with that child. I would like to sit down and talk to any woman who has ever had a miscarriage. However, in keeping with the scope of this research project, I was satisfied with finding 10 women of AMA who had experienced a miscarriage and had a desire to talk about what they had lost.

Chapter Four: Analysis and Findings

The purpose of this study was to examine the lived experience of women who suffer a miscarriage at an AMA. It is hoped that the findings from this study will facilitate a better understanding of this population of women. A descriptive representation of each participant's pregnancy history is displayed in Table 4.1 (shown below). The purpose of this chapter is to present the salient findings that were garnered through analysis of 10 in-depth participant interviews. Table 4.2 (shown below) displays the final clustering of 24 meaning units into four primary themes derived from the participant interviews and ecomaps. First, I offer a sampling of quotations for the themes and sub-themes. Then I follow this with individualized textural and structural descriptions of each participant's experience. Finally, the four primary themes and the conceptualization of each participant's textural and structural descriptions were integrated into an overall "essence" of miscarriage at an AMA.

Table 4.1 Participant Pregnancy History Overview

Participant Pseudo Name & Number	Total Number of Miscarriages	Type of Miscarriage				Number of Neonatal Deaths	Number of Stillbirths	Time since most recent miscarriage	Number of Living Children	Reported Fertility Issues
		Early, Within First 13 weeks	Chemical Pregnancy	Ectopic Pregnancy	Late, between 13 and 20 weeks					
Stacey (001)	3	1		2		1		10 months	0	X
Joni (002)	1	1						1.5 months	5	
Penny (003)	1	1				1		24 months	3	
Rachele (004)	6	6					1	18 months	2	
Sharon (005)	2	2						24 months	0	X
Geri (006)	1		1				1	3 weeks	2	
Carmen (007)	5	4	1					19 months	2	X
Teri (008)	1	1						24 months	2	
Lacey (009)	3	2			1			9 months	0	X
Pamela (010)	3	3						1.5 months	1	

Primary Themes from the Findings

The 24 meaning units clustered into four themes shown in Table 4.2 reveals the findings from this study. The four primary themes are:

1. The Physical Context of the Experience
2. The Emotional Context of the Experience
3. The Temporal Context of the Experience
4. The Social Context of the Experience

These themes and meaning units (or sub-themes) are listed below in Table 4.2 and then follow as a narrative with examples from the voices of the participants.

Table 4.2 Meaning Units Clustered by Themes

	Themes			
	Physical Context of Experience	Emotional Context of Experience	Temporal Context of Experience	Social Context of Experience
Meaning Units	Unexpected Nature of Experience	Feelings of Grief and Loss	Age Specific Influence	Significance of Family and Friends
		Meaning of Pregnancy		
	Corporeal Experience	Meaning of Motherhood	Influence of Previous Losses	Experience Having an Influence on Relationships with Others
		Meaning of Miscarriage	Timing of Pregnancy Announcement	
	Issues Related to Infertility	Attachment to the Would-Be-Child	Loss of mother-to-be status	Influence of Medical Community
		Oscillation Between Having Hope and No Hope		
		Religious – Spiritual Aspect of Coping	Influence of Time Pass on Experience	Emotional Support Seeking Behavior
		Woman's Intuition Memories and Triggers		Gendered Differences with Grief and Loss Experience
		Regrets and Self-Blame Acts of Memorialization		

The Four Primary Themes and the Clustered Meaning Units

The primary themes from the interview and ecomap data were related to the physical, emotional, temporal and social aspects or contexts of the experience of miscarriage. The following discussion will provide the details that will explicate each theme and will authenticate the supporting meaning units that are clustered into each of the four themes. Quotes from the interview transcripts will illustrate the identified themes of the experience and will provide an understanding of the phenomenon of miscarriage experienced at an AMA. This chapter will privilege the participant's voices, using verbatim quotes whenever possible.

Theme One – Physical Context of Experience

Participants in this study described, in varying detail, the physical context of their miscarriage. Participants described the unexpected manner in which they became aware of their loss, with some participants miscarrying naturally though unaware of the imminence of the loss while others found out about their loss through blood analysis or by sonogram imagery. Upon discovering the loss, participants described various bodily aspects of their miscarriage experience, whereby some participants began to miscarry naturally on their own, while others required or elected to take medication to help the natural, biological processes along, and others were required or elected to have a D & C procedure. Participant experiences ranged from the chemical pregnancy, which typically manifests as a heavier than normal menstrual period, to the experience of labor pain and delivery.

Unexpected Nature of Experience

At some point, the miscarriage experience was unexpected for each of the participants. Although early blood analysis and sonogram imagery can indicate unfavorable viability odds, it is generally an unanticipated event when a pregnancy that had started suddenly stops.

Participants described a range in the degree of unexpectedness of their loss. Some participants only realized they were experiencing a miscarriage when bleeding and cramping began. For these participants the miscarriage was a complete shock. Others experienced the same level of unexpectedness when during a routine prenatal appointment it was revealed through sonogram imagery that their baby had died. Other participants had earlier indications of the probability of a loss through early blood analysis, though even for those participants their initial positive pregnancy test had already provided the basis for their belief that they were expecting a baby. Each of the participants described that moment, that instant when she was made aware that she was experiencing or would soon be experiencing a miscarriage. As one participant described, she was preparing herself for the inevitability of her miscarriage:

“And so those numbers, the Beta testing for pregnancy viability, they weren’t right and they [OB/GYN] told me it could pick up and be ok, but that it might not be ok. So, they were monitoring me and then yea, here at home, I have the doctor calling and telling me that’s what was probably happening, that I was probably having a miscarriage, with my numbers not where they should have been for the weeks’ gestation and all and then the terrible cramping starts and all the blood starts coming. It was terrible; my husband took the kids out for me so I could just be here at home...” – *Penny*

Similarly, another participant seemed to have a little forewarning that a miscarriage was probable as she stated:

“So I talked to my OB/GYN on that Friday and asked, ‘So what am I to do? Just wait? Are you saying I’m going to have a miscarriage?’ I asked her, ‘What do I do in the meantime? Am I pregnant?’ I just kept asking, ‘Am I pregnant?’ ‘Am I really pregnant? I don’t get this. How can you be half-assed pregnant? I don’t get it.’ But what could she say? And then I was thinking, what if this apparent chemical pregnancy does carry on into a pregnancy? But she really couldn’t answer those questions but she did say, ‘Don’t take any more tests. I want you to stop. You’re wasting your money.’ I think that was her way of saying – ‘You had a chemical pregnancy and it’s not viable.’” – *Geri*

One participant described the unexpected physicality of her miscarriage experience; she had only known that she was pregnant for just a few days before miscarrying. Not having had a chance to

share the news of the pregnancy with her husband, the miscarriage came as a complete shock to her husband:

“My husband was initially confused when I started to miscarry, he didn't even know I was pregnant. We were on a trip when it all started and it was hard for me to wrap my brain around what was happening once it started happening. I've never given birth vaginally and I didn't understand what the pain was and how the pain was really like, so much worse than I could have imagined. I was in the bathroom in the hotel, it was about two in the morning, the kids are there in the room and I didn't know what to do. So fast forward to about five in the morning and my husband woke up, he was coming to go to the bathroom and when he came in he could see that there was kind of a mess and so I told him and he hugged me and he was confused. He said, 'I don't understand, I don't understand' and so then I had to tell him and he was really hurt that I hadn't told him that I was pregnant.” – *Teri*

Conversely, one participant's miscarriage experience played out entirely within a hospital setting, where she had several agonizing hours of having to digest what was starting to happen:

“Everything started to seem fine then in the hospital. And then, I woke up Sunday and I'd got up to go to the restroom, and my water broke, and from that point on, it was just hell. Everything went downhill from there. They came in, and they checked me, and said I was dilating, and that there was a prolapsed cord. So, they did an ultrasound where we literally saw our daughter's heartbeat stop on the screen. She was the one that had the prolapsed cord. Our little boy was still alive and kicking, but they said, 'There's nothing to do at this point. You're only 19.5 weeks pregnant and not at viability. She needs to be delivered and he will more than likely come right afterwards.' So, it's all kinda a blur to me now, but I started contracting pretty heavily and she came. Her name was S. She was born, she was not alive when she was born, and she was 10 ounces and about nine inches long. My labor continued to progress after that, they had doped me up really well. I had all kinda pain medicine and part of me, now, is like, I think I had so much that it's a fog; I don't remember a lot. I was praying that our little boy would stay intact, but it just wasn't meant to be and he just kept moving down in the birth canal. His bag of water was bulging and the doctor said, 'There's just not anything we can do.' So, he broke the water, and then, he was born shortly after and he lived about two hours, we named him B. I think he was 9.5 ounces, and something like ten inches long.” – *Lacey*

In one case, the participant's retelling of her series of miscarriages underscored the often unpredictable nature of miscarriage as she stated:

“The first miscarriage I took a pill, and I just kinda went with it, ‘Okay, this is happening.’ And then the second miscarriage, it just happened naturally. And I mean, that was like labor, it was so awful and so was this last one. This last miscarriage we were at a wedding and I was in, well not really a Port-a-Potty but close to it, and I’m in there thinking like, ‘Oh my gosh, what do I do?’” – *Pamela*

Another participant described her fear of the unknown nature of miscarriage following her previous losses:

“The thought of pregnancy is just sheer terror. And, for us, each subsequent pregnancy just became another reason to be afraid. So, by the time the second ectopic pregnancy rolled around, it was weeks of going in for ultrasounds and having them [OB/GYN] say, ‘We can’t see anything, we’re not sure, but here are the symptoms you should watch out for.’ And it was just terrifying all the time. And I’m like, ‘Well great, this is it, this is how I’m gonna die. I’m gonna have an ectopic pregnancy that ruptures, and I’m gonna bleed out.’ This has affected every part of my life.” - *Stacey*

One participant described the blow she and her husband experienced when becoming aware of the loss of one of her twins during a routine sonogram:

“The twin loss was very tough. We had had it in our heads we were going to have twins, and we were planning on buying a minivan. We were so far along that I thought for sure it was a done deal, we were having twins. So that was a shock because that one never showed signs of not doing well. And then I was like 11 weeks and 7 days or something when we found out that there was no longer a heartbeat, that twin was no longer alive. So that was tough, ugh it was horrible. It was sad. My husband was so upset. He was crying, I was crying. You know, I just felt horrible, it was awful and it was such a surprise, a horrible surprise.” – *Carmen*

Corporeal Experience

Closely connected to the manner in which one finds out that a pregnancy is no longer viable is the actual physical, bodily experience of miscarrying. There was a distinguishing factor related to miscarrying on one’s own, naturally versus electing to have medical intervention to expedite the impending bodily process. One participant described her options once she was made aware that she had experienced a missed miscarriage:

“My OB/GYN said, ‘We can wait and let your body get rid of the baby naturally or you can take a pill and we can speed it up or we can do a D&C.’ I really wanted to go on this trip with T [husband] and I was very afraid of miscarrying on the trip. I opted to do the D&C and that was on Friday. I had talked to one of the women in my Bible study group, her niece is a nurse practitioner, she was saying how with the baby having died at seven weeks, it was in me for three weeks already passed away. She said, ‘You need the baby taken out, it’s been in there for a while.’ – *Joni*

Several of the participants mentioned the mind-body connection as it pertains to miscarriage, whereby once the mind is made aware of the loss the body can then begin to let go. One participant put it this way:

“Almost every single time, before anything was scheduled for a D & C or whatever, I would just miscarry on my own, naturally. It was almost as though I had to find out there was no heartbeat to let go. It’s so in our minds, we have such power over our bodies.” – *Rachele*

Issues Related to Infertility

Four of the 10 participants noted their experience with issues related to infertility. In each instance of infertility those women described the infertility as a compounding loss experience relative to their miscarriage losses. As one participant explained:

“We went into it saying, ‘Okay, well, we’ll try to have a child, but we won’t do fertility treatments.’ And then when it didn’t work on our own, we’re like, ‘Okay, well, we’ll do IUI, but we would never do IVF.’ And then we’re doing IVF and we started doing all these things that we said we would never do, which I know is very common for people to do. But still...” – *Stacey*

Similarly, another participant described her experience with infertility and the use of artificial reproductive technologies:

“We had to go the IVF route, and that is just so stressful, so hormonal, all of the shots, and all of the scans, and poking, and prodding. Nothing about it is natural.” – *Pamela*

While two of the four participants who reported issues related to infertility had diagnosed infertility causes, the other two participants both described unexplained and undiagnosed

infertility. One participant described her frustration with the unknown cause of the fertility issues:

“When we first started to go to an RE [reproductive endocrinologist], that was in 2010 at the beginning of that year they did all the blood work on both of us, did his analysis, everything. The RE said ‘on paper you guys should be having kids.’ I’m like, ‘Well shit then, burn that piece of paper because something is not working.’ So we went on Clomid, did that for a couple months and then I had to take a break because I was I was getting cysts. So my doctor said, ‘Just keep doing what you’re doing, because you never know you might get pregnant on your break.’ Sure enough, got pregnant on our break and that was the second one [miscarriage]. And it has been nothing since then.” – *Sharon*

Likewise, the other participant with undetermined infertility described her experience in this way:

“We had undiagnosed infertility for about two, three years. We had gotten pregnant right away after I had gone off the pill. And then we had lost that child. And then we did not get pregnant with the second one for two years after that. So here we were, devastated that we lost the first baby, and then we didn’t realize we had a problem because we had got pregnant so quickly, so we went that two years with nothing, so that was extremely frustrating because we didn’t know what was going on. We had all the tests and everything, and it was just undiagnosed, unexplained, they call it. They didn’t know why we were not getting pregnant.” – *Carmen*

Theme Two – Emotional Context of Experience

Primary within this study were themes of the emotional context of the miscarriage experience. Every participant discussed experiences with feelings of grief and loss and the ongoing efforts to define the meaning of pregnancy, motherhood and miscarriage. Participants described their sense of attachment to the would-be-child which was later lost. Participants described feelings of hopefulness combined with not so hopeful feelings, with respect to their miscarried pregnancy outcomes, as well as the outcome of possible future pregnancies. A theme regarding women’s intuition, women’s ways of knowing, regarding the pregnancy outcome was also described. Additionally, the emotional aspects of pregnancy and miscarriage memories along with grief triggers were commonly discussed themes for participants. A pervasive

emotional theme shared by each participant was related to feelings of regret and self-blame as pertaining to the miscarriage itself. Further, each participant described acts to memorialize the baby lost during their miscarriage experience.

Feelings of Grief and Loss

Throughout this study, participants provided strong themes of the grief and loss feelings associated with the experience of miscarriage. Although it was difficult for some participants to truly conceptualize the baby who was lost, every participant knew she had in fact lost something that she had very much wanted. For instance, one participant stated the following:

“Looking back when I was actually going through that first miscarriage, it was just so all of a sudden, you just got used to that idea of, ‘Oh this is great, we’re going to have a child.’ And then it’s gone in a split second. And it’s funny how you don’t realize that you really wanted something until you don’t have it or can’t have it.” – *Sharon*

One participant described her heightened sense of loss with the miscarriages she experienced subsequent to giving birth to her son:

“I won’t say that it wasn’t hard-hard losing that first pregnancy because it was, but then we had J [son] and then I really think the September and May miscarriages after him were harder because we had J and we had seen the ultrasound and saw J’s heartbeat and everything, and then in September, with that pregnancy when we went for the ultrasound, we just saw nothing. And, well we knew after having J what we had really lost with that miscarriage.” – *Pamela*

This same participant went on to describe her bout with depression following a recent miscarriage:

“I do know that after this last miscarriage, I kinda went into a depression. And there for a while, I felt like I was just going through the motions of life, and then D [husband] would come home and I’d say, “I don’t feel good,” and I would just go to bed. I’d be in bed by like 6:00 every night. And then just one day I thought, “I can’t do this. I have a child that needs me, and needs me more than a typical child.” I guess J [son] is my whole reason for getting over that hard time after this last miscarriage. I can’t just sit here and wallow because I’ve got a family and a house to clean and I’m a stay at home mom right now, so you know, I have responsibilities. With my first miscarriage, I was in grad school, and I just kinda shut down with that one because I really didn’t have anything to do except go to school.” – *Pamela*

Another participant described her experience with depression as well:

“It’s hard, even with all the spirituality that I have gained in the process of all these miscarriages and the support system I have, I will still occasionally have depressive days. I’m dysthymic that was my diagnosis; I’ve been since forever, probably since I was a child. And so, some days, I still don’t feel that I’m fit to be a mom, spiritually or whatever. Because I do struggle with depression somewhat, it will kinda rear its head from time to time, and before my kids were born there were things that I would do regularly to kinda manage myself better, but now with a newborn, you can’t do as much of that stuff. ” – *Rachele*

One participant described what she has been grieving, and what she felt she had lost:

“My husband and I always talk about the first miscarriage, that one was so special, not that they weren’t all special, but that one we got all on our own, no treatments or anything. We always talk about how that baby would be seven years old now, or how that baby would’ve been born in July. It’s weird because J’s [daughter] going to be 4, but I think that baby was supposed to be my first baby and it would be seven years old, and going to school and all that. ” – *Carmen*

Meaning of Pregnancy

For many of the participants, part of the grieving process required an attempt to make sense of what once was. Many of the participants spoke of the meaning they assigned to pregnancy. As one participant described, pregnancy and the ability to become pregnant and sustain a pregnancy are core aspects of her sense of femaleness:

“I’ve gone through a lot of guilt about it because it’s [to produce a baby] what your body was built to do. So your body was designed to carry a child. It’s kind of the whole make-up of how we are designed, and, when you can’t do that, you feel flawed in this very fundamental, biological, evolutionary-based way, and it makes you feel less of a woman because you can’t do what your body was designed to do. ” – *Stacey*

Similarly, one participant described pregnancy this way:

“And when it’s your first pregnancy you don’t have that confidence of, ‘Well, my body does know how to do this, it was just a fluke.’ I think being a first pregnancy and losing it makes it worse, harder.” – *Carmen*

This participant also suffered with issues related to infertility and went on to describe the meaning of pregnancy, fertility and femaleness:

“I certainly think too that having miscarriages and fertility issues rattles your confidence, as a woman. You know it’s nothing you did, but it totally rattles your confidence and your self-esteem that you can’t have this baby like everyone else. As a woman, you feel that producing a child is what’s expected of you, and it’s what you want too.” – *Carmen*

Meaning of Motherhood

Many of the participants’ understood miscarriage as an event that precluded them from realizing their dream of first-time or renewed motherhood. For many of the participants, their miscarriage disrupted their sense of what motherhood would have been or could have been:

“I think about things like, ‘Gosh, that baby would have come in October, it was perfect timing, everyone would be in school, I would’ve had just the baby and M [youngest child] home with me all day.’ The baby would have been three months old by Christmas time.” – *Joni*

Another participant shared her desired view of motherhood and how it has been reshaped by losses:

“It’s so cool to see my daughter like me and my son like M [husband]. And that made it very difficult, too. Who would N [stillborn son] have been like? And that baby just now that could have been [recent chemical pregnancy loss], too, who would that baby have been like. I really wanted a girl. So that’s my other thing. Was that baby a girl? I don’t know. I just hope I get pregnant again. That’s all I hope. I would love to have two more live births. I would love that. I really would. That would be my ideal picture.” – *Geri*

Several participants spoke about how miscarriage muddled their response to the basic and frequently asked question, “How many children do you have?” As one participant mentioned:

“It’s hard, you know, when you get that dreaded question of how many kids do you have...’Uh, five, three here with me and two in heaven,’ well that’s the short answer, you know for those who can handle that much...some can’t even handle hearing that. But it’s important to us to celebrate and honor all of our children.” – *Penny*

Similarly, another participant stated:

“And then some people ask me, “So how many kids do you have?” And sometimes I just say one, and sometimes I say four, if I know how they’re gonna react, it just depends on who I’m talking to, whether I’m a mother of one or a mother of four.” – *Pamela*

Meaning of Miscarriage

Requisite for any grief journey is the task of assigning meaning to one's loss. Making meaning of one's loss does not then suddenly render the loss tolerable, acceptable or reasonable. No reason could ever be good enough or acceptable to satisfy the griever. Rather, the search for meaning relates to trying to make sense of one's life after loss. By creating meaning, one is better able to gain some control over and find order in the chaos of grieving. Assigning meaning to a miscarriage is challenging, due in part to the ambiguous nature of miscarriage, and it is more than likely an iterative process that evolves over time. As one participant stated:

“Well after the first one [miscarriage], it was three months later that C [husband] lost his job and I thought well maybe that was the reason I had the miscarriage. But you start to grab at straws at that point because you just don't understand. Why did this happen? So that's kind of how I looked at that one miscarriage. But the second one [miscarriage] I don't even know, I was just dumbfounded by that, I don't know what the meaning was behind that one. It was just not meant to be I guess. It is very ambiguous because...well, there are just no answers. It leaves you wondering, why? And yeah, they [OB/GYN] can do testing on everything, some of the time. So the first one, I just heard it was a normal miscarriage. How do you call it normal? It's not normal, ever...is it?” – *Sharon*

To further establish the difficulty in making sense of one's loss and life after a miscarriage, one participant described the unique challenge of suffering a miscarriage knowing it was her last pregnancy:

“When you have a loss and the loss is your last pregnancy, you cannot have another baby, that's just an altogether different situation. On the Facebook support group boards, I'm almost finding a need for a separate group for those who suffer a loss and have no chance for a next pregnancy, for a rainbow baby, because even among the miscarriage group, so many of them are trying to conceive again and have a chance for that, but some of us do not.” – *Teri*

This same participant described the alternative miscarriage scenario in which one has no living children and the added burden of coping with loss under those circumstances:

“And I think a miscarriage is a whole different loss situation when you don't have any living children. I have two at home, I can go hug my two kids. I really feel for those women who don't have any living children, I think that's a whole different world. Even from what I have had to experience with having my miscarriage. I am very grateful that God gave me the two I do have and my miscarriage experience has made me realize that I better take doggone good care of them while I still have them in my care.” – *Teri*

Further meaning was made by several participants who had described their losses as informing a new appreciation for the children that they do have:

“I was a teacher and N [oldest child] spent his those early years in day care and I remember coming home after M [deceased son] had died, I remember one of my teacher friends saying ‘Why don't you take your six weeks and come back and you'll be fine.’ And I thought ‘Oh you don't understand, I wasted so much time in that building on 28 other kids and not my kid, I'm not gonna waste that time again.’ I think that after losing a child you realize what a blessing they are and that they're not a burden.” – *Penny*

One participant described the importance of trying to make meaning of her loss, although it was a challenge, at best:

“We try to do things that give our children's lives some purpose somehow. For me, I feel like I live for them now so to give back and do something purposeful in memory of them then that's some form of meaning and purpose to them having been in our lives, for however long or however short it was. And so that's why we do the Walk to Remember. That's why we took it on to keep it going. That's why we do the March of Dimes events. Because, then, there's some purpose in it, to help other people. Although, I don't know that I've come up with anything that really gives me any comfort or ways of finding any meaning in it. I can come up with reasons [for her losses], but none of them are acceptable reasons or reasons that somehow balance out the losses that we've had. So that's [meaning making] a struggle.” – *Stacey*

Finally, another participant added the following:

“But my husband and I always felt like all the losses and infertility issues make us better parents, for what we went through. That's how we've come to try and make sense out of all the losses. I feel like we have a different appreciation, not, that everyone doesn't love their children, but I feel like because we worked harder for it, just to get there, I feel like we have a different appreciation for the children we do have. A 2:00 a.m. feeding sucks for everybody, but sometimes I would sit there and think, “Okay, I am tired but this is what I wanted, and I cried for,” so it's just made us to be better parents. And another thing that I feel has come out of all of this is the choice I made to stay at home. I was career-oriented, especially because we didn't have children until we were in our 30s. I already had had a huge career, and I never saw myself staying at home. I always saw myself as a

working mom, not giving that all up. But I think I have a different appreciation now, I know life is so fragile; I'd rather be home with my kids." – *Carmen*

Attachment to the Would-Be-Child

Grief, in general, is the response of longing that typically follows the loss of an attachment figure. Attachment is often conceptualized in terms of the young child's attachment to her/his primary caregiver. However, attachment runs both ways, and for most mothers attachment begins in utero. Several participants described the early feelings of attachment that were felt for their would-be-child, before the miscarriage had occurred. As one participant stated:

"Well I knew I was still this [miscarried] child's mother and I think that's where I'm so thankful for our faith. I mean I knew that this child still existed and I had that huge smack on the head from God reminding me, this child was a child that I created. Although that miscarried baby was mine for only a moment, she was mine. And I think it just reminds us that our kids are our kids for the time that they're given to us and first they're God's children and so I think coming back to that, I think that's comforting in that way, I chose to see it that way. For me, I know I'm going to see this child again and for the short time that I carried her, she was mine." I have found that in the end, with this sort of child-like perspective, it simplifies and makes things look a little brighter and a lot less bleak." – *Penny*

One participant described the ambiguity in forming an attachment to her would-be-child:

"It's easier for me to go through and recount how my pregnancies have all went until this one [chemical pregnancy loss]. This is harder because I don't know if it was a boy. I don't know if it was a girl. I don't know – is there really a baby? Was there actually a heartbeat? Or was it just my body creating a placenta and a sac? I don't know. I haven't really went in and talked to the doctor. I just want to know. Was there actually a baby? Is it a baby at six or eight weeks? I don't know. So I have questions. And it's hard because we do our blessings every night with my kids. With my daughter we always say, 'Please watch over me and my brothers.' And what do I say to my daughter now? I don't want to forget about this baby. But what do I say? 'Please bless me and my brothers and the baby that could've been?'" – *Geri*

Oscillation Between Having Hope and No Hope

With the grieving process there is a need for respite from the emotional work of feeling sorrow and sadness. This is where hope comes in. All of the participants spoke of the vacillation

in their feelings of hopelessness along with a renewed sense of hope at other times. As one participant recalled upon learning that her pregnancy hormone levels were low, she did try to remain optimistic, even excited:

“So the nurse tells me the blood work showed I was positive for pregnancy and of course there's excitement. ‘I'm pregnant!’ I remember asking her in the middle of the conversation, ‘Can I tell people? Am I really pregnant? Really?’ So that's when she said that my levels were looking low. She said it was a 5.8 hCG level and she would need the doctor to give me a call because she wasn't sure. She was saying it was basically faintly pregnant or slightly pregnant or something like that. And I was like, ‘What does that mean? Am I pregnant or not pregnant?’ She said she wasn't sure of the hCG cutoff for pregnancy. So that night I got online and started looking up everything. And that's where I found a lot of stuff about chemical pregnancies and ectopic pregnancies which started to scare me. And because my levels with N [son] were so high I thought, ‘5.8. How is that even possible?’ But everything I read indicated that zero to five – not pregnant, at 5.8 you are pregnant.” – *Geri*

One participant who had suffered several miscarriages described her continued feelings of hopefulness that carried her through her last pregnancy, which resulted in the birth of her infant son:

“You would think after all those miscarriages that I would have had so much fear while I was pregnant with him [infant son], but I didn't. I felt sure it was going to be ok, and of course it was and I just knew, somehow.” – *Rachele*

Another participant described her oscillating feelings of hope and hopelessness and how her doctor has been a source of continued hope for her:

“Everything that we've tried [Artificial Reproductive Technologies], nothing has worked. And we've done Follistim with IUI's, Clomid with and without; we've done it both ways, all the way up to IVF. I always had hope going into all of these things and after the first failed IVF cycle and then whenever it failed I felt like I was losing hope. But then it seemed like after I talked with my doctor and I went and spoke with another doctor at a different facility, it seemed like the hope is coming back. They dangle that hope out there for you. You feel like you're dangling on a line and you're never catching the prize. But I felt better for a while. And I had given myself, I thought okay we'll just go to the end of the year. We're not going to worry about anything. And so in December I thought ‘okay we'll try it [IVF] again. We'll give it a go, what the heck right.’ So we went through the second one [IVF] end of February – March, and that one failed too.” – *Sharon*

Another participant described the way in which her doctor contributed to her sense of hopelessness:

“Well, for me, with the losses that I’ve had over the age of 35, which there have been two, I feel like my time is now running out. Before, when I was 21 with that first miscarriage, I was upset about that loss, but I still had my whole life ahead of me, all those reproductive years still ahead. And I remember with that first loss when I was real young, I remember the doctor and my friends, everyone just saying, ‘Oh don’t worry, you know you’ll have more children.’ But now, as an older person, nobody is saying those cliché words to me, no one, not my doctor or anyone has said that after I lost the twins, ‘You’ll have more children’ because even they know that my biological clock is running short, and who knows if I will have a child.” – *Lacey*

Religious – Spiritual Aspect of Coping

Relying on religious and spiritual beliefs and values was a strategy frequently used by several of the participants in this study. Religiosity and faith were ubiquitous concepts that were woven throughout various participant contexts of experience. Notably, religious beliefs and spirituality were referenced by several participants in this study as pertaining to their efforts to cope following their miscarriage. Some participants mentioned a strained sense of faith and anger towards God during their loss experience. However, those participants who mentioned a loss in their religious faith and the subsequent distress that their loss is faith produced did note that those feelings were only temporary. With time, their sense of religiosity and faith returned. In many cases, their faith was strengthened by their miscarriage experience. As one participant noted:

“When we lost the twins, I was pretty pissed off at God. I felt like, ‘Seriously? After all this time, I’ve wanted this forever, and then, we go through IVF which doesn’t even work for some people. They do it a million times, and it never works, and the first attempt worked for us and then boom, at 19.5 weeks you take the twins away from us? Why?’ So, I was very angry and G [husband] was, too, for a while. But then, somehow, we got lifted up by God through all this, I believe, and we started to attend a church. And we began to feel that we really weren’t alone in this journey. That there was some bigger force than us kinda pushing us through. So, the losses have brought us closer together, full circle and definitely stronger in our faith. Which, if something good had to come out of losing the babies that certainly is a good thing.” – *Lacey*

Several participants spoke of having a renewed sense of faith and chose to put their trust in the Lord God. Additionally, many of the participants spoke of their belief in God's will for their lives, and believed that God and prayer would conquer all, even their grief over the loss of their wanted child. Some participants remarked about their spiritual sense of themselves, their inner selves, as an aspect of coping with their loss. Nearly every participant mentioned their reliance on their sense of religiosity or spirituality to help them through their grief. One participant spoke of her heightened sense of spirituality following her first miscarriage:

“Reiki a form of energy medicine; it's like a hands-on healing technique where you're basically channeling energy and what I believe is that it's divine energy. It's from God, basically, and you are just a channel, as a Reiki practitioner. So, I heard about this Reiki clinic and I started going there for treatments for the miscarriages and everything and it made me feel really peaceful, and I became trained as a Reiki practitioner because of my really positive experience with that. So, I feel like because I had that first miscarriage, I was led to this healing modality, which is also a spiritual thing for me, it opened up a certain level of spirituality for me.” – *Rachele*

One participant spoke about her faith as a means of coping during her time of loss:

“We're religious people [participant and husband] and we believe that God has our plan and everything. So He influenced me a lot by holding me up during the miscarriages, I guess. We have faith that it's [another live birth] going to happen, and when it happens, it's gonna happen the way it should be.” – *Pamela*

Woman's Intuition

One factor that may inform a sense of hopefulness or hopelessness is a woman's innate sense of things, her perception and intuition. An overwhelming number of the women in this study relied on and described their sense of knowing or intuition as it related to their pregnancy and their miscarriage. Although, as it was previously stated that there is an unexpected aspect to the miscarriage experience, many of the participants had at some point in time suspected that something was not right with their pregnancy. As one participant noted, even her husband picked up on her woman's intuition:

“I don’t know what it was but even the day we went in for our OB/GYN appointment, before we had left the house my husband sat me down on our bed and he said, ‘You’re not right with this one, you’re not right, what’s going on with you?’ And I wasn’t right and he noticed it. I was struggling with being pregnant. I still to this day don’t know why I was not right about it...well I guess I knew something, I guess there was a reason I wasn’t feeling right about it - [sighs]” – *Joni*

One participant described her intuition of impending doom and pregnancy difficulties and the discomfort she felt in ignoring her hunch:

“Our first IVF attempt, we put in two embryos and got pregnant with twins. And the pregnancy was fine, it took off fine. I had had an underlying fear though for forever that I would have issues in pregnancy because, way back when, way before I ever knew my husband, I had had a cervical conization – cervical – something done on the cervix. And I had always, heard that that could cause some issues in pregnancies, and here I was, well over the advanced maternal age. I was 45, carrying twins. So, those two right there are big flags for being a high risk pregnancy. And then I had had this prior surgery, and so, those three things combined put me at a higher risk for having an incompetent cervix. I had this fear and even had mentioned it to the doctor, and he was very casual about it and said, ‘We’ll just do a wait-and-see approach. And I was uncomfortable with that, but I didn’t open up my mouth and really say much about it, and so that’s just what we did.” – *Lacey*

Another participant described her intuitive sense becoming honed with each miscarriage experience:

“This last time, the last miscarriage I could tell something was up, with the little pains I had been experiencing. I thought, ‘Oh, that’s not normal, why do I have a pain there?’ And with pregnancy symptoms, I had had heartburn and my breasts were sore and all that and then it just stopped all of a sudden. And so with this last miscarriage in May, that was the same thing. I remember thinking, ‘Oh, I don’t feel pregnant anymore.’ I think now I’m just more in tune with my body.” – *Pamela*

One participant explained her conceptualization of intuition as:

“I think your intuition is God telling you, ‘Listen up. This is what’s going on.’ I think I felt that with the 20-week one [stillborn son] too, because I remember driving to see the midwife and just having these sort of thoughts, weird thoughts that there was just something wrong.” – *Rachele*

Memories and Triggers

Many of the participants in this study described the interaction of memories of the miscarriage and other grief triggers as facets of the emotional context of their experience. One participant described the grief trigger she experienced when returning to the OB/GYN office for a follow-up exam after her miscarriage:

“Then I went to do the follow up and my OB/GYN asked me, ‘How are you feeling, are you struggling with anything, how was it coming back here?’ I said ‘I don’t like coming here anymore.’ I said ‘When I was walking into the hospital I saw the waiting area before I went into the D&C and I just have bad feelings about it.’ She said ‘I hear that a lot with women who miscarrying, they don’t like to come back to where it happened.’ And I can believe that. But other than that, my OB/GYN was just all doctor about it. I think they have a tough job and some OB’s I think so many of them just over the years they kind of desensitize themselves.” – *Joni*

Another participant described the memory she had of having a D & C performed on her birthday after suffering a missed miscarriage:

“But the one miscarriage and D & C that I had was on my birthday. My husband and I actually, we had the week off for vacation, we were just doing things around Ohio. And one of the things we were doing that day, we were going to the doctor’s office for the ultrasound and then we were heading to Columbus because we were going to stay the night down there and watch a volleyball game at Ohio State. Well that all changed because we couldn’t do it. They [OB/GYN] scheduled surgery [D & C] for the next day and that was my birthday. They actually felt bad about that but it was really the only time that my doctor could do it [D & C] that week.” – *Sharon*

Many of the participants reported feelings of anxiety, ambivalence or even anger when having had their grief triggered when confronted with other pregnant women:

“I don’t go to birthday parties. I don’t go to baby showers. I don’t do any of that stuff because I can’t. And, for people who have had baby showers since my losses, I usually tell them it’s for both of us. It would be painful for me, and then I’m sitting in the corner crying and taking away from your happy occasion, and you don’t want that either. So it’s best for both of us that I just don’t go. And you can then enjoy and celebrate and not have to worry about what’s going on with me sobbing in the corner. And I don’t have to do it.” – *Stacey*

Another participant shared her feelings regarding a close friend becoming pregnant when she had already suffered multiple losses:

“When I had the first two miscarriages, a very close friend and coworker got pregnant and she had already had a baby. I remember thinking, ‘Why does she get another baby and I don’t even have one?’ And she’s such a good friend, I love her so the jealousy thing rearing its head back then, it was just ugly and made me think, ‘Gosh, what is that?’ I hated feeling that way, but that was just my authentic feeling at the time. And then, I actually got pregnant with V [daughter] just a couple months after that. So, we ended up having kids really close together in age, which is nice, but you know, there was definitely that jealousy in the beginning, especially before V. That feeling of, ‘Why is it just so much easier for some people?’” – *Rachele*

Another participant who had reported issues related to infertility also shared her feelings when encountering pregnant women or mothers of small children:

“People around you, just having healthy pregnancies, I think is the hardest. It was hard just to go to a store and seeing a mom in there with a baby. It was hard sometimes for my husband and I to go to a restaurant, if we’d be sitting next to somebody that had a family, it would just be sad. And it would just totally ruin our dinner. And once on an airplane, we were stuck next to a mom and a baby the whole flight, just looking at this baby the whole way, it was an ‘in your face’ type of thing. And it was really bothersome, seeing pregnant women everywhere. So, sometimes you just avoid people in general. You just don’t want to deal with it.” – *Carmen*

One participant shared her feelings of being forced to confront a new mother and her infant following the participants’ own recent miscarriage experience:

“So then fast forward, it’s after I’ve had my miscarriage, I’ve helped SA [pregnant acquaintance] against my real desire to and then there’s this situation where SA was gonna need somebody to be there at the hospital for the birth and there wasn’t anybody else, so I went. And she kept trying to get me to hold the baby and I wouldn’t look at the baby, I never looked at that baby, I never looked at his face, it’s a little boy and I hear he’s beautiful but I’ve never looked at his face, I just can’t, I couldn’t.” – *Teri*

Regrets and Self-Blame

With all of the participants there was some degree of regret and self-blame regarding their miscarriage experience. The regrets largely had to do with optimal reproductive years having gone by and the self-blame tied to the miscarriage itself. As participant Lacey had stated,

“I remember feeling so disappointed in my body after the loss, like, ‘You failed me.’” And another participant had said:

“After we lost V [deceased daughter], then there was a miscarriage, and then the next two losses were ectopics. It kinda leaves me feeling like my body is a death trap. I have regret about that [the time that has gone by] all the time. I have no regret in marrying my husband, and we’ve talked about, if I met him any earlier, he wouldn’t have been ready to get married anyway. So it wouldn’t have worked. But, yeah, there is an element of “I did all the right things. I waited for the right person, and I waited until I was financially stable and stable in my career. I did all these things right and now, it’s [having a bay] impossible?” – *Stacey*

Assigning blame is mostly an attempt to gain some control over something which we have no answers or control. Most of the participants tended to blame themselves for their miscarriage(s).

One participant wondered whether she would have miscarried if she had taken her prenatal vitamin sooner. She stated:

“Yeah, and I think about why I didn’t start taking a prenatal vitamin. I wanted a good one; I wasn’t able to get to that store to take that good one. I finally broke down at Giant Eagle and bought their whole food one. But I didn’t take one for a while. I didn’t get on it until I was five weeks pregnant. You question that, what did I do wrong? I was making myself drink those smoothies that were kale, celery, they were awful. I said “these are so good for the baby.” Yet, the baby was already gone by that time. I was trying to eat well and be good. So many things you can get angry about and blame yourself for.” – *Joni*

Another participant reflected:

“With miscarriage, you just don’t know. And with the research you do on the Internet, you know it’s nothing you can control. But then again at the same time, it’s there in the back of your mind. My specialist prescribed low-dose aspirin because that sometimes can help if you have a clotting issue that’s causing miscarriages, so I used aspirin and then it makes you just wonder, ‘Is it the use of the aspirin, was that wrong to do, did that cause this one miscarriage?’ You ask yourself, ‘Is there anything I could have done?’” – *Carmen*

Most commonly, the participants in this study described regrets over the loss of the reproductive years which had gone by; as one participant stated:

“I have definitely had thoughts of, ‘Well, gosh. If I had only started thinking about wanting to have children sooner, if we had not wait until I was 35 or whatever; maybe this wouldn’t have happened, all those miscarriages, maybe it would have worked sooner and with no losses.’ But I do know that if we hadn’t waited to start having kids, if we’d have started and had kids earlier than we did I would have been a different person and maybe not as fit to be a mother. I definitely wouldn’t have been in the same spiritual place that I am now.” – *Rachele*

Another participant echoed similar feelings of regret:

“Sometimes I think ‘Well who’s to say that had we started 10 years ago we still wouldn’t be going through this [losses and infertility]?’ But, ya don’t know. I try not to dwell on that but yeah; I regret not saying something, not having the guts to tell him my husband about my desire to have a baby sooner, that’s what it boils down to. [Weeping] It’s funny because you’d think after all these years that I’d be used to talking about all of this.” – *Sharon*

While others described specific physical activities that could have been to blame for their miscarriages, one participant stated:

“What’s still so hard is that I kept saying, ‘No, I can’t be pregnant right now, I can’t be pregnant right now’ and I didn’t want a baby then. I just denied it and said, ‘No, its menopause, it can’t be, it can’t be,’ and after the miscarriage it felt like God was punishing me because I put myself first. And the medical community couldn’t confirm or deny that it was my fault or not, but I did not take care of myself during that time.” – *Teri*

And another participant questioned the role of her fitness program:

“My first miscarriage, I was taking a Zumba class. I love Zumba. I would do it every day if I could. I got pregnant and the doctor said, you know, ‘It’s fine, you know, just don’t go crazy. Keep it light.’ So I took my Zumba class, we lost the baby. So I didn’t do any Zumba whatsoever, and then we had J [son]. And then these last two times when I’ve miscarried, I was taking Zumba each time. And after my last loss just in May, I gave it up. I told my instructor, ‘I don’t think I can do this until I have another baby.’ And she kinda looked at me like I was crazy. And I, I know that Zumba class is not totally, totally why I have miscarriages, but that’s such a connection that it gets into my head now that ‘Okay, if I don’t do Zumba, then I’ll have a baby. But if I do it, then I’m gonna lose it.’ So the Zumba class is another part of my guilt, I guess.” – *Pamela*

Acts of Memorialization

In addition to reconciling attachments and finding hope, another aspect to healthy healing from grief and loss is finding ways to memorialize what was lost. Several of the participants in

this study mentioned the importance of and manner in which they memorialized their would-be-child. For instance, one participant stated the following:

“There was no time to even pause after the miscarriage and so it really wasn’t until after the first ectopic pregnancy, and I had been talking with a friend of mine from one of my support groups. And I said, ‘I just feel like these are babies that need to be recognized too but I don’t really know how to.’ And she had had a miscarriage, and she gave the baby a name. And she’d said, ‘My husband really struggled with the naming it, but I needed to do something. This was a baby that we wanted and we looked forward to.’ And so I went home, and I talked to G [husband] and I said ‘How about giving them [pregnancy losses] names?’ He was like, ‘No. No.’ And I was like, ‘Okay. So what about a symbol for them? Is it okay that we give them each a symbol so we have something that kind of was theirs?’ And he was okay with that. I picked them all and passed them by him. And he was like, ‘If that’s what you wanna do, that’s fine.’ But he just really didn’t feel the same sense of loss. To him it was, I think, more the loss of time than it was necessarily the loss of another child.” – *Stacey*

In 2008, Ohio passed legislative bill 517-071, the Grieving Parents Act, making Ohio one of a few states with options specific to the disposition of fetal tissue or remains under 20 weeks gestation. Despite this state sanctioned legislation, one participant had to demand her baby’s remains following her D & C procedure in order to have a funeral ritual for her miscarried baby. As she explained:

“So, I drop the bomb about wanting the baby and I hear them [hospital staff] out in the hallway whispering. T [husband] came in and I said, ‘I’m making everyone very uncomfortable.’ Then Dr. B comes in before the D & C and says, ‘I hear you want the baby?’ I said, ‘I do’ and she said, ‘You know it’s just pink fluff.’ I said ‘I don’t care if it’s pink fluff,’ which I can’t stand that they would even go that route with me. I teach the Choose Life program in the school part-time... Anyway, I know having a funeral made it probably more real for everyone else. T, at first was very worried about the kids and I talked to the counselors at Cornerstone [grief center] and asked, ‘Should I not let some of the kids be involved?’ and they suggested that I do let them be involved, giving them that closure and we did. It was beautiful, we had the priest come do a little service, we put flowers there for the baby and they [grief counselor] had said, ‘Go do something fun afterwards, release energy, go bowling.’ So we did, we went to lunch and went bowling. I think that day I made my kids more prolife during that than anything. I told them, ‘This was a baby, this was your sister or brother and it’s a part of our family.’ ” – *Joni*

One participant spoke of her wish to have been able to have a funeral ritual after her recent chemical pregnancy loss:

“This sounds disgusting, but I kind of wish I had kind of taken some of the blood or something and taken it to the cemetery and buried it with N [stillborn son]. I thought about it afterwards, but I don't know. ” – *Geri*

One of the most difficult aspects to healing after a miscarriage is that the memories are so few and the physical mementos of the would-be-child are limited. As one participant stated:

“Anyway, yea we do have that one sonogram picture of her [miscarried baby] and we keep it out, on the mantel, along with M's [deceased son] picture and our other three kids. That picture of M [deceased son] there, it's not a great picture of him, poor little monkey, he started looking bad there, his color started to change as he was getting sicker. He had contracted sepsis e.coli the day after he was born and the antibiotics they were using to treat him weren't working...he started getting sicker, his belly started to bloat because he wasn't pee-ing or poop-ing anymore. We have other pictures of him...He was born a pink, healthy, breathing baby; he looked like any other baby, just small. Anyway, it's just important for us to have those pictures out, of all of them. It's just so hard ya know, to know I have five kids but they're not all here. ” – *Penny*

Several participants mentioned jewelry, mother's jewelry specifically, as a means of memorialization:

“And so I have a necklace and originally I had like a pea pod with three pearls in it representing my two living children and M [miscarried baby], and I don't wear it now because I had bad dreams about losing one of the pearls. So then I got these birthstones for each of my children, so of course one is for M [miscarried baby], and this shell is the same size as a 12-week-gestation baby hand. So I got this shell charm and I hold it and think about her and think about what it would be to hold her hand, it's silly, but it's meaningful to me. I wear this necklace every day and that's how it gives me an in for talking about my baby because if people will see it they'll say, ‘That's really pretty, what do all the charms mean?’ And I say ‘Those are my kids.’ And if they know me and they know I have two living children and if I choose to, I can say, ‘I have a baby in heaven. We lost one of our children.’ Or I could just walk away and let them think.” – *Teri*

One participant had considered a piece of memorial jewelry but felt conflicted about it as she stated:

“Within the first year or two after that first miscarriage every time December 1st came along, that was the first one's due date, it would hit me, ‘Yeah, that's the date, let's move on.’ But yet I can remember the dates and things, so yeah, I'm really not moving on, you know? And I'm actually having a ring made and I wanted to have specific colored stones on the ring to represent different things. I had mentioned all the colors of the stones I wanted to my husband and he's like, ‘Do you want all those?’ And then when I sit back and I think about it, I guess I think, ‘Yeah, that is a lot of negative stuff, isn't it?’

Because I had one stone for December, one for June because that's when the second one was supposed to come along. And I thought no that is kind of negative. Do I really want to look at that and be reminded of it [miscarriages]? So sometimes it takes him [husband] to say something and then it will put things into perspective for me. And then I'm like 'You're right, I know I need to step back out of it.' But, you still think about it, you still grieve about it. But I'm trying not to let it consume my life because I wouldn't have found the strength to move on if I allow that. " – *Sharon*

Theme Three – Temporal Context of Experience

A pivotal aspect of the miscarriage experience for women of an AMA was the concept of time, specifically, chronological and biological age. Those women who delay motherhood or extend childbearing into their advanced maternal years face unique challenges as they race against time. For those participants who had endured previous maternal losses, there was an added layer of grief that complicated their miscarriage experience. The timing of the pregnancy disclosure to friends and family was an influential aspect of the miscarriage experience for many of the participants in this study. As such, the subsequent loss of the mother-to-be status among one's family and friends, as well as with oneself, was an especially painful process of adjustment following the miscarriage experience. Lastly, participants discussed the evolution of their loss experience with the passage of time.

Age Specific Influence

Every participant in this study shared her sense of anxiety regarding the number of reproductive years remaining. Age seems to be the great equalizer. Regardless of fertility treatment advancements and independent of financial resource availability...at some point, every woman's reproductive capability halts. As one participant disclosed, she was not terribly concerned about her age initially, but as she proceeded in her trying to conceive efforts, time soon became a concern:

“When I first saw my RE [Reproductive Endocrinologist] I was 39, actually I may have just turned 40. And he said to me, ‘Well how fast do you want to do some of these procedures?’ I said, ‘Well we’re just going to start at the beginning and we’ll work our way up.’ I said, ‘If I was concerned about time, we would have just jumped to the end-all be-all.’ And I said, ‘Not only that but if I were that concerned about time I would’ve tried having kids a lot sooner than this. So obviously I’m not concerned about it.’ But fast forward three years and now I’m concerned about it. So I don’t know. It’s funny because all of a sudden the age has become a factor. Where four years ago it was not. And I wasn’t even concerned with it.” – *Sharon*

Another participant described the influence age played in her efforts to conceive again after her first loss:

“I don’t think I would have pursued pregnancy again, so soon after a loss in my 20's like I have now at my current age. I would have given myself and my body time to heal. I’ve been pregnant three times just since 2011. That’s a lot on a body, the hormones and emotions, and all. I certainly would have given myself much more time to heal as a young person, but being older, my time is limited.” – *Lacey*

Some participants were made to feel a heightened sense of their maternal age through interactions with their OB/GYN, as one participant shared:

“My OB/GYN put me out to pasture before I was even 35. I remember being pregnant at 30 and them saying, ‘At 35 we do amnios. At 35 there’s a heightened risk.’ I’m just like, ‘What the hell happens at 35? Does something go off in your body like a light bulb?’ So that really put heightened fear in for me. Did I do this to N [stillborn son who had Trisomy 18]? And then everybody just kept telling me with him it was just a fluke a terrible genetic lottery, a lottery which of course nobody wants to win. And then to have another loss now with this chemical pregnancy and now I’m very scared. Where do I go from here? Does this mean I’m done? Did something truly happen in my body because I’m freakin’ 35? Why is it eggs are less good after 35? I don’t get it.” – *Geri*

Similarly, another participant described her increased awareness of her maternal age through experiences with her OB/GYN:

“We moved here and I got pregnant, and so then I switched and saw a new OB/GYN up here and the past two times that I’ve miscarried she basically told me that I’m too old. And I’m 38 years old, ya know, I’m not like 60 trying to have a baby. She implied that I’m too old, that I probably don’t have enough hormones left in my body to support a pregnancy and she’s just really a Debbie Downer about the whole thing.” – *Pamela*

Influence of Previous Losses

The majority of the participants in this study had endured multiple losses. The compounding grief effects of multiple losses influenced those participants' ability to cope with each additional loss and to remain optimistic for their future pregnancies. As one participant had noted:

“After you’ve had a loss, instead of saying ‘Oh, we’re having a baby,’ you tell people, ‘We’re pregnant.’ It’s different. ‘We’re having a baby’ is a whole different thing than, ‘Well, we’re pregnant,’ because being pregnant doesn’t really mean that you’re actually gonna have that baby.” – *Lacey*

Many of the participants who had experienced previous losses described conceptualizations of their future pregnancies in a very different way than the typical pregnant woman. Most pregnant women do not have to consider the things that one participant had noted:

“Another thing that scares me is that after we lost N [stillborn son] I had thought maybe N will come back, in spirit, in my next baby. Well, now I get scared thinking was he in the baby I just lost [recent chemical pregnancy]?” – *Geri*

And another participant tried to make sense of her previous losses in this way:

“Just like M [deceased son], M never knew the misery of this world. You can put this in the perspective of a stillborn child, their first breath is heaven. Their first sight, whatever they see is of heaven and that’s so amazing. So yeah, we have at least two children who never have to make that choice to be faithful or not but then we have these three and we do the best we can as parents to help them understand and help make them faithful Christians.” – *Penny*

Timing of Pregnancy Announcement

Of great consideration with every pregnancy is the time when expectant parents feel comfortable to disclose their pregnancy news with others. It is a highly personal choice as to when to share such news. Some pregnant women and couples will disclose their pregnancy right away, while others feel the requisite waiting period is somewhere near or after the twelfth week of pregnancy. For many women and couples, the fear and the meaning associated with the mere

possibility of having to share the bad news of a miscarriage precludes them from disclosing their pregnancy before a certain time frame. The desire to spare themselves of the experience of having to share their loss later on (as well as sparing their family and friends of this experience) outweighs the potential benefit and excitement of sharing the news of their pregnancy sooner. Alternatively, in theory, if news of the pregnancy is shared with family or friends early on, it should stand to reason that those already aware of the pregnancy will then serve as readymade supports when a miscarriage is discovered. While if the pregnancy news is not shared before a miscarriage is discovered, then there are potentially fewer supports already in place. Participants in this study shared their experience of telling, or not telling, others about their pregnancy and the effect the announcement, or withholding of the announcement, had on their subsequent miscarriage experience. One example of the effect of not sharing one's pregnancy news with others was noted as follows:

“I feel like the miscarriage was hard for people to understand. We hadn't told anyone that we were pregnant. It was very early. And so people only knew that I was pregnant after I had already miscarried. And so, it's like there's nothing real to attach to in that way for other people. We don't have ultrasound photos. We don't have really anything beyond a positive pregnancy test. So there's not as much for people to kind of latch on to, to try and understand.” – *Stacey*

Conversely, one participant described her experience with having the news of her pregnancy shared early:

“Unfortunately the pregnancy news got out very early. I think I was only, my gosh, four weeks pregnant at the time when the news got out, maybe not even four weeks. We were almost upset in some ways how it got out so early, I wish so much it wouldn't have gotten out that early. So many people knew. I was okay with the close people around me knowing, especially when we miscarried, but it was really difficult when I still had people I didn't know that well coming up to me congratulating me days after I miscarried and I was a wreck. One person I didn't even say anything, I said ‘Oh thank you.’ I didn't even tell her about miscarrying. That part of everybody knowing early on was tough.” – *Joni*

Loss of Mother-To-Be Status

Several participants described their experience of belonging to the status of mother-to-be and then suddenly having to shift and no longer belonging to that status upon miscarrying. One participant spoke of her brief inclusion in the role of mother-to-be in this way:

“It’s funny how you’re just starting to get used to the idea, ‘Oh, yeah I’m pregnant.’ You go and get the book so that you know what to expect and all that stuff. And then all of a sudden, it’s taken away from you [pregnancy] in a second and you’re at a loss.” – *Sharon*

Another participant spoke of the transition from expecting twins and being a mother-to-be of twins to unexpectedly being the mother-to-be of a singleton:

“And there’s like a sisterhood, for sure, where you can join in on the conversations about pregnancy issues, morning sickness and all. At least five to twelve weeks you can and you have that status. It’s a status of would-be mom to twins. And then suddenly you’re not that. Because you know, I had even joined a message board on the Internet of mommies-to-be with twins. And then it’s like, well I’m not that anymore.” – *Carmen*

Another participant shared her experience of having others around her perceive her sense of being insider or outsider to the role of mother:

“Every year before my miscarriages, my mother would send me a Mother’s Day card for my dogs. And this year, the year after all of these losses; I never got anything, and I remember I talked to her on the phone and she said, ‘Well, I was going to send you a Mother’s Day card, but I just couldn’t do it this year.’ I told her, ‘Well, this would have been the year to do it of all the damn years.’” – *Lacey*

Influence of Time Pass on Experience

The passage of time often changes one’s grief experience. To some extent time heals, and grief evolves. With time, the emotional space necessary to create meaning for one’s loss is created. As one participant described the changes and reshaped meanings that time brings:

“It [losses] just changes everything, how you see things, what’s important and so we are just doing our best as parents to demonstrate this new normal, as they call it, the lessons we’ve learned, to our kids, and we just have to trust in the sovereignty of the Lord, this is not in our control, despite our best efforts and our hopes and desires. Only God knows and only God is truly in control of this life.” – *Penny*

One participant spoke of how her perspective of her miscarriage experiences has now shifted to a more positive reframing of those difficulties she endured to the positive spiritual gains she received in the process of multiple losses:

“Now looking back, when you talk about meaning and all, I feel like with all these losses I had to go through I did gain a richer life in some respects afterward, like each experience, though awful, did lead me to something good, like divine, a closeness to God...learning to do Reiki, going to the meditation group and then the Bible Study group, finding really spiritual people along the way like C G, the prayer bowl artist, and finding out about The Servants of Mary Shine there in Windsor and all...it was like each loss brought me closer to all of the spiritual aspects of who I am now.” – *Rachele*

Lastly, one participant described the progression of her grief over time and how she managed the grief triggers that women who miscarry often encounter:

“But as time has passed and as I’ve had time to grieve, I find and this is what I tell on the miscarriage support site that I help administrate on Facebook, what I tell the newly grieving moms is that the pain is not gonna get less, when you have a trigger the pain is not gonna be less but with time you’ll recover from the grief triggers faster. I’m able to pull myself together and stand up and walk a whole lot faster than I used to when I would get triggered. I can see time has done that and I can sometimes see it coming and avoid it.” – *Teri*

Theme Four – Social Context of Experience

The very personal experience of miscarriage influences the public and social aspects of one’s life. Participants in this study described the significant role that their family and friends played in their miscarriage experience. In addition, participants related that their experience influenced relationships with others. Since miscarriage is often seen as a medical issue, participants discussed the role of the medical community within their experience. Several participants discussed their emotional support seeking following their miscarriage. Lastly, each participant in this study was in a heterosexual marital relationship, and several participants discussed the gendered differences with grief and loss experiences.

Significance of Family and Friends

The participants in this study spoke about the significant and varied roles that their family and friends played in their experience of miscarriage. Many participants mentioned the benefit of a supportive spouse, while others spoke of the value in speaking to someone else who had been through a similar loss experience. One participant noted her mother-in-law as particularly helpful to her during the days and weeks after her miscarriage, as she added:

“My mother-in-law was a huge influence. She really helped me because she experienced a miscarriage; she suffered a loss farther along than I was, like at four months along. I remember her talking about it on occasion, even before my loss last month. So when it happened I was more comfortable talking to her.” – *Joni*

Another participant shared a similarly meaningful experience she had with her mother, who was sensitive to the participant’s loss experience since she too had had a miscarriage herself:

“I told my mom about this recent chemical pregnancy and she was wonderful. We've grown so much closer and things have become so much better between us since N [stillborn son's death], it's changed night and day with her. I don't know if it was a fear that came up in her after my son died or what...my mom lost her only sister and she lost a set of twins through a miscarriage.” – *Geri*

Experience Having an Influence on Relationships with Others

While all of the participants described those key individuals who were significant during their miscarriage experience, the participants also portrayed a message regarding the influence their miscarriage has had on relationships with others. A similar theme from each participant was that the miscarriage experience created a sense of their own otherness or dissimilarity, as compared to their friends and peers. As one participant stated:

“Well for me, because I don’t have any living children, and having children is kind of a life stage change, I feel like, in some respects, I don’t fit in with the group anymore. They [social peers] have their children, and they do play dates, and they do family stuff, and there’s no role for you to play in that. So that part is hard. And because I’m older, most of my friends who have children had children earlier. So their children are older and so their ability to relate to somebody who’s still trying to have a child, when their kids are 13 or 14 years old, is very difficult for them. And their childbearing years for

them are so far gone or behind them, and I'm still trying to get mine started. And then because my husband is younger, his friends are mostly just having their children. And we had a friend who was due a couple months after V [deceased daughter] was due but ending up having her about six months after V was born, and I've still never seen their child because I can't. And so you start to associate dates and times and how old would they be and where would they be. And it becomes difficult to see." – *Stacey*

Another participant described her sense that it was difficult for her family or friends to relate to her and her perceptions of life and pregnancy since her loss experiences:

"And it's hard for the people around you because, like when we would get a positive pregnancy test, I'd call my mom and be like, 'Well, don't get too excited.' She's like, 'Stop thinking like that!' And I'd say, 'That's just the way it goes, Mom. I count on nothing going the way it's supposed to go for everybody else.' As a loss parent, you know how fragile it all is in a way that other people can't even fathom." – *Stacey*

One participant felt that her grief response relegated her to an outsider status relative to normative "mom culture," and she felt she could only grieve her losses in isolation:

"And that's the thing ya know, when you're a mom, there's just no time to grieve. You have to just get on with life an all, there's floors to scrub and laundry to do and the other kids you still have to take care of. So I would cry when I could, with M [deceased son], I would always cry in the shower, because I just could there. And then with the miscarriage, I would feel like I couldn't cry in front of people all the time. So I would be crying [after miscarriage loss] on the way to drop my boys off at school and then I would have to hurry up and [pats face as if drying eyes and cheeks, then smiles big] straighten myself up, like I don't need people thinking I am this crazy, crying, incompetent mother." – *Penny*

Influence of Medical Community

In relating to the medical community, specifically their OB/GYN, many participants stated that their experience with their doctor was mixed, at best. Some participants described an overall favorable experience when interacting with their physician during and after their miscarriage. For instance, as one participant framed it this way:

"My OB/GYN, I gotta give him a lot of credit because he never discouraged me and people were shocked and would even say to me, 'What does your doctor say after you have had all these miscarriages?' He was just great, he would say to me, 'I'm not God. I don't understand this stuff; we can't find anything physically wrong with you.' He did have me taking baby aspirin because he said that can somehow prevent small microclots

in the placenta. He didn't know if that was doing anything, but he said, 'Let's just do this.' I did it for four pregnancies though and it didn't help. But yea, my OB was always supportive and he never told me stop trying. It was just amazing and especially with my age. I'm 43. I'm not young as far as having babies. I mean, there are people that have them even older than me now, but most of them are doing it with eggs that they had from before or donor eggs. " – *Rachele*

Several others described less than satisfactory experiences with their doctor during and after their miscarriage. One participant felt her miscarriage was minimized by her OB/GYN:

"I didn't get a hold of my regular OB/GYN until the next morning or so after miscarrying on the road in that hotel room. Now, she was more sympathetic than the staff in the ER. However, I was kind of surprised because I've been with her for years when I was pregnant with K [daughter] and when I was having problems I could call her at home but with this she seemed very different. She's not had a loss and maybe that's what it is, she seemed to kind of just brush it off, she was all concerned with the cancer scare discovered right after the miscarriage. She switched right into that just like everybody else did, forgetting all about the miscarriage I had just had." – *Teri*

Emotional Support Seeking Behavior

Several of the participants mentioned that they had begun attending either a hospital based, monthly pregnancy loss support group or had begun seeing an individual therapist who specialized in grief following a pregnancy loss. Some participants joined local chapters of various miscarriage and neonatal loss support groups, and some joined infertility support group, while a few others joined online message boards or forums for grief and loss. One participant spoke about her reaching out to an area artist who specialized in designing prayer bowls made from gourds as a means of seeking guidance following the stillbirth of her son:

"After I went back to see C G, who was the lady that made the prayer bowl, and I said, 'Are you still seeing that I'm gonna have this baby? I've had two more miscarriages.' She said, 'I still see this spirit that wants to be with you.' And she said, 'But it's always your choice, this is just a possibility, this spirit wants to come and manifest to live with you.' And she had also said to me that I had to stop being a lady-in-waiting about it, she said that she was getting something from my guides or my guardian angel that I needed to live my life, and not just be waiting for this baby and that that was part of what needed to happen. Then, she said she was getting message or reading for me about the number 7, but she didn't know what it meant. She said, 'Somehow, seven is a significant number for you; I don't know why, but it is.' And, well I had seven miscarriages as it turned out,

in the very end, and she never said that's what it was about, but clearly it seems like that is what it was about, seven losses before finally getting my two children." – *Rachele*

Gendered Differences with Grief and Loss Experience

Much can be said about the gendered differences in the grief response among spouses, even when the loss is ostensibly of equal bearing or is a shared loss, i.e. the loss of a child versus a spouse experiencing the loss of their parent or a friend. Nearly every participant mentioned the difference in grieving in their spouse's response to the loss. One participant explained:

"My husband has admitted, he says 'It's different for me. I hate to say it, I don't feel it like you feel it.' I don't blame him for that, he was being very honest. He said 'The cemetery made it very real.' He said 'When I had to carry that little baby casket,' - it hit him more. But ultimately, it's different for a guy." – *Joni*

Another participant noted her difficulty in even discussing her grief with her spouse as she stated:

"Before I made the name for the [miscarried] baby official or whatever, I thought, 'No, he [husband] has to agree to this, I need him to participate with me in naming our child', and so I couldn't find my voice, every time I tried I stopped, so I was on Facebook and he was on Facebook just around the corner in another room in the house and I sent him a chat message and we had probably an hour-and-a-half long Facebook conversation which was the most we had ever talked about it [miscarriage] ever. I told him what I felt and he had said, 'I thought you were getting past this.' And he didn't know I was not moving on from the miscarriage, I couldn't figure out how he didn't know that I wasn't past it, so I told him that I needed to give the baby a name and asked him if he liked the name, all of this is over Facebook, not face to face. So after I told him everything then he could hear me crying in the other room and he came into the room and held me and said, 'I love M just as much as I love you,' and I really needed that." – *Teri*

And finally, one participant described the difference in how she and her spouse proceeded in their journey through grief:

"So, my husband and I started attending the hospital based grief group and I went consistently; monthly, G [husband] and I went for quite some time. And then, he didn't feel like he needed it as often. So, there were a few times after that I went by myself and that was okay. I did learn, you know, through the counselor and the grief support group that we're not always on the same page with grief, men and women, spouses." – *Lacey*

Overall, the participants in this study recognized that men and women grieve differently and they seemed to accept their spouses' differentiated style of grieving as normal.

Textural Descriptions

The textural descriptions of each participant's experience of miscarriage at an AMA were gleaned from the participants own telling of "what" had happened. As defined by Moustakas, it is the "what" that must be explicated texturally in order to arrive at the noematic phase, i.e. the phase of describing the perceptual meaning of some experience. Thus, the texture of each participant's experience is the basic, overarching details of what had happened to them. Using the relevant horizons, meaning units, and overall themes from the transcript, and ecomap data individual textural descriptions of experience have been constructed for each participant. A verbatim example selected from each participant's transcribed interview will be included to draw out further texture of personal description of "what" occurred.

Participant 1 – "Stacey"

Stacey's experience with miscarriage was informed largely by her first maternal loss which happened in August 2011 with the loss of her daughter V. Stacey's first pregnancy resulted in her daughter V being born prematurely at 22 weeks and 1 day gestation, she was born alive and lived for 8 minutes. After the traumatic loss of her daughter, Stacey went on to get pregnant again, and that pregnancy ended in an early miscarriage in January 2012. This was followed by an ectopic pregnancy for which she took medication and lost at the very end of February 2012, and then another ectopic pregnancy occurred for which she had surgery in July of 2012. During our interview Stacey recounted her first miscarriage experience:

"With my miscarriage, I didn't have to have a D&C. I just miscarried naturally, but I was at work when it happened. And I was sitting in a meeting when I knew it was starting to happen. And I'm sitting there, and I remember sitting there feeling like, 'Am I actually

losing a child right now, and we're all just sitting around here talking about work as if nothing's going on?' It was like this out of body experience that was so surreal and bizarre. It's like 'I'm having a very traumatic experience here, but I have to sit here and look at you all and pay attention to what you're saying', and it was a really strange experience. I will remember always where I was sitting at the table, in what conference room. I vaguely remember the people that were there, but I remember everything about where I was sitting, having this outer body experience of having a miscarriage right now. And I remember thinking, 'I can't tell any of you because none of you even knew that I was pregnant.'"

Participant 2 – "Joni"

Joni's experience with miscarriage took her by storm on many levels. First, being a mother of five children, Joni and her husband T had not decidedly proclaimed to be finished having children, but at the same time, she and T were not trying to conceive when she discovered she was unexpectedly pregnant with their sixth child. Secondly, anyone who has had five pregnancies resulting in five live births would surely get some sense of confidence in her ability to carry a pregnancy to term. Although Joni did have some degree of uncertainty, a sense that something may be off with the pregnancy, she was completely shocked when she was handed the news that there was no heartbeat upon sonogram inspection. Joni remembered that fateful doctor's appointment when she found out that she was not carrying a viable pregnancy:

"Because the OB/GYN doesn't take you now until you're pretty far along I didn't go in until ten weeks. I had T [husband] there with three of the kids and I get to the exam room, they measured me and said 'You're not ten and a half weeks, you're less.' I said 'No, I know I'm that far' she said, 'Well, you're measuring smaller.' She tried to find the heartbeat and she couldn't find it. She said, 'Let's call upstairs and get an ultrasound'. Nothing was registering. And it was so weird, you know, everything has always worked out for me. I am one of those people who always kinda feels like it's going to be fine, because that's how my life has been; I've been very blessed in so many ways. So we're waiting and I watched a couple who was very pregnant and must have gotten bad news because she was a mess and I was watching this couple and their body language and actions. I looked over at T and said 'You and the kids have got to go.' But he said 'I'm not leaving you' and I said 'It will be fine, just go.' So he left with them, I made him; he did not want to go. So, I finally get back there in the ultrasound room and the sonogram technician first does the outside ultrasound and said 'We're going to have to do an internal' and she must have known already because she said, 'I will be right back', and she went and got a doctor to do the internal sonogram. I could see the baby and I just

kept asking ‘Where’s the heartbeat?’ It was one of those surreal moments. She just handed me the box of Kleenex and told me ‘We will give you a few minutes, the baby is gone.’”

Participant 3 – “Penny”

Penny describes herself as the mother of five children, three children living with her here on earth and two of her children living with the Lord in Heaven. Penny’s second pregnancy resulted in the premature birth of her second son, M, who was born at 26 weeks gestation. M was born alive and lived for three days. After losing her son M, Penny went on to have another son followed by a pregnancy that resulted in a miscarriage at 8 weeks gestation. Following her miscarriage Penny almost immediately became pregnant again and gave birth to a daughter in 2011. Penny described what was happening for her during her miscarriage experience in this passage:

“Knowing that my body was in a miscarriage as it started then, I was so sad. I really was. I didn’t want this to be happening and I didn’t want the doctor at the other end of the phone to be telling me ‘Yeah, this is probably what’s happening or maybe this is what’s gonna happen.’ I just didn’t want to be in the situation, you know, so you’re fighting it even though you know it’s what’s happening and you know what the end is going to be. So, I had to find something to hold onto at that point and it was, I guess I’d say I can’t really remember, it was 41 or 40 of Isaiah, ‘Do not fear for I am with you. Do not be afraid for I am your God. I will strengthen you and teach you. I will uphold you in my righteous right hand.’ And that passage is what kept going through my head while it was all happening, and again, my husband had taken the kids out, knowing I needed this time and what all was happening to me and my body. But yea, that’s what framed that loss for me; that I wasn’t alone even though my husband and the kids were out. I was so afraid of what was going to happen, was it going to be as bad as labor and I’d had such a tough labor with my first child. So, it was scary, and you hear all these miscarriage stories and how awful it can be and I just had to trust again in the Lord that this was right even though everything about it felt so very wrong.”

Participant 4 – “Rachele”

At the time of our interview, Rachele had fairly recently given birth to her second living child, a son named E. Rachele also has a six year old daughter, V. Before and in between the

births of her two living children, Rachele had experienced six miscarriages and one stillbirth. Rachele's motherhood journey has been filled with many ups and downs. During our interview Rachele described the first two miscarriages she experienced, which were her first two pregnancies, followed by the birth of her daughter V. After her daughter's birth, Rachele continue to suffer more losses including the stillbirth of her son born at 20 weeks gestation and four more miscarriages. One of the miscarriage experiences that stood out to Rachele she described as follows:

“So then after my daughter was born we started trying to conceive again. I then had another miscarriage, it was at nine weeks gestation and that was a bad one. I remember I had the flu during that pregnancy, and I'll always wonder if that didn't somehow contribute to it because the gestational size of the baby was about when I got the flu, at nine weeks. And I was just whipped, wiped out, physically and mentally from that one.”

Participant 5 – “Sharon”

Sharon had gone many years of her marriage voluntarily child-free. Sharon described how she and her husband C had made a happy life together focusing on their careers. Only in her late thirties did Sharon decide she did in fact want to have a child. After deciding to try to conceive, Sharon and her husband were happily expecting their first child until she unexpectedly miscarried. At the time of our interview, Sharon had been pregnant twice, with each pregnancy resulting in miscarriage. Both of Sharon's pregnancies occurred early on after deciding to try to conceive. Since her two losses, Sharon and her husband have been experiencing infertility issues. Sharon vividly remembered her first miscarriage experience:

“I was having extreme cramping the day after I found out there was no heartbeat. So then I had, because I found out on a Monday and I had it [D & C] scheduled for a Wednesday. So I was miscarrying on my own on Tuesday.”

Participant 6 – “Geri”

Geri’s first two pregnancies resulted in her daughter I, who is 4 years old and her son L, who is 2 years old. Geri’s third pregnancy was a little unexpected, though not at all unwanted. Geri had some underlying concerns all along with her third pregnancy, and she felt something was amiss. At her 20 week ultrasound Geri found out that her third baby was a boy and he was diagnosed with Trisomy 18. Geri named her third child N, and was told that N had a condition that is typically incompatible with life outside of the womb. Geri had hoped that N would be able to receive lifesaving heart surgery upon his birth, however, during an in-depth sonogram to determine the plausibility of such a surgical procedure it was determined that in the weeks following her 20 week sonogram N had passed away in utero at 24 weeks gestation. Geri was induced for labor and delivered N. Subsequent to the tragic loss and stillbirth of her son N, Geri had unknowingly become pregnant again, yet suffered another devastating loss in the form of a chemical pregnancy earlier this summer. At the time of our interview it had only been three weeks since Geri’s early loss experience, as she recalls those events in the following way:

“June 2nd I took a pregnancy test and that was negative. So on June 3rd I called my OB/GYN and asked if I could get testing done and get on Clomid [fertility drug]. So my doctor told me in order to go down that path they needed to make sure I was not pregnant and told me to go get a blood draw. I told her, ‘I’m not pregnant. I’ve already taken several tests. There’s no way I could be pregnant.’ But, so on Wednesday I went and had my blood work done, I took a pregnancy test the morning of the blood work, again, negative. And then on Thursday, I got the results and that was when she said it was a positive test. And I was like, ‘How could I be positive, positive for what?’ I was thinking, ‘Do I have AIDS or something?’ I never in my wildest dreams thought she was going to say pregnancy. But so, she said it was positive for pregnancy, the nurse said, ‘Positive for pregnancy’. And there was that excitement, you know, I was pregnant again! But only for like a second, then I guess I was suddenly, like a couple days later, not pregnant. Which I still just don’t understand.”

Participant 7 – “Carmen”

In the span of seven years of trying to conceive, Carmen experienced five miscarriages and two live births. Once she had decided to go off of birth control pills and started trying to conceive a child, Carmen almost immediately became pregnant but ended up having a miscarriage at 8 weeks gestation. That loss was followed by two years of infertility. Once pregnant for a second time, Carmen again suffered another miscarriage at 8-9 weeks gestation. Carmen’s third pregnancy resulted in the birth of her daughter J in 2009. Subsequent to J’s birth, Carmen went on to have another miscarriage at 8-9 weeks gestation and then a chemical pregnancy. After those two losses following the birth of her daughter, Carmen once again became pregnant, this time with twins. Everything seemed to be going along fine until a routine sonogram showed that one of Carmen’s twins no longer had a heartbeat and had stopped growing at approximately 11-12 weeks gestation. Carmen’s son, the other twin, survived that pregnancy and was born in 2012. In the following passage, Carmen describes that sequence of events with the miscarriages being staggered throughout the births of her two living children:

“I didn’t know if we were going to be one of those couples that, once you finally had that first baby, you know, then it just gets all worked out, all of a sudden you’re good, your body knows what to do. I was worried if my endometriosis was going to come back. I was worried if I was going to have any more losses. And then when we had that first loss after I had J [daughter], I was like, ‘oh no, we’re back to this again’. It was real upsetting because I kind of felt renewed after having J, like ‘Okay, we’re good, we got this’. And then when that happened, another miscarriage, it was so defeating. And then when the second one happened after she was born, it was even more so of thinking, come one, I really thought we were done with this. And it put things in perspective that for sure, made us think ‘Wow, J [daughter] really was a miracle.’”

Participant 8 – “Teri”

Teri had unknowingly become pregnant many years after the births of her two older children, now aged 16 and 14. There was a time a few years ago when Teri and her husband J had considered having a third child, but seemingly, that time had passed. At age 43 Teri had

figured she was possibly perimenopausal and brushed off her missed menstrual cycle as a symptom of early onset menopause. As the weeks went by, Teri decided to take a pregnancy test and it was positive. She knew she must have been pretty far along and was waiting for the right time to tell her husband about the unexpected pregnancy. Before Teri could tell her husband about the pregnancy she had a miscarriage at approximately 12 weeks gestation, while away on a family trip. Adding another layer of complication to Teri's miscarriage experience, it was discovered at that time that Teri had a uterine mass. Teri's uterine mass was removed surgically through a hysterectomy procedure. The timing of the miscarriage and discovery of the uterine mass were inextricably linked and shaped the overall miscarriage experience for her as she shared in this passage:

“And so then everybody just was concerned about that uterine mass and then they wanted me to have a hysterectomy because the doctors said they couldn't just cut it out. I wanted them to just take the tumor out and they said they couldn't, they were really pushing me into getting it removed right away and I didn't. And everybody, except for my kids, everybody was pushing me to get the hysterectomy and take care of the tumor issue and so I think now looking back, I delayed it because of the finality of that and because I hadn't grieved yet.”

Participant 9 – “Lacey”

Lacey had met and married her husband G later in life and only began trying to conceive a child at the age of 45. Lacey's husband already had two children, now young adults, and he had had a vasectomy many years ago. After meeting Lacey and learning of her desire to become a mother, G had a surgical vasectomy reversal procedure done, however it was unsuccessful. Lacey and G had to use artificial reproductive technologies in order to get pregnant and upon their first attempt, Lacey was expecting twins. The twin pregnancy however resulted in what the medical community would still consider a miscarriage, when Lacey went into preterm labor at 19.5 weeks gestation. Lacey's one twin, a daughter named S passed away in utero due to a

prolapsed umbilical cord, she was delivered first. Shortly after her daughter's delivery, Lacey's other twin, a son named B was delivered and lived for just under 2 hours. After the traumatic loss of her twins Lacey went on to get pregnant again through the use of in vitro fertilization, however that pregnancy resulted in a miscarriage at approximately 9 weeks gestation. Lacey described what happened with that subsequent loss in the following passage:

"The nine-week loss was tough, we got pregnant through IVF. So, with that cycle, we knew when we went in within five weeks or something, that there was just a sac, so we kinda knew it wasn't going good. There wasn't a heartbeat. Went back a couple weeks later, and still, the same thing. So, it's not that it wasn't difficult; it was, but I kinda was expecting it and bracing for it, part of me kinda wasn't surprised when he told us that it wasn't gonna be a viable pregnancy, and I ended up having the D & C, I didn't have to have a D & C, but I chose to have one."

Participant 10 – "Pamela"

At the time of our interview, Pamela had experienced three miscarriages. Pamela's first pregnancy resulted in a miscarriage at 11 weeks gestation. Following that loss, Pamela went on to have a son, J, who endured a traumatic birth. After the birth of her son J, Pamela went on to get pregnant two more times, both of those pregnancies ending in miscarriages at approximately 9-10 weeks gestation. Pamela described her experiences of miscarriage in the following way:

"I don't know if you know anything about my son J, but he's got cerebral palsy. We had a very traumatic birth, I had a placental abruption. So he was in the NICU for almost a month, and by the grace of God, he is doing wonderfully. But I always have that in the back of my head, 'Well, maybe I'm not supposed to have another baby because of him.' I kind of feel like I'm being selfish. But I mean, he's doing so well, so it's hard to know. I guess I just try to justify it, why I have had all these miscarriages...because we just do not knowing why I have had so many, why it keeps happening because all my genetic tests came back there's nothing wrong, they can't find anything wrong."

Structural Descriptions

The structural description of each participant's experience provides an account of the main dynamics that underlie the way in which the experience was endured. The structure of the

participant's miscarriage experience tells the story of the "how" of the incident. Using the participant textural descriptions and the researchers own personal experience with miscarriage at an AMA, the process of imaginative variation allows the researcher to become aware of and to reveal the feelings associated with how a miscarriage is experienced.

Participant 1 – "Stacey"

The structures that pervade Stacey's miscarriage experiences and produce penetrating thoughts and feelings regarding her losses were clearly expressed when she described her ambiguous role as a mother to children who she cannot parent. Stacey has struggled to find ways to meaningfully honor her children and to mother them when she knows that they need nothing from her, in the practical, conventional mothering sense. Stacey feels that her chances to become and sustain pregnancy have passed. Not only is she coping with the feelings of loss and grief for the four losses she already has sustained, there is the added loss and grief associated with infertility and the compounding loss effect felt by the decline of her reproductive years. Not having a living child excludes her from many social functions from which she now insulates herself. So on some level, Stacey feels that there is no place for her to fit in socially, with her peers. Stacey struggles with the notion that some people would define her exclusively as a loss mother. Although with each loss she has become more and more deeply affected by her losses, being a loss mother does not represent the entirety of her own sense of self identity. Stacey blogs about loss and infertility, and she had mentioned her concern that although those are topics about which she writes, she hopes that her readers, many of whom she does not know personally, are not making the false assumption that she lives a life filled only with sadness and grief. Stacey is exhausted, physically and emotionally and it has become difficult for her to strike an emotional balance as she stated:

“Some days I feel like I could do anything after what I’ve been through, and some days I feel very broken by it. One of the jokes that my friend S, who’s been such a great support to me, we joke about is how when someone posted on my Facebook profile in response to my blog, ‘You’re so strong!’ And S wrote it to me as this big joke, ‘Oh yes, you’re so strong! How do you do it?’ And I wrote back to S, ‘If by strong you mean laying in the fetal position and crying uncontrollably, that was how strong I was last night.’ And so she made up this ongoing joke about it, about people always coming off with that, yet I’m so strong that I’m crying on the floor, uncontrollably, yeah that’s how strong I am! But then, when you have those breakdowns, you feel that much weaker in those moments.”

Participant 2 – “Joni”

Joni is in a unique motherhood sphere, she has children in all stages of childhood. Joni struggles with the notion that her sixth pregnancy, which ended in miscarriage, is her last experience with pregnancy. Joni was unsettled with the idea of her reproductive years ending with a loss. She felt very torn about having to make the decision to try to conceive again or to proclaim her family as complete. As many of the women felt the near immediate urge to be pregnant again soon after her miscarriage, Joni was no different in that respect. Although, Joni felt overwhelmed with the prospect of having to make that choice and preferred rather that the story of her family be written by God’s will for her. Joni found much peace during the days following her miscarriage and D & C procedure in the comfort of her large family and through her strong Faith. As Joni stated:

“I think God knew, if this baby is not going to make it, thank God it left my body at ten and a half weeks because I don’t know how it would have been if it had been later. It was so extremely hard for me because I know when life begins and I know how much I love them before they’re even here and I already loved that baby so much.”

Participant 3 – “Penny”

Penny’s miscarriage experience was greatly influenced by the earlier loss of her son M, who had died three days after his preterm birth. Following the death of her infant son, Penny spent considerable time and energy establishing a non-profit organization which focuses on

disseminating grief support information to families touched by miscarriage, stillbirth and neonatal loss. Penny found solace in her strong religious convictions, whereby Penny described feeling completely at the mercy of the Lord and believed in the power of the Lord with respect to hers and her family's life and emotional wellbeing. Experiencing a miscarriage following the loss of her son M was a tough loss for Penny, and like many others had described, her previous loss colored and compounded her miscarriage loss experience as she described here:

“The miscarriage it was difficult, it wasn't like M [deceased son], I got to hold him, see him, but still losing that baby was really, really hard.”

Participant 4 – “Rachele”

Rachele had many experiences of loss. She mentioned experiencing bouts of depression throughout her life and she mostly attributed her depressive symptoms to a preexisting condition, dating back as far as her early childhood. Although many women struggle to make sense of their miscarriage, Rachele firmly believed that she had a lesson to learn from each of her losses. Rachele felt certain that her spirituality was strengthened during her times of loss. She believed that new and helpful forces were at work in her life, bringing her new experiences and insight with each miscarriage. With her last pregnancy resulting in the live birth of her infant son, Rachele believed that finding and routinely visiting the Servant of the Blessed Mother Mary Shrine in Windsor, Ohio was pivotal in her spiritual journey as well as contributing to the live birth of her son. Rachele felt that certain influential people, places and practices were made available to her as part of a larger plan to bring her closer to God and to experience motherhood as she had planned. Rachel was passionate about the purposeful aspect of her loss experiences and her spiritual journey. She has authored an article related to her spiritual work and her maternal experiences. Rachele had gone through many losses along the way, but through it all she remained strikingly optimistic and hopeful. As she described:

“My mom gave me this prayer card that had belonged to my grandfather that had a picture of Jesus on it. I remember I just would kinda look at it sometimes and it would just make me feel comforted. I remember feeling discouraged after the losses, obviously, but I still had this hope.”

Participant 5 – “Sharon”

Having experienced two miscarriages Sharon seemed to oscillate between feeling encouraged that she was twice able to get pregnant and feeling completely powerless in her pursuits towards motherhood. Sharon had described feeling unsure if she had ever felt like she qualified as a mother either time when she had been pregnant, due to the brevity of both pregnancies. Sharon struggled with her decision to withhold from her husband her feelings of desiring motherhood when she first experienced such a longing. Sharon feared that her changed perspective on their long standing family arrangement of choosing to be child-free would put unfair pressure on her husband, C. After two years of pondering motherhood Sharon shared her desire for a baby with C. Sharon’s delight that C was happy to comply with her desire to have a baby was quickly replaced with sadness following her first miscarriage. Although Sharon and C’s purported infertility issues triggered their utilization of artificial reproductive technologies, Sharon had remarked that both times when she had become pregnant, she and C had not used any fertility interventions. While on the one hand, this gave Sharon a boost in confidence that her body is capable of pregnancy, it also seemed to add a layer of ambiguity to her unexplained infertility issues. She recounted:

“There’s nothing, no reasons - I mean, sure they [OB/GYN] can do a test and by the test results everything looked fine but it didn’t answer the question - why isn’t this [conceiving] working or why is this [miscarrying] happening? And that’s just it, it’s the unknown and that’s the part that I struggled with, the having zero control. I have a hard time not having control or relinquishing it. But it’s like with this I have zero control. I got nothing. There’s nothing I can do.”

Participant 6 – “Geri”

Given the enormity of Geri’s two losses within a short period of time, she found it unsettling to comprehend the legacy of her most recent pregnancy history. Geri expressed on many occasions her fears of continued losses moving forward. Geri wants to expand her family to include two more children, and she alternates between the excitement of possibly becoming pregnant again and the complete fear and anxiety of being pregnant again. Geri felt inspired by the recent revitalization of her marriage to M having gone through such an emotionally turbulent time with their two losses. She mentioned in our interview that she and M are stronger than ever before, having weathered the storm of their son’s stillbirth and her recent chemical pregnancy. While Geri spoke of her enthusiasm to try to conceive again, she also spoke of her concerns regarding her age and her recent pregnancy complications as she reflected on her last pregnancy in this way:

“It’s just tough cuz, it was a joy, for that brief time I knew I was pregnant, for that short, short time. It was an excitement. And then it turned to pure sadness, again for us.”

Participant 7 – “Carmen”

Throughout our interview Carmen routinely mentioned the agony of the unknown, why the miscarriages continued to happen for her and her husband, why miscarriages happen at all. Carmen described the great sorrow she and her husband felt with their last miscarriage, which had begun as a twin pregnancy and ended with the live birth of her son. Carmen mentioned how she and her husband had requested placental testing following the birth of her son with the hopes of gaining some insight, some answer as to why she lost one more baby. By the time Carmen’s son was delivered the miscarried twins’ placental material was too far disintegrated to allow for any causation testing. Carmen articulated her disappointment and genuine sadness that fetal remains testing could not be performed on her miscarried twin as she and her husband had hoped

to find out the gender of that baby. Carmen declared that not knowing the gender of her miscarried twin made it increasingly difficult to grieve. Carmen was not alone in contending that being unaware of the miscarried baby's gender added a layer of ambiguity to an already unclear loss. Not knowing why she miscarried was especially difficult for Carmen to tolerate, as she stated:

“And so we [participant and her husband] both, we just wonder why it happens. We never knew why we had so many miscarriages. So you just think, ‘Is it me? Is it him? What's happening here?’ So you just worry if it's something in your body that's not right, or do you have bad eggs, bad sperm? So you just, you wonder, ‘Is it something that I'm doing to contribute?’ Indirectly, obviously, but you do wonder just what you could be doing wrong, why is this happening to me, to us? You just wonder, what causes it to happen.”

Participant 8 – “Teri”

Teri's unexpected pregnancy and subsequent miscarriage followed by her hysterectomy surgery all conspired to create a great deal of grief and sadness for her. Teri described a delayed grief response following her miscarriage in light of the impending hysterectomy surgery she had to undergo. After her hysterectomy surgery, Teri experienced PTSD symptoms from unmet pain management needs she had to endure immediately following her recovery room stay. The horror of her hysterectomy surgery recovery along with the inherent meaning associated with a hysterectomy represented the finality of the chapter of her motherhood experience being shut permanently. This all conspired to further worsen her grief response following her loss. With her husband unaware of the pregnancy before she miscarried and the sense of minimization of the loss, Teri's grief is complicated and causes her to feel somewhat disenfranchised. As Teri stated:

“When you lose your best friend or your dad or your mom, people continue to talk about them. Maybe they don't ask you how you are doing with the grief long after the loss, thinking you've moved on but they'll say from time to time, ‘Oh, remember when your dad did that’, or my friends will say, ‘Oh, do you remember when you and C [deceased friend] sang that song and you did that’ and I'll say, ‘Oh, yeah, I really miss her,’ and I have a chance to say that, ‘Yeah, I really miss her’ and I get to think about her and have

her acknowledged. But with a miscarriage, nobody talks about the baby. Nobody says anything, mostly probably because there's nothing, there's no memories, they didn't see the baby, there's no story to tell, there's no 'I remember when...' nothing. Nobody talks about them."

Participant 9 – "Lacey"

Lacey was 23 weeks pregnant at the time of our interview, and has since gone on to give birth to a healthy rainbow baby girl named, A. Lacey made mention of the extreme stress and anxiety she was living with every day being pregnant the 4th time in her life, hoping to welcome her first living child into the world. Having experienced two previous miscarriages, as well as the premature birth and loss of her twins, B & S, Lacey feels that she not only lost all of those babies, but she had also lost the ability to revel in a blissful mother-to-be experience. She shared with me that "pregnancy after a loss is no fun," her loss experiences took away any possibility for her to relax and enjoy the process of expecting a baby. While Lacey was very much aware of the risks associated with pregnancy, specifically at her age, she was also struck with disbelief that she had actually gone through all that she had endured. As she stated:

"So after the twins were born and died we went home and the whole nightmare continued, as a grieving parent. We left the hospital and they were wheeling me out and I was sitting in this wheelchair with two teddy bears instead of two babies. And all these pregnant women were coming in with their spouses, must have been child birthing classes or something. And the nurse that wheeled me out, she was sweet. I remember her patting my arm and saying, 'It's just not fair. It's just not fair.' I kept thinking, 'This is a dream right?' Like, I'm gonna wake up from this. This has – this has got to not be happening. But it did and that was how my pregnancy ended with the twins at 19.5 weeks."

Participant 10 – "Pamela"

Pamela mentioned in our interview that she has relied heavily on her faith to help her through three miscarriages. Unfortunately, since the time of our interview, Pamela has endured a forth miscarriage. When describing her motherhood journey, Pamela indicated that her husband

and son have been her primary sources of support. Pamela has one good friend who had also experienced miscarriages, and she found this friend to be a good source of guidance during her losses. Pamela mentioned the silence surrounding the miscarriage experience as she noted those family members and friends who chose not to speak openly about Pamela's or their own miscarriage experiences. This noticeable silence made Pamela feel like an outsider to those who seemingly do not struggle to have a baby. As she provided the following remarks:

"I think you start out, everyone starts out thinking it's gonna be so easy, you want a baby so you have a baby. As if you just say, 'Hey, let's have a baby,' and then nine months later you get to have a baby. It's definitely not that easy. It's not that simple. That's just not how it works every time for every person."

Synthesized Composite Textural and Structural Descriptions

I integrated each participant's textural and structural descriptions of their miscarriage experience into a composite portrayal that represents the essence of the experience. The essence of the experience depicts those essential features inherent to the experience of miscarriage at an advanced maternal age. The essence of any experience represents those features without which an experience would not be.

Essence

As mentioned at the opening of this chapter, four salient features surfaced from the findings of this study. Those four features represent the essential essences of the experience of miscarriage at an AMA for the participants in this study. Although each participant experienced her miscarriage(s) in a unique and personal way and with some variation among the actual processes of miscarrying, the participants tended to respond to the experience in very similar ways. They experienced the physical feelings of intense loss and grief. They experienced a sense of otherness as compared to their peers. They continue to search for the meaning in their loss.

They each shared a sense of regret and self-blame as related to the unknown cause of their miscarriage(s).

Although miscarriage represents an ambiguity of what once was, what was lost and why it is no more, the associated grief is real. Each of the participants in this study revealed their feelings of deep sorrow over the loss of the hopes and expectations for their would-be and wished-for child. Their loss, as well as their associated grief over the loss, created for each participant a sense of otherness relative to those around them. For some participants the sense of otherness was rooted in their notion and society's notion of appropriate social and developmental progress, as it pertains to achieving the goals of reaching conventional motherhood. For other, the sense of otherness was rooted in their response to and handling of their miscarriage and the ensuing grief. The sense of otherness as it related to the participants' grief following their miscarriage is linked to the ambiguity in the loss which shrouds miscarriage.

Many of the participants expressed how theirs was a loss not entirely recognized by some of their friends and family. Every participant noted their sense of a societal silencing and lack of acknowledgement of miscarriage as a real form of loss. Each participant worked toward gaining understanding, clarity, wisdom and meaning relative to their loss experiences. All of the participants expressed a longing for the unanswered questions regarding their miscarriage to someday be resolved, though each was aware that they might never fully understand. Finally, an inveterate feature of the miscarriage experience, as noted by each participant in this study, was the sense of self-blame and regret over what one could have done or should not have done in order to have a different pregnancy outcome. Independent of the medical establishment's unequivocal stance that the vast majority of miscarriages are the result of bad luck and biology,

women who suffer a miscarriage still tend to turn this back on themselves. As one participant maintained:

“The reproductive years, that fully falls on the woman in this scenario because my husband could go out and meet somebody else at 60 and still have a child, and it’s not an option for me. And so a lot of that responsibility or blame and guilt then falls on me, that I’m the one who has the problem in this scenario because of my age, because of all of these other issues. And it just adds to the guilt. And we’re the ones [women] who have the limitations on what producing a baby can be.” – *Stacey*

Chapter Five: Discussion

The purpose of this chapter is to report a summary of the study, to relate and distinguish the study findings from prior research literature, to present a conceptual-theoretical model of the study findings, to denote the limitations and clinical implications of this study and to provide suggestions for future research.

Research Study Summary

In Chapter One I introduced the purpose of this study and the theoretical underpinnings of the study. I discussed the relevance of applying concepts from ambiguous loss theory and the human ecological model to the study while viewing this research through a feminist lens. I discussed the significance of this study as it relates to the societal shift in the timing of entrance into motherhood. I discussed the various types and risks of miscarriage and presented the rates of miscarriage by reproductive age group. I also introduced the primary research question; How do women of advanced maternal age perceive and describe their experience of miscarriage? Finally, I presented a combined theoretical and conceptual map and tabular depiction of the research question tied to the research goals and the pertinent theoretical concepts from ambiguous loss theory, feminist theory and the human ecological model for a more comprehensive explanation of this study's design and approach.

In Chapter Two I presented the current body of literature as it relates to miscarriage and advanced maternal age. Specifically, I organized the existing literature along the human ecological models' levels of context, among various concepts from ambiguous loss and feminist theory. The existing literature relating to ambiguous losses and miscarriage touched on the following issues: unresolved social role, loss of social and personal status of mother-to-be, ambivalence towards pregnant others, unclear cause of miscarriage, unresolved meaning making, loss of attachment to

the wished-for-child, loss of biologically optimal reproductive years, and ambivalence toward future pregnancies due to the oscillation of having hope and having no hope at all. The existing literature relating to feminist thought and miscarriage touched on the following issues: motherhood myths, the motherhood mandate, the motherhood tax, societal silencing and disenfranchisement of grief with miscarriage, the politicization of miscarriage, the medicalization of women's bodies and of miscarriage, lacking acknowledgement of the loss from family, friends and co-workers, self-blaming, and issues related to miscarrying at an AMA versus at a younger maternal age. I described the gaps in knowledge that exist regarding women's lived experience of miscarriage at an AMA.

In Chapter Three I presented the rationale for utilizing a qualitative research mode, specifically Moustakas' (1994) transcendental phenomenology approach. I presented the framework for addressing my research question; How do women of advanced maternal age perceive and describe their experience of miscarriage? I detailed the sample recruitment and selection criteria utilized to arrive at the 10 participants who engaged in this study. I substantiated my use of epoche in preparing to engage in study related activities and recognized my role as a feminist field worker. I described the stages of data analysis utilized for this study per Moustakas' (1994) modification of the Stevick-Colaizzi-Keen method of analysis of phenomenological data. Finally, I concluded the third chapter with a discussion of the measures of trustworthiness I utilized in conducting this study and I describe my own personal experience with miscarriage at an AMA in my initial reflexive passage.

In Chapter Four I presented the results of my analysis, including the 24 meaning units identified, the four primary themes of the experience, the textural and structural descriptions of each participant and what I found to be the essence of the experience of miscarriage at an AMA,

all of which were derived from the participant interviews. The 24 meaning units, derived from the participant interviews, were as follows:

1. Unexpected Nature of Experience
2. Corporeal Experience
3. Issues Related to Infertility
4. Feelings of Grief and Loss
5. Meaning of Pregnancy
6. Meaning of Motherhood
7. Meaning of Miscarriage
8. Attachment to the Would-Be-Child
9. Oscillation Between Having Hope and No Hope
10. Religious – Spiritual Aspect of Coping
11. Woman's Intuition
12. Memories and Triggers
13. Regrets and Self-Blame
14. Acts of Memorialization
15. Age Specific Influence
16. Influence of Previous Losses
17. Timing of Pregnancy Announcement
18. Loss of Mother-To-Be Status
19. Influence of Time Pass on Experience
20. Significance of Family and Friends
21. Experience Having an Influence on Relationships with Others

22. Influence of Medical Community
23. Emotional Support Seeking Behavior
24. Gendered Differences with Grief and Loss Experience

The four primary themes of the experience of miscarriage at an advance maternal age for the study participants were as follows:

1. The Physical Context of the Experience
2. The Emotional Context of the Experience
3. The Temporal Context of the Experience
4. The Social Context of the Experience

The textural and structural descriptions of each participant's experience underscored the individual, unique aspect of the experience of miscarriage. These descriptions were developed from a synthesis of my personal experience with miscarriage, incorporation of the 24 meaning units and four primary themes, which were derived from the interview data, and the use of imaginative variation. A synthesis of the composite (combination of all 10 participants) textural and structural descriptions of the participants and their experience led to an understanding of the essence of the miscarriage experience at an AMA. The essence of the experience was delineated into four primary features: 1) there are physical feelings of intense loss and grief, 2) there is a sense of otherness among women who miscarry as compared to those around them, 3) there is a continuous search for the meaning after the loss, and 4) there is a sense of regret and self-blame related to the unknown cause of miscarriage.

Conceptual Model of the Findings

The phenomenological approach is based on the notion that things become clear as they are considered again and again. The challenge then is to gain the clarity necessary to explicate

the phenomenon in terms of its constituents and possible meanings, whereby discerning the features of the essence of the experience. Ambiguous Loss Theory in combination with Feminist Theory proved to be an ideal platform for viewing women's experience of miscarriage at AMA. Applying concepts from Bronfenbrenner's Human Ecological model provided an ideal frame for situating the physical, emotional, temporal and social contexts of the miscarriage experience, as shown in Table 5.1 below.

Table 5.1 Relating Theory, Essence, Theme and Meaning Unit

Theory	Phenomenological Essence	Theme Rooted within the Human Ecological Model	Meaning Unit
Ambiguous Loss	Grief and Loss	Physical Context of Experience	<ul style="list-style-type: none"> • Unexpected Nature of Experience • Corporeal Experience • Issues Related to Infertility
	Search for Meaning	Emotional Context of Experience	<ul style="list-style-type: none"> • Attachment to the Would-Be-Child • Meaning of Pregnancy, Motherhood and Miscarriage • Oscillation Between Having Hope and No Hope • Religious – Spiritual Aspect of Coping • Memories and Triggers • Acts of Memorialization
		Temporal Context of Experience	<ul style="list-style-type: none"> • Influence of Previous Losses • Timing of Pregnancy Announcement • Loss of Mother-to-Be Status • Influence of Time Pass on Experience
		Social Context of Experience	<ul style="list-style-type: none"> • Significance of Family and Friends • Emotional Support Seeking Behavior
Feminist Theory	Sense of Otherness	Emotional Context of Experience	<ul style="list-style-type: none"> • Woman's Intuition
	Regrets and Self-Blame	Temporal Context of Experience	<ul style="list-style-type: none"> • Age Specific Influence
		Social Context of Experience	<ul style="list-style-type: none"> • Experience Having an Influencing on Relationships with Others • Influence of Medical Community • Gendered Differences with Grief and Loss Experience

The meaning units uncovered by the data analysis procedures were fairly characteristic of those concepts shown in the initial conceptual and theoretical map (See Figure 1.1) as well as in the table of the research question, goals and concepts, (See Table 1.3) depicted in chapter one. However, of those initial concepts, some were expanded upon, further developed, added to and some proved to be irrelevant. It is important to note that the concepts which were presented in chapter one and then appear non-applicable during the analysis stage of this study represents a hallmark of phenomenological research. My preconceived research design and conceptual understanding of the experience of miscarriage at AMA served only as a basis for exploration of the phenomenon. It was not a goal of this study to make the participants' descriptions fit the theory, but rather the aim of this study was to determine what the experience of miscarriage at AMA means to the participants in this study.

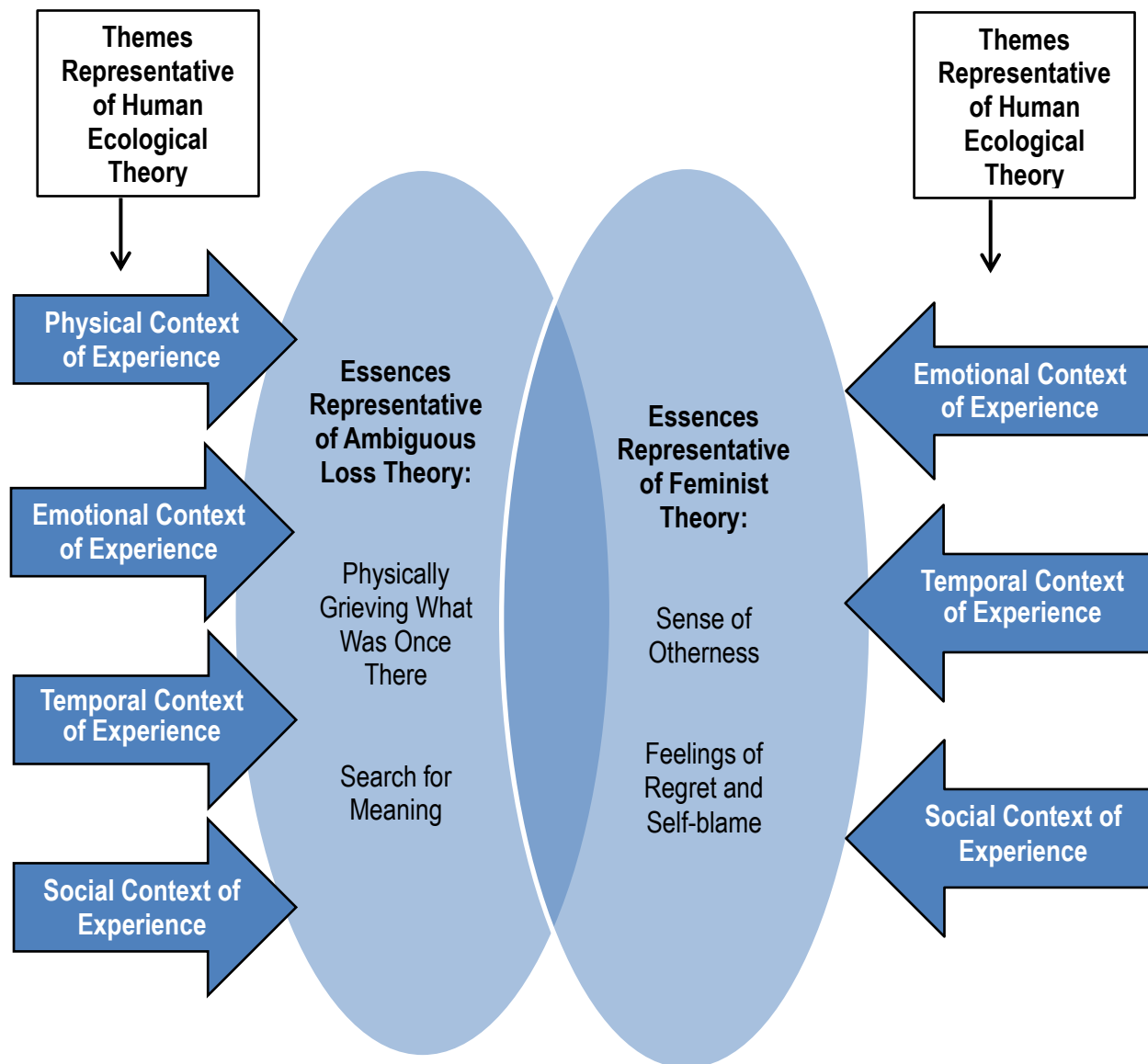
The "motherhood tax," is among those initial concepts noted in the conceptual and theoretical map (See Figure 1.1) which proved to be non-applicable to the participants' lived experiences. The participants in this study experienced a reversed or altered motherhood tax. Instead of motherhood creating lowered wages or reduced career advancement, it seemed that career development created a tax on their fertile years. Interestingly, while half of the participants reported being employed, most of the women in this study did not seem highly identified by her occupation, but rather seemed more focused on motherhood or on entering motherhood for the first time. In Sheryl Sandberg's recent book, *Lean In: Women, Work and the Will to Lead*, (2013) she discusses the tendency of younger women to "leave work before leaving," whereby many women unnecessarily tend to limit their careers before they need to, in preparation for the possibility of future motherhood, resulting in less satisfying jobs. By the time actualized motherhood necessitates a career pullback, these women are more likely to opt out of

the workforce and their unfulfilling career, altogether. From a different view, in the book, *Ready: Why Women are Embracing the New Later Motherhood*, Elizabeth Gregory (2007) describes the “clout effect,” which speaks to the fact that more and more women are delaying motherhood in an attempt to achieve their career goals first, giving them greater power and freedom to influence and shape their focus on family, rather than having to juggle priorities. For many women, work life and a professional identity offers a buffer for the stresses of our personal lives. However, among the employed participants in this study, work and occupation was not mentioned as a stress relieving resource or a welcome distraction from the miscarriage experience.

It should not be assumed that the themes and meaning units identified in this study are mutually exclusive categories. For instance, the “Memories and Triggers” meaning unit primarily represented an emotional context of experience, however, it could also represent a social context of experience. Among the memories and triggers that participant’s mentioned, feeling ambivalent and even resentful of pregnant women tended to present as an emotional experience, yet there are also social ramifications embedded within this attribute. Given societies adoration for pregnant women, feeling ambivalent or resentful towards a pregnant woman is another aspect of the participants’ sense of their own otherness or dissimilarity relative to society and those around them.

The meaning units and themes that emerged from the collective description of the participant’s experiences informed the essence of the miscarriage experience for this study. As such, a conceptual model of the study findings shown below in Figure 5.1 more accurately depicts the relevant contexts and essences of experience as defined by the study participants. Thus, the conceptual model of the study findings regards each of the components as an individual and collective aspect of the miscarriage experience at an advance maternal age.

Figure 5.1 Conceptual Model of the Study Findings



Relating Study Findings to Extant Literature

Through data analysis, the unified essence of the experience of miscarriage at AMA was gathered and is represented by four elements of description. I will briefly describe each of the four essential elements of miscarriage at AMA, and I will return to the existing literature to relate those essential findings from this study to prior research.

Essential Element One: Physical Grief and Loss

The participants in this study each described the physical experience of grief and loss during and after their miscarriage. For the purposes of this study, grief was defined as an emotional response to loss (Stroebe, 2008). For each of the participants, the experience of loss was real, and the grief which followed was intense. Although the baby that was lost was never held in the participant's arms, the baby was held in their hearts and minds. Participants in this study experienced their miscarriage anywhere from 3 weeks to 2 years prior to the interview, and each participant expressed the intense, physical and emotional response to their loss. The ambiguity of loss with miscarriage adds a layer of complication and disenfranchisement to the grief experience. Boss (1999, 2006) notes that a loss which is ambiguous in nature often leads to frozen grief, whereby the griever is unable to process her/his feelings due to the lack of clarity imbedded in the loss. A typical loss experience, such as the death of a family member with socially sanctioned death rituals, is deemed an unambiguous loss (Boss, 2006). The participants in this study reported that the unclear nature of what was lost and why the loss occurred was a challenge to their coping with the loss. This is congruent with a study conducted by Beutel, Deckardt, von Rad, and Weiner (1995) that sought to discern grief and depression following miscarriage. They found that a normative grief response following miscarriage was found to occur in the majority of study participants, while a depressive reaction was predictive of a history of depression, lack of social support and ambivalent or mixed, unclear feelings regarding the miscarriage. Similar findings were shown in a study conducted by Lok & Neugebauer (2007) measuring psychological morbidity following miscarriage.

The disenfranchisement of the grief that typically follows miscarriage was noted by each participant in this study. The concept of disenfranchised grief was first introduced by Doka

(1989) and usually occurs with a death or loss of any kind that is socially unrecognized or minimized (e.g., a miscarriage or the loss of a job). Because miscarriage does not fall under society's typical "grieving rules," family, friends, co-workers and acquaintances generally expect less grief with disenfranchised losses and may provide less social support for the disenfranchised griever. Every participant experienced, on some level, a failure to recognize their loss by various others in their lives.

Essential Element Two: Sense of Otherness

As previously mentioned, the participants in the study experienced disenfranchised grief, indicating dissimilarity in the typical form of grief. In addition to the disenfranchisement of their grief, the mere fact of having miscarried generated, to varying degrees, a sense of otherness for the participants in this study. As noted in chapter one, motherhood is a central theme in society's construction of womanhood and femaleness and motherhood is perceived mandatory for adult women to reach their purpose in life (Parry, 2005; Russo, 1976). Failing to enter or re-enter motherhood after becoming pregnant intercepts this developmental milestone and creates a sense of failure and divergence from one's peers. The participants in this study all felt that motherhood, whether it was their first experience of motherhood or a subsequent experience of motherhood, was their biological destiny once they became pregnant, and miscarrying disrupted this expected trajectory. Such perceptions are consistent with a qualitative study conducted by Loftus (2009) with infertile women, some of whom had experienced a miscarriage, and all of whom reported a profound sense of loss and did not feel like "real women."

As summarized in the literature review, we are raised in a society that values motherhood as women's most prized and primary role, whereby, miscarriage cuts short this realization and engenders a sense of not living up to those basic cultural standards (Arendell, 2000). Participants

remarked about their sense of feeling as an outsider from their peers and friends who had children as well towards those friends who had not experienced a miscarriage. Participants in this study had remarked about those fortunate women who have never miscarried lacking the understanding of what it is all about, how it is to lose a baby through miscarriage. This aligns with the results of a study by MacGeorge & Wilkum (2012) seeking to predict comforting quality in the context of miscarriage. In this study, 182 college students who had never been pregnant themselves provided feedback regarding their relative sensitivity and empathy for the experience of miscarriage. The results showed that those students who had never been pregnant had a low level of empathy for the experience of miscarriage when compared to women who had experienced a miscarriage. In another study of college students' rating loss situations, Thornton, Robertson, and Mlecko (1991) reported that grief following a miscarriage was evaluated as needing less social support from the survey participants and those who suffered with grief following a miscarriage were perceived as having poorer personal and social role functioning than traditional grievers. Lowered levels of empathy from society towards women who suffer a miscarriage leads to disenfranchised grief and a sense of otherness.

Essential Element Three: Continuous Search for Meaning after the Loss

As noted in the literature review, meaning making significantly influences one's ability to tolerate and to adapt to loss. Beliefs about death and the meanings assigned to particular forms of loss are rooted in ethnic, cultural and religious beliefs, family legacies, and in the dominant societal values and practices surrounding death and loss rituals (Walsh & McGoldrick, 2004). In an attempt to make sense of a loss, questions of *why* and *how* regarding the loss event surface along with questions of possible preventions for such a loss (Neimeyer, 2012). Addressing these questions with any loss can be difficult and in the case of an ambiguous loss such as miscarriage,

gaining meaning is made even more difficult because the loss remains, to some extent, unresolved. The participants in this study all spoke to the difficulty in making sense out of their miscarriage and their grief. The struggle ensued when participants described pressure, put forth by themselves or others, to “move on” from their loss when that process had been made more challenging by the paradox of having to find some way to change, while the ambiguity remains.

The search for meaning, which was an element of miscarrying at AMA, was illuminated by the various unresolved meanings associated with each participant’s experience. Based on the interview data, meaning units were created to represent the participants’ search for the meaning of their pregnancy, the meaning each held of motherhood and the meaning of their miscarriage. As previously mentioned in the findings, some participants found comfort by defining the meaning of their loss within the context of their spiritual and religious beliefs. Others were bothered by the notion of the common response of well-meaning friends and family, that the loss was “God’s will.” To some participants, the “God’s will” explanation of their miscarriage brought on even more ambiguity as to why God would want to punish them or hurt their baby. This same sentiment was also shown among participants in a study by Cowchock, Lasker, Toedter, Skumanich, and Koenig (2010) of religious beliefs’ effect on grieving after pregnancy loss. Cowchock et al., found that the statement regarding miscarriage resulting from God’s will produced higher grief scores on the Perinatal Grief Scale among participants in their study.

Boss (1999) states that, in unclear loss situations, metaphors and symbols aid in finding meaning and transcendence from the immediate situation more so than scientifically precise answers. This notion of symbols and metaphors resonates with what the participants of this study noted regarding their own acts of symbolism related to their miscarried baby. Participants of this study made attempts to make meaning of their loss through various memorialization acts

including: naming their miscarried baby, creating symbols representative of the time of year of the conception, the due date or the loss date, wearing symbolic jewelry, engaging in traditional burial rites, engaging in prayer bowl ceremonial efforts, framing and keeping on display any artifacts which were obtained relating to their pregnancy and miscarriage, among other acts. Yet, as Layne (2003b) states, memory of what was lost is a matter of individual, deliberate choice. This choice often comes in the face of social pressure to forget, to “move on,” and to have a replacement child...balanced with notions of what good parenting entails and the contemporary American view of memorializing as a moral act. Is it any wonder that such complexities and divergent messages further confuse an already ambiguous loss experience?

A final aspect of the search for meaning specific to miscarriage at AMA is the sense of time running out and what that means to women’s larger context of desiring motherhood. Each participant struggled with the notion that her time for producing a live child was quickly running out. Some participants understood this to mean that they may have to explore other options for achieving motherhood (e.g. donor embryos, gestational surrogacy, adoption) while others felt it could mean that their journey to motherhood may be ending. In the autobiographical book entitled, *Sweet Grapes*, Jean and Michael Carter (1989) give a compelling perspective on their own experiences of miscarriage, infertility and ultimately their choice to embrace and accept a childfree lifestyle. The Carter’s emphasize the challenge and tasks of meaning making throughout their experience, underscoring the shift in meaning from childless to childfree. Several previous works have spoken to the mixed meaning and anxiety provoking nature of AMA and the dwindling biological clock (Friese, Becker, and Nachtigall, 2006; Wu & Macneill, 2002). A study by Lewis, Legato, and Fisch (2006) reported on the medical implications of the male biological clock and the necessity for the medical community to shift in its

conceptualization of age-related fertility issues as a woman's problem. Thus, it becomes a couples' task of making sense of the ambiguous nature of miscarriage and of trying to conceive at an advanced age when a male partner (if a male partner is present) is included.

Essential Element Four: Feelings of Regret and Self-Blame

Closely related to the aforementioned element of feeling a sense of otherness is the elemental sense of regret and self-blame. Participants in this study felt a strong sense of regret and self-blame over the possibility, however unlikely, that they had contributed in some way to their miscarriage. The participants reported regrets and self-blame ranged from not taking a prenatal vitamin soon enough, a lack of healthy foods and adequate sleep, to not being worthy or deserving of the baby and not having wanted the baby enough. Madden's (1988) study spoke directly to women's beliefs that they could avoid a miscarriage in the future by simply behaving differently and taking better care of themselves. Alternatively, participants in this study also subscribed to the belief that they had very little, if any, control over their reproduction and birth outcomes. This corresponds with studies that note that in their attempts to understand the reason for their miscarriages, many women experience a vacillation between fatalism and self-blame (Barr & Cacciatore, 2008; Kevin, 2011; Stirtzinger et al., 1999). Further, women who miscarry at an AMA, who have pushed their attempts at childbearing to the furthest limits, often report harsh judgments of themselves, including self-blame for having miscarried but also for having waited too long (Tough et al., 2007). Several participants in this study made note of their feelings of regret, though each made it clear that their regret was not tied to their delayed marriage. Those participants in this study who had delayed marriage felt that there was a serendipitous nature to how they met and married their spouse, and none would have changed those circumstances.

An additional attribution of self-blame was related to the experiences of previous maternal losses. Of the 10 participants, all but two had had more than one maternal loss, those previous losses ranging from miscarriage, stillbirth to neonatal death. Those participants who had suffered previous losses felt an intense sense of blame for their miscarriage(s) due to the fact that there were previous losses that may or may not have been explained. Even among the previous losses that were identified as resulting from chromosomal abnormalities, such as Trisomy 18, some of those participants accepted the full burden of blame for those losses as well, believing that their eggs were no longer viable due to their AMA. Several studies have reported on the increased levels of distress, anxiety and self-blaming ideologies of women who have suffered multiple maternal losses (Blackmore et al., 2010). In fact, a Finnish study conducted by Toffol, Koponen, and Partonen (2013) found that a diagnosis of major depressive disorder and the presence of depressive symptoms were more prevalent among women with a history of miscarriage. The higher the number of miscarriages, the worse the participant's reported current state of mood and the higher the frequency of psychiatric diagnosis.

Study Limitations

A discernible limitation of this study is that, as a phenomenological study, it only aims to reveal the lived experience of the participants interviewed. With that, the findings from this study cannot be generalized to the larger population. The goal for this study, therefore, was to gain a rich understanding of what the miscarriage experience at an AMA was like for the 10 women I interviewed. The findings from this study do serve to provide those who may suffer a miscarriage at an AMA one representation of that experience. The findings from this study can provide a basis for future research regarding women's experience of miscarriage; however, it

should not be presumed that the findings from this study apply to all women who suffer a miscarriage, at any age.

Additionally, the small sample size presents another limitation of this study. While data saturation was met, a sample size of 10 does not allow for tremendous depth and difference determinations among the participants. Another disparaging aspect of a small sample is the limited diversity among participants. Although there was one participant of Mexican-American decent, this study lacked ethnic and cultural diversity; all of the participants were living in the United States and in the state of Ohio. As noted in Chapter One, later life child-bearing is typically seen among women of a higher socioeconomic strata, and this study reflects that generalization. However, delayed child-bearing is not entirely exclusive to women of a higher social class, as some women of various cultural backgrounds and religious sects actively procreate through the later reproductive years. For example, a more culturally representative sample could have included women of an Amish background, as Amish women are known to have large families and traditionally reject all forms of birth control (Hildebrand, Phenice, Gray, and Hines, 2007). With a broader social diversity among the participants perhaps additional insights could have been gleaned.

All of the participants were recruited through word of mouth and internet advertisements. Recruitment through internet advertisement accounted for 5 of the 10 participants interviewed. Internet advertising may have swayed the sample to only include those who have internet access and who belong to online miscarriage support groups. This creates the possibility that those participants who participate in an online miscarriage support group may be experiencing a more intense grief response following their miscarriage and would be more likely to volunteer to

participate in this study than someone else who does not belong to an online miscarriage support group.

Finally, I experienced a miscarriage at an AMA. As the researcher, having experienced the phenomena of interest can serve as a strength and a weakness of this study. As someone who miscarried at age 35, I approached this study with a cursory understanding of what the participants in this study may have experienced. I was able to utilize my miscarriage experience to construct an informed interview guide of questions and to elicit relevant aspects of the experience from the participants. This personally informed stance however, could have biased my analysis of the participant data. Furthermore, my own thoughts and feelings about miscarriage could color the findings. In order to address this limitation, I attempted to embark on the phenomenological epoche process of bracketing out my own assumptions about the experience of miscarriage before and after each participant interview and before engaging in each data analysis activity. I spent 10-15 before and after each participant interview writing a pre- and post-interview note regarding my in-the-moment feelings about the impending interview and preconceived notions I had about the participant. After the interview, I again followed up with a note regarding my feelings concerning the participant and the interview process. Although pre- and post- interview note taking is a very directed and intentional attempt at epoche, it is recognized that complete and pure epoche is rarely, if ever achieved. As Moustakas (1994) notes, some life experiences are not “bracketable.” Thus, epoche is a resource for increasing one’s ability to freely receive whatever the participant is offering. To further minimize the possibility of researcher bias I engaged in other tasks which included the maintenance of a study audit trail, pre- and post-analysis reflexive writing, and participant and peer data review at various points in the data analysis phase.

Clinical Implications of the Study

Normalizing emotions and creating the safe space for the expression of the various grief reactions following a miscarriage (e.g. “Are these feelings normal?”, “Am I going crazy?”, “Why do I feel resentful toward other women who are pregnant?”) play an important role in Worden’s (2009) tasks of grieving model. Kubler-Ross and Kessler’s (2005) staged model of grieving originates from Kubler-Ross’s (1969) classic work on the stages of death and dying. Essentially, Kubler-Ross and Kessler’s more recent work is the result of applying her earlier model of the stages of death and dying upon the griever. It should be noted that many grief scholars espouse the notion of resolving grief rather than recovering from grief, as grief may continue throughout the life span as an evolving process, versus viewing grief as an acute occurrence or event. As a society, we must shift away from viewing grieving as a linear, staged process, which implies that there is always an end stage, whereby the grief process is often conceptualized in terms of “moving on.” Grievers typically respond better to the notion of “going on” in their grief. Going on does not insinuate a *movement* away from the deceased, but rather going on and taking with them the newly defined context of their loved one.

Several research studies have documented the need for the recognition of women’s miscarriage as a real loss that produces a real grief response (Cosgrove, 2004; Layne, 1997; Rowlands & Lee, 2010; Wright, 2011). Moreover, several studies have spoken to the necessity for a higher standard of care for women who miscarry (Geller et al., 2010; Layne, 2006; Paton et al., 1999; Séjourné, Callahan, and Chabrol, 2010). Yet a therapeutic approach targeted for women who miscarry, much less an approach specific to women of AMA who miscarry, has not been identified. With that, the therapeutic landscape is in great need of distinguishing a clinical model of treatment, or guidelines for best practices for working with women who miscarry.

Clinicians working therapeutically with women who suffer a miscarriage should acknowledge and normalize their clients' grief symptoms. Normalizing the client's grief response can be an effective measure for attending to the client's sense of otherness.

In addition, therapy (or counseling) with women who miscarry at AMA should focus on meaning making. The results of this study indicate that miscarriage creates a crisis of meaning. Ambiguous in nature, grief following a miscarriage is more difficult to resolve due to the challenge of make sense of it. As previously mentioned in the findings of this study, women attempting to make meaning of their ambiguous loss are often influenced by their spirituality and religious beliefs. Boss (1999) notes the importance of viewing the lack of understanding with an ambiguous loss as the result of an external force and not one's own shortcomings, which makes it both tragic and freeing. The loss is not resolved in viewing it in this context, but some people are able to find meaning in this way. Additionally, remembering and honoring the baby lost through miscarriage often helps with creating meaning, and can facilitate the grieving process. Participants in this study mentioned several ways in which they had memorialized their babies. There are various means by which to memorialize and honor a lost baby, e.g. speaking openly and often about the miscarried baby and by name when applicable, having a special candle to light in honor of the baby, creating a special memory or prayer place in the home or in nature designated for thinking of the baby (having a tree or annually blooming plant in this space can serve as a symbol for the baby), crafting a memorial blanket, baby hat or holiday ornament for the baby, donating to a charity in the baby's memory, participating in a "Walk to Remember" in honor of the baby, writing letters to the baby, wear symbolic jewelry, compiling meaningful music dedicated to the baby's memory, engaging in butterfly and balloon releases. These and

many other activities facilitate remembering and incorporation of the lost baby into the family system and into consciousness.

Several participants in this study made mention of their less than satisfactory experience with their medical doctor and some of the support staff at their OB/GYN office during and after their miscarriage experience. Although some literature in the field of maternal and perinatal nursing care has explored the appropriate protocol for caring for women following a miscarriage, much more emphasis must be paid to this aspect of the miscarriage experience (Johnson & Langford, 2010). Medical and mental health professionals have a significant role in the grief experience of women who have a miscarriage. It is important for medical professionals to operate from a place of empathy when a woman experiences a miscarriage. Medicalizing the loss is a form of minimization of loss. Since a woman's medical healthcare team is often the first social interaction she has upon finding out that she has miscarried or soon will, the medical community's role is critical to the course of that woman's grief reaction.

The results of this study indicate that women who have miscarried experience feelings of otherness, regrets and self-blame. The needs of women who miscarry at an AMA vary depending on the multiple contexts and individual nature of her experience. As such, clinicians working with women who miscarry should seek to privilege their clients voiced needs, rather than to apply a generic form of grief counseling. The focus of the grief work should center on emancipating women from their stance of self-blaming. Self-blame has no value in the healing process, as it prevents us from going on with our lives (Boss, 1999). Regret is only helpful when it illuminates the error in our ways. In the case of miscarriage, the cause of the loss is rarely identified. As noted in chapter one, when a cause is determined, it is most often a chromosomal abnormality and not necessarily of either parents' contribution of genetic material, but rather of

the embryo's own doing unto itself (Lerner, 2003). Medical healthcare professionals, including genetics counselors, should make this information of the complete randomness of chromosomal abnormalities better known to women who miscarry. When there is no clear cause for the miscarriage, rather than to try to accept a no-fault and no-answer solution, women tend to assume the full blame for their loss (Brier, 2008). The focus of clinical work with women who miscarry should focus on finding tools to manage and become more flexible in accepting the unclear nature of their loss. Additionally, therapeutic goals should align with freeing women from their self-blaming account of the loss. Utilizing a narrative therapy approach can be especially effective in externalizing or shifting a self-blaming perspective away from the client by re-storying the client's account of their loss experience devoid of blame.

Therapists and medical healthcare professionals would do well to make their client aware of any local grief support group offerings specific to miscarriage, along with any other pertinent miscarriage support resources. In terms of the aforementioned need for meaning making, support group participation can play an important role in allowing women to draw upon the ideas and beliefs put forth by other women in the perinatal support group setting as a means of making sense of their own loss. A miscarriage grief support group may be helpful, not only for women but also for couples. As previously noted in the findings of this study, men and women grieve miscarriage differently. Sometimes, couples are unable to support one another because of gendered differences in grieving. Couples sharing their feelings within a group support format, while in each other's presence, can create the safe space necessary to reveal their needs and can bolster couple communication (Doka, 2002; Fairchild & Arrington, 2012; Gold, Boggs, Mugisha, and Palladino, 2012; Séjourné et al., 2010).

Future Research

It has been well documented in previous work, as in this study, that grief is a fairly normative psychological reaction following miscarriage. Scant research, however, focuses on the typical course of grief following a miscarriage or the most effective skills for coping with grief following a miscarriage. Since miscarriage is considered an ambiguous form of loss (Lang et al., 2011) and its psychological sequelae often creating a disenfranchised form of grief (Doka, 2002) it should not be assumed that the coping skills most effective for enfranchised grief, or typical forms of grief, would be as beneficial or applicable to the grief following a miscarriage. Thus, additional qualitative research is needed to further clarify the nature of grief and loss following miscarriage. Although several studies have focused on men's experience of miscarriage (McCreight, 2004; Puddifoot & Johnson, 1999; Rinehart & Kiselica, 2010) scant research to-date, focuses on the couples' experience of miscarriage. A study focusing on the conjoint experience of miscarriage should be explored.

Several participants in this study reported issues with fertility. As noted by many participants, miscarriage for the nulliparous woman (a woman who has never given birth) is experienced differently. The context of the loss and the meaning assigned to the loss is varied among those women who have previously given birth and have a living child versus those who have not. Research further exploring the distinction between these two populations should be conducted. Another closely related direction in research could focus on recurrent miscarriage, specifically, and its link to issues of infertility. Bick and Hoppensteadt (2005) conducted a quantitative study of recurrent miscarriage syndrome and infertility, however, the speed at which fertility treatments advance and change justifies further exploration and updating. Freda, Devine and Semelsberger (2003) conducted a qualitative study with eight women regarding their lived

experience of miscarriage after infertility, still further exploration of the intersectionality of miscarriage, infertility and maternal age is warranted. In addition, women who have experienced previous or multiple losses in the form of miscarriage, stillbirth, and neonatal death and then experience a miscarriage also merit further exploration.

Lastly, the relative degree of sensing otherness, searching for meaning and feeling regret and self-blame should be further explored as moderators of grief following miscarriage. Once a better understanding of the nature and course of grief following miscarriage is facilitated, research examining mechanisms for coping would provide for critical clinical insight.

Ockhuijsen, Boivin, van den Hoogen, and Macklon, (2013) conducted a qualitative study of women's coping after recurrent miscarriage. This was a study that sought to understand how women with single or recurrent miscarriages cope during the waiting period after a miscarriage while anticipating a pregnancy confirmation in their attempts to conceive again. However, the Ockhuijsen et al. study only focused on participants who were trying to conceive following a miscarriage and their cognitive coping strategies for dealing with the anxiety experienced in the two week pre-testing time period following their fertile phase, not on coping strategies with respect to their previous miscarriage experience(s). Ratliff (2009) a feminist author, wrote about infertility blogging and the use of humor in many infertility blogs as a benefit to the blogger's healing process. Ratliff further detailed the power and value of infertility blogging as evident from the 2005 case of infertility bloggers who engaged in feminist activism to defeat a bill put forth in the Virginia state legislature by Delegate Cosgrove in late 2004, House Bill 1677, which would have required women to report a "fetal death" to police within twelve hours of the death. If this legislation had passed, it would have effectively required women to report miscarriages to police or be charged with a misdemeanor.

Many self-help books have been written for laypersons regarding miscarriage, many of which include a chapter on various means of coping. However more research must be conducted to determine the evidence-based, best practices for coping with the psychological sequelae of miscarriage.

Final Researcher Reflexivity

I must begin by expressing my feelings of sincere gratitude and appreciation for the 10 participants in this study. Without each of their stories, my knowledge of miscarriage at AMA would be far less informed and less meaningful. They each provided their own unique contribution to this work and for that I am grateful. In meeting each participant from this study, my own sense of the meaning of loss and of hope for what lies ahead have been forever influenced. These women broadened my understanding of grief's journey and of non-conventional motherhood. I continue to feel intimately connected to each of their stories of miscarriage. Although I feel fortunate for having met them and learned of their stories of miscarriage, I also feel tremendously sad given the circumstances of our becoming acquainted. This is the struggle I routinely experience as a therapist; I am happy to help, I am sad that help continues to be needed. My life's passion, for as long as I can remember, has been grief and loss. Many people find it difficult to explore the depths of sorrow. I believe grieverers are stigmatized by much of society because of their pain and suffering. Often, the social world would like to dismiss or ignore that which is unpleasant. I feel it is my feminist perspective, desiring to uphold those who are oppressed in society, which engenders in me a desire to work with the bereaved, especially those whose grief is complicated by a lack of acknowledgment by others. My own miscarriage was a very painful experience for me, one that I would have preferred to not have

endured. However, this study has become an element of my own miscarriage meaning making efforts.

Conclusions

There is a noticeable overlapping of the meaning units, themes and essences of this study, which speaks to the interconnectedness of the participant's descriptions of their experience. It is hoped that woven together, these elements of experience have highlighted a richer, deeper understanding of the phenomenon of miscarriage and an AMA. This study contributes to the overall body of theoretical work as it applies to the examination of the experience of miscarriage. This study demonstrates the usefulness of viewing miscarriage as an ambiguous loss event, which can be theoretically conceptualized along various contexts of experience and through a feminist lens.

This study was largely comprised of upper-class, majority race women whose experience of miscarriage may differ from that of women among other social groups. Time is the great leveler, and independent of social status and financial resources, time cannot be bought. Although artificial reproductive technologies have assisted in extending and improving fertility, there are limits which stretch beyond financial constraints. Economic wealth does not guarantee the procurement of fertility. Given that, it is important to note that women of less privileged social classes would probably experience miscarriage and infertility in a different context regarding the medical care and fertility treatment options available to them. Those women of lower social status would likely have no choice other than to accept their reality of loss and possible childlessness. For this and many other reasons, it is important to continue to explore the various contexts of the miscarriage experience.

For those 10 courageous women who participated in this study, it is hoped that their engagement in this work was beneficial for each of them. It is my hope that each participant found it somewhat therapeutic to speak openly about having experienced a miscarriage at an AMA. Further, it is my sincere hope that the participants in this study were able to create some meaning in and of their loss through helping others by speaking out about their experience. Hearing the voices of other women in a similar context underscores the importance of breaking the silence which surrounds miscarriage, and hopefully diminishes some sense of otherness regarding pregnancy loss and non-conventional forms of motherhood. The silenced or invisible voice should never be confused as an absent voice.

As previously noted, scholarly investigation of miscarriage has largely been left to the medical community. The findings from this study lay the ground work for establishing and executing future research in this content area. Additionally, this study offers clinicians specific practices and a sensitive approach to working with women and their families who have suffered a miscarriage. It is hoped that the clinical implications and the suggested areas of need regarding future research are undertaken as continued efforts to raise the social consciousness of this form of loss. Women who suffer a miscarriage at an advanced maternal age are an important population for future research. This form of loss is real and demands acknowledgement and attention.

APPENDICES

Appendix A – Recruitment Flyer

Miscarriage (Pregnancy Loss) Research Study

Have you experienced a miscarriage in the last two years?

Were you 35 years of age or older at the time of the loss?

Willing to share your story?

Take part in a research study seeking to understand the nature of women's experience of miscarriage at age 35 years and older

Who can participate?

- Any woman who has experienced a miscarriage within the last two years, at age 35 years or older
- The loss must Have been a spontaneous miscarriage, under 20 weeks gestation

How long will the interview take?

- 1~2 hours

Where will the interview take place?

- You decide...the researcher will come to you!

(In or around the Greater Cleveland, Ohio area)

You will receive a \$25 gift card for your participation!

Contact: Rebecca Wright, MA, MFT

Marriage and Family Therapy Doctoral Candidate, Michigan State University

Phone: (330)961-1015 or Email: pregnancylosshelp@gmail.com

Appendix B – Informed Consent Form

This consent form was approved by a Michigan State University Institutional Review Board. Approved 04/11/13 –valid through 04/10/14. This version supersedes all previous versions. IRB # 13-341.

Informed Consent Form

An Examination of Women of Advanced Maternal Age and their Experience of Miscarriage: A Dissertation

Introduction and Background:

The purpose of this research study is to explore and understand women's experience of miscarriage at an advanced maternal age (35 years of age and older). It is hoped that through this study, an increased understanding will evolve of women's emotional process of loss as it pertains to the experience of miscarriage, at an advanced maternal age.

My name is Rebecca Wright, MA, MFT, and I am a doctoral candidate in Marriage and Family Therapy, at Michigan State University. This study is being conducted in order to fulfill requirements towards my doctorate degree.

Today, I will explain this research study and informed consent form with you and then you will be asked to participate in the study.

Procedure:

By signing this consent form, you are consenting to participate in a one-on-one interview, to complete a demographic questionnaire and eco-map activity with me, the researcher. It is a requirement of this study that the one-on-one interview be audio-taped. During the one-on-one interview, topics which will be covered will pertain to, but are not limited to the following: your experience of having had a miscarriage (pregnancy loss under 20 weeks of gestation), issues that are unique to miscarriage as a particular form of maternal loss, issues specific to miscarriage at an advanced maternal, sources of support and sources of stress to you during your miscarriage experience.

Your active participation will entail:

- 1) The researcher's complete explanation of the study and this consent form.
- 2) A one-time meeting with the researcher to complete a demographic questionnaire, eco-map and an audio-taped one-on-one interview regarding your experience of miscarriage at age 35 years or older. This one-time meeting with the researcher should take approximately two hours or less to complete.
- 3) With you permission, the researcher will contact you at the end of the study to share the study findings. You do not have to agree to follow-up contact to participate in this study today.
- 4) At the end of this process you will receive a \$25.00 gift card as a show of my appreciation for your participation in this study.

The purpose of this project is to gain understanding of women's experience of miscarriage at an advanced maternal age. Your participation in this research project is completely voluntary. You can refuse to answer any questions that you do not wish to answer. The one-on-one interview will be audio-taped, however you may request at any time that the taping be stopped and withdraw your participation in this study.

Potential Risks, Discomforts, and Benefits:

There is the potential for minimal risk involved with participating in this project. Some psychological discomfort may be experienced from revealing personal information or thinking about the loss(es) you have endured when talking about your own experience of miscarriage. You are able to take a break at any point during the interview process; you are also able to refuse to answer any questions that make you uncomfortable. After the interview, should you feel overwhelmed or stressed please contact the researcher for a referral for a local mental health professional.

You will not directly benefit from your participation in this study. However, you may experience indirect benefits from your participation by talking about your experience. In addition, your participation in this study may contribute to the understanding of the needs of other women who have a similar loss experience with a miscarriage at an advanced maternal age.

Confidentiality and Interview Recording:

All information that refers to you, or that can be identified with you will remain confidential to the maximum extent permitted by law. The researcher must audiotape the one-on-one interview in order to ensure accuracy. Additionally, the researcher will utilize a professional transcription services company to transcribe (type written word for word) the interview. All information will remain confidential per the non-disclosure agreement or confidentiality agreement between the researcher and the professional transcription services company. You may request at any time during the interview to have the audiotaping stopped and withdraw your participating in this study. Once the audiotapes are transcribed by the professional transcription services company, any identifying information will be deleted (i.e., names of people or places) so that you cannot be identified. Typed transcripts of your interview, your demographic questionnaire and your ecomap will be kept as password protected files, and access to the information will be limited to the researcher, the researcher's graduate advisor and the Michigan State University Institutional Review Board (IRB). Michigan State University may review your research records.

Transcripts of your interview as well as your ecomap may be reproduced in whole or in part for use in presentations or written products related to the study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from this study. Immediately following the one-on-one interview, you will be given the opportunity to have the recording deleted if you wish to withdraw your consent to participate in this study.

Other than this consent form, all other study documents and data will be identified with a code number only. A list linking your name to the code will be kept in a locked file for the duration of the dissertation study. Once all the data are collected and analyzed, the list linking the names to the code numbers will be destroyed. Upon completion of this dissertation study, all research data

gathered for this study will be kept with Dr. Marsha Carolan, my graduate advisor and the principal investigator for this study (see her contact information below in the “Questions, Concerns and Contacts” section) in a password protected file and/or locked file cabinet for 5 years.

Confidentiality and Interviews Conducted in Participant’s Home:

In accordance with my professional licensing organization (the American Association for Marriage and Family Therapists -AAMFT) ethical requirements and the Michigan State University Institutional Review Board recommendation, I must note that the only foreseeable breach of confidentiality on my part would be my mandated obligation to report to the proper authorities any suspected incidences of child abuse I may discover while in your home.

Voluntary Participation:

Your participation in this study is strictly voluntary. You may decline to answer any question in the study. You may decline participation at any point during the study by simply telling the researcher/interviewer that you no longer wish to participate. Refusing to participate will not result in any form of penalty or loss of benefits to which the participant/subject is otherwise entitled.

Questions, Concerns and Contacts:

If you have any questions or concerns about this research study, such as scientific issues, how to do any part of it, if you believe you have been harmed because of this study or to report an injury (i.e. physical, psychological, social, financial, or otherwise), please contact the researcher (Rebecca Wright, 201 Hidden Glen Trail, Chardon, Ohio 44024, email wright353@msu.edu, phone 410-868-5055). You may also contact my graduate advisor, Dr. Marsha Carolan, (Michigan State University, 552 W. Circle Drive, 13B Human Ecology, East Lansing, MI 48824, email carolan@msu.edu, office phone number 517-432-3327).

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or postal mail at Michigan State University, 408 W. Circle Drive Room 207 Olds Hall, East Lansing, MI 48824.

***Please read and sign on the next page.**

You will be given a copy of this consent form to keep.

Consent:

YOUR SIGNATURE ON THIS FORM MEANS THAT YOU CONSENT TO PARTICIPATE IN THIS STUDY. YOU HAVE READ THE CONSENT FORM. YOUR QUESTIONS HAVE BEEN ANSWERED. YOU ALSO CERTIFY THAT YOU ARE 18 YEARS OF AGE OR OLDER.

- ☐ ☐ I voluntarily agree to participate in a one-on-one interview. _____Initials
- ☐ ☐ I voluntarily agree to complete a demographic questionnaire and an eco-map activity, _____Initials
- ☐ ☐ I voluntarily agree to having my interview audio-taped and transcribed by a professional transcription services company and to the use of the written transcript of my interview and to my eco-map in presentations and written products as explained to me. _____Initials
- ☐ ☐ I voluntarily agree to have the researcher contact me at the end of the study to share the research findings. _____Initials

Your signature below indicates that you voluntarily agree to participate in this study.

Signature of Participant

Signature of Researcher

Typed/Printed Name of Participant

Typed/Printed Name of Researcher

Code#

This consent form was approved by a Michigan State University Institutional Review Board. Approved 04/11/13 – valid through 04/10/14. This version supersedes all previous versions. IRB # 13-341.

Appendix C – Demographic questionnaire

Demographic Questionnaire

Code#_____

What is your age? _____

What is your marital status?

- ☐ Married: If so, how long? _____
- ☐ Single
- ☐ Living with my partner: If so, for how long? _____
- ☐ Divorced

Highest level of schooling completed?

- ☐ Not yet graduated from high school
- ☐ High school diploma/GED
- ☐ Some college
- ☐ College degree completion
- ☐ Graduate school
- ☐ Other _____

What is your total annual family income?

- ☐ Less than \$5,000
- ☐ \$5,000-\$19,999
- ☐ \$20,000-\$29,999
- ☐ \$30,000-\$39,999
- ☐ \$40,000-\$49,999
- ☐ \$50,000-\$59,999
- ☐ \$60,000-\$69,999
- ☐ \$70,000-\$100,000
- ☐ Over \$100,000

What is your work status?

- ☐ Full time, outside of the home
- ☐ Part-time
- ☐ Not employed outside of the home
- ☐ Retired

What is your race/ethnicity? (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Arab
- ☐ Asian
- ☐ African American or Black
- ☐ Caucasian or White
- ☐ Hawaiian or other Pacific Islander
- ☐ Hispanic
- ☐ Indigenous or Aboriginal
- ☐ Latina
- ☐ Mexican American
- ☐ Multiracial
- ☐ Puerto Rican
- ☐ Prefer not to say
- ☐ Other _____

Appendix D – Interview Guide

Interview Guide

Code# _____

- Re-introduction of researcher
- Review interview process
- Review informed consent

One-On-One Interview Guiding Questions:

- 1) How many times have you been pregnant?
- 2) How many living children do you have?
- 3) How many pregnancies have you had that resulted in a stillbirth and/or a neonatal death?
- 4) How many miscarriages have you experienced and what was the gestation associated with each?
- 5) Tell about your experience as a woman of advanced maternal age (35 years of age and older) and having had a miscarriage.
- 6) Were there issues that seemed particularly unique to the miscarriage experience versus other losses you have experienced?
- 7) Were there any issues that seemed particularly unique to experiencing a miscarriage at your age?
- 8) Did you feel that your experience of miscarriage was acknowledged as a true form of loss by those around you (i.e. friends, family, partner/spouse, co-workers, doctors, nurses, etc.)? Who or what made this situation better for you? Worse for you?
- 9) Has having experienced a miscarriage changed how you view yourself, your future?
- 10) What meaning, if any, did you or do you assign to your having experienced a miscarriage? How do you make sense of what was lost with the miscarriage? Was a cause of the miscarriage ever determined? Has knowing the cause or not knowing the cause of the loss influence your experience?
- 11) Did you have a good support system in place following the miscarriage? Were there any people around you who were not supportive after the miscarriage?
- 12) What are some of the preconceptions you held for yourself regarding pregnancy and subsequent motherhood?
- 13) How do you conceptualize or think about your status and role as a mother, would-be-mother, etc.?
- 14) How did having a miscarriage influence, if at all, your experience of those around you who were or soon became pregnant?

Is there anything else you would like to mention, add, that we have not discussed?

Appendix E – Ecomap Activity

Ecomap Activity

Ecomap Activity:

As an additional source of data gathering I am asking each participant to complete an ecomap. An ecomap is a graphical representation of all of the systems that affect your life and experience. These systems represent the people and elements in your life which play a role in your experiences. The ecomap will depict the “who and what” of your miscarriage experience and the relationship qualities which you describe regarding those individuals. I will draw your ecomap and in order to do so I will have to ask you some questions about your miscarriage experience and your interactions with others who are significant to you. Topics to be covered during this ecomap activity will pertain to, but are not limited to the following: your experience of having had a miscarriage (pregnancy loss under 20 weeks of gestation), issues that are unique to miscarriage as a particular form of maternal loss, issues specific to miscarriage at an advanced maternal, sources of support and sources of stress to you during your miscarriage experience.

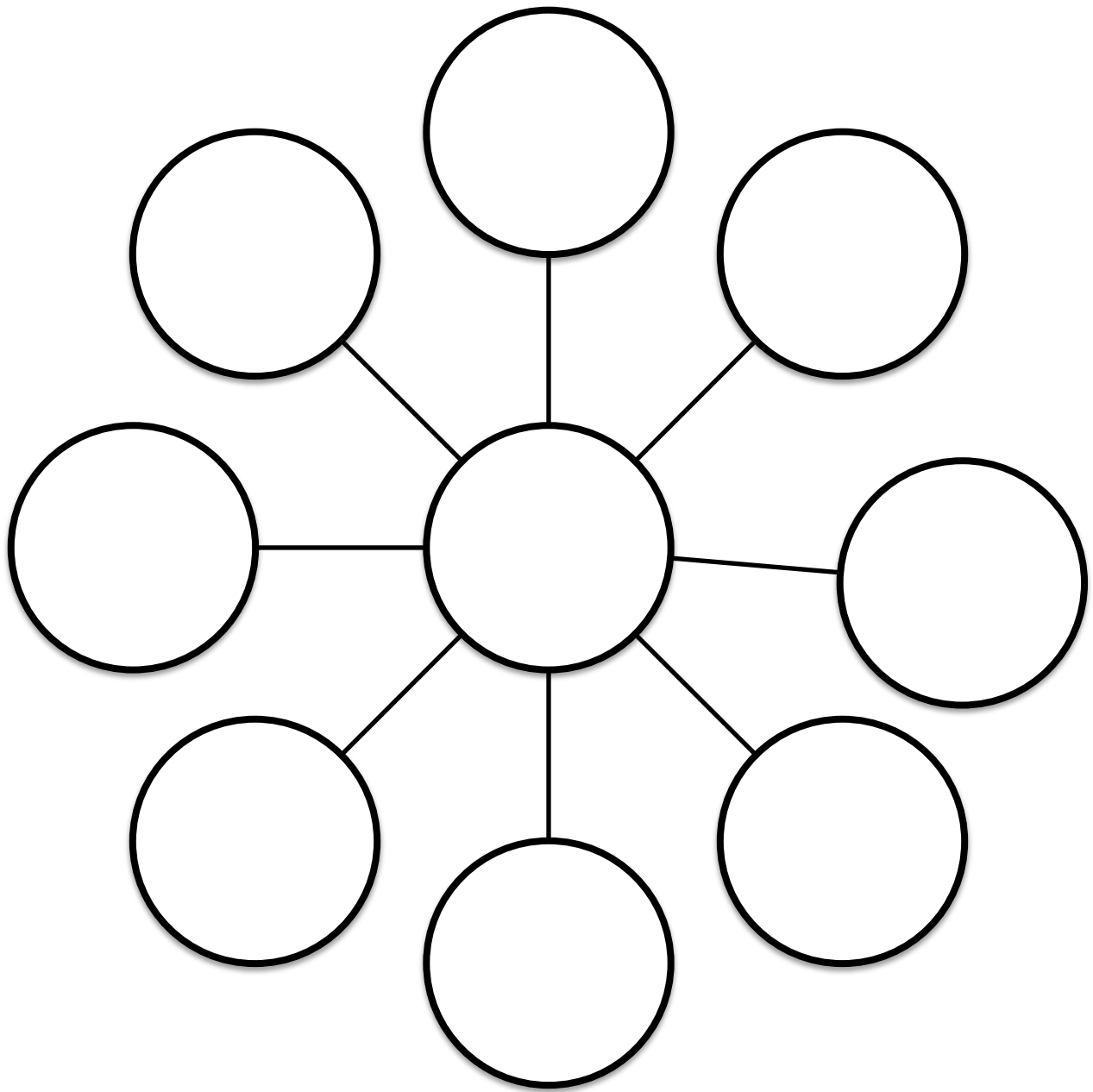
Ecomap Instructions:

- 1) The central circle on the ecomap represents the participant. Identify in all of the surrounding circles connected to the central circle those people/systems/resources that the participant identifies as influential forces regarding their miscarriage experience.
- 2) For each person/system/resource indicated, on the circle connection lines indicate the directional flow arrows, i.e. the person/system/resource as influencing the participant, the participant influencing the person/system/resource, or both/bidirectionality.
- 3) Using colored pencils color the surrounding circles of persons/systems/resources influencing the participant as either a strong/helpful/positive relationship (blue) or as a weak/unhelpful/negative relationship (red)

Ecomap Guiding Questions:

- 1) Who are the significant people/systems/resources in your life?
- 2) What type of relationship do you have with each significant person in your life?
- 3) What are some elements, factors or areas of your life which provide strength for you?
- 4) What are some elements, factors or areas of your life which cause stress for you?

Figure E.1 Ecomap



Notes: _____

Appendix F – Audit Log

Table F.1 Audit Log

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION OF THE ESSENCE OF THE EXPERIENCE – Audit Trail		
An audit trail assists the researcher in reflecting on how his/her thinking evolved throughout all phases of the study. A physical audit trail documents stages of a research study, from identification of the research problem to development of new theory; and it reflects the key research methodology decisions.		
Date	Entry Categorical Type: - Preliminary Study Development Information - Meeting - Materials related to Intentions and Dispositions - Process Notes - Raw Data - Data Reduction and Analysis Notes - Data Reconstruction and Synthesis Products	Entry Details
3/3/2013	Preliminary Study Development Information	Dissertation Proposal (first three chapters) emailed to committee members for review prior to dissertation proposal defense meeting
3/18/2013	Meeting	Dissertation Proposal Defense meeting with committee members
3/26/2013	Preliminary Study Development Information	Creation of document summarizing committee edits/suggestions for study & the proposal document...saved as doc titled "Proposal Defense Meeting Edits.docx"
3/26/2013	Preliminary Study Development Information	Created document of edits/suggestions for IRB application document...saved as "Dr. C recent IRB app comments.docx"
3/26/2013	Preliminary Study Development Information	IRB application for study submitted (IRB application # i043144)
3/27/2013	Materials related to Intentions and Dispositions	Created a list of area OB/GYN and Fertility Spec. Offices...saved as "Area Fertility and OBGYN sites.docx"
3/27/2013	Preliminary Study Development Information	Extensive editing per committee suggestions complete on all five study supportive documents (Informed Consent form, Demographic Questionnaire, Ecomap Activity, Interview Guide, Recruitment Flyer) and edits complete on the first three chapters (dissertation proposal)

Table F.1 (cont'd)

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION OF THE ESSENCE OF THE EXPERIENCE – Audit Trail		
4/18/2013	Materials related to Intentions and Dispositions	IRB Application for study APPROVED
4/25/2013	Materials related to Intentions and Dispositions	Emailed Recruitment flyer to Cornerstone of Hope - Grief Center, my internship placement, which conducts an 8 weeks intensive neonatal and infant loss support group several times throughout the year
5/1/2013	Materials related to Intentions and Dispositions	Recruitment Flyer's given out...recruitment flyer's taken around to 8 area OB/GYN offices...met with some general annoyance and resistance from nearly every receptionist.
5/2/2013	Raw data	Study Interview 001 completed
5/11/2013	Raw data	Study interview 002 completed
5/18/2013	Materials related to Intentions and Dispositions	Recruitment flyer's given to local hospital bereavement group member, meets once a month, 3rd Thursday of the month (Love Lives On @ Hillcrest Hospital)
5/28/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to the National SHARE (Organization of Pregnancy and Infant Loss Support, local chapters nationwide) and requested information about creating a Cleveland area SHARE group
5/28/2013	Materials related to Intentions and Dispositions	Spoke via telephone and followed up with an email with recruitment flyer attached to Dr. Linda Henderson of the Cleveland Pregnancy Center who leads the "Tears of Hope" program
5/28/2013	Materials related to Intentions and Dispositions	Spoke via telephone and followed up with an email with recruitment flyer attached to Mr. D. Rossback of the MetroHealth System "HOPE" program (Healing Other Parents Emotionally a loss group for bereaved parents) - MetroHealth Bereavement Program via Pastoral Care Department
5/30/2013	Materials related to Intentions and Dispositions	Emailed Fairview Hospital FEEL (Families Experiencing Early Loss) group leader...group meets once a month, 1st Thursday of each month.
5/30/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to RESOLVE (National Infertility Support Organization) local Cleveland chapter point of contact, Becca

Table F.1 (cont'd)

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION OF THE ESSENCE OF THE EXPERIENCE – Audit Trail		
5/30/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to RESOLVE (National Infertility Support Organization) Akron chapter point of contact, Pandora
5/31/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to two points of contact at the Hospice of Western Reserve "On Eagles Wings" perinatal bereavement support group, Ms. Lakin & Ms. Tyler
6/4/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to content administrator at www.ohiomarriageresources.org - Mr. Cronk
6/4/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to content administrator at www.mymiscarriagematters.com - Esther
6/4/2013	Materials related to Intentions and Dispositions	Emailed recruitment flyer to content administrator at www.reconceivingloss.com
6/13/2013	Raw data	Study Interview 003 completed
6/17/2013	Raw data	Study Interview 004 completed
6/19/2013	Raw data	Study Interview 005 completed
6/29/2013	Raw data	Study Interview 006 completed
7/8/2013	Raw data	Study Interview 007 completed
7/11/2013	Raw data	Study Interview 008 completed
7/11/2013	Raw data	Study Interview 009 completed
7/16/2013	Raw data	Study Interview 010 completed
7/22/2013	Raw Data	All ten interview transcripts complete, from GMR transcription company.
7/30/2013 & 7/31/2013	Materials related to Intentions and Dispositions	Between 30th & 31st emailed all 10 participants a 2-3 page excerpt document of their interview transcript for their perusal. Ultimately, 5 of 10 participants responded in favor of transcript appropriately reflecting gist of our interview.
8/13/2013	Data Reduction and Analysis Notes	Opened up new project in NVIVO, uploaded all 10 participant transcripts to project titled "My Dissertation - Miscarriage"
8/17/2013	Data Reduction and Analysis Notes	Reviewing before and after interview hand-written notes
8/17/2013	Data Reduction and Analysis Notes	NVIVO-First pass at highlighting and node coding meaningful statements, for each participant
8/27/2013		NVIVO -Going through each source node of each participants meaningful statements and clustered into tree nodes by meaning unit, 16 tree nodes

Table F.1 (cont'd)

WOMEN OF ADVANCED MATERNAL AGE AND MISCARRIAGE: AN EXAMINATION OF THE ESSENCE OF THE EXPERIENCE – Audit Trail		
8/30/2013	Data Reconstruction and Synthesis Products	NVIVO - Continued meaningful statement thematic clustering, increased to 26 meaning units
8/31/2013	Data Reconstruction and Synthesis Products	Identified four themes representative of the 24 meaning units
9/7/2013	Data Reconstruction and Synthesis Products	NVIVO - Further clustering, merged several tree nodes to result with 24 meaning units
9/11/2013	Data Reconstruction and Synthesis Products	NVIVO - Began pulling statements from each meaning unit node to be used in chapter four write-up. Identified 141 quotes for use across all 24 meaning unit sub-themes
9/13/2013	Data Reduction and Analysis Notes	Reduced 141 quotes across all 24 meaning units to 91 quotes
9/15/2013	Data Reconstruction and Synthesis Products	Further reduced quotes to distribute 9-10 quotes from each participant across the 24 meaning unit sub-themes in chapter 4.
9/16/2013	Data Reconstruction and Synthesis Products	Compiled participant data sources to create textured and structured descriptions for each.
9/18/2013	Raw data	Completed chapter four write-up
9/20/2013	Materials related to Intentions and Dispositions	Returned to miscarriage literature for chapter five write-up
10/5/2013	Materials related to Intentions and Dispositions	Chapter 5 write-up complete
10/6/2013	Materials related to Intentions and Dispositions	Full five chapter dissertation editing complete

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BIBLIOGRAPHY

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