

## Restrained Expectations in Late Pregnancy Following Loss

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### **Abstract:**

*Objective-* To describe women's late pregnancy after loss experiences (from 25 weeks gestation to birth), document the timing and frequency of their common discomforts and events, and explore changes in these experiences over time.

*Design-* A longitudinal, qualitative study of pregnancy calendar entries and field notes.

*Setting-* Prenatal care providers and community canvassing in Central New York and the Internet.

*Participants-* Pregnant women ( $N= 69$ ) with a history of perinatal loss.

*Main Outcome Measures-* Women's pregnancy calendar entries and field notes.

*Results-* Thematic data analysis yielded two main themes and several subthemes: (a) Precarious Pregnancy Security with subthemes of Informed Awareness and Varying Emotions and (b) Prudent Baby Preparations with subthemes of Physical, Social, and Emotional Preparation.

*Conclusion-* Women reported an increased sense of security about the pregnancy and baby over time but this security was easily shaken. For women with a history of later or multiple loss, anxiety may remain high or increase as the due date approaches. Fetal movement is the most common barometer of fetal well-being during this part of pregnancy. With a better understanding of pregnancy after loss, clinicians can have a positive impact on women's prenatal experiences.

### **Article:**

Women pregnant after previous pregnancy loss (PAL) are known to be more anxious and worried about their pregnancies and their outcomes, feel more vulnerable, and protect themselves from emotional attachment to their fetuses compared to women without loss history (Armstrong & Hutti, 1998; Côté-Arsenault, 2003; Phipps, 1988).

Cross-sectional studies, in both quantitative and qualitative paradigms, have described women's experiences of pregnancy after a perinatal loss. It has been suggested that women only worry in subsequent pregnancies until they reach the point where a previous loss occurred and then they relax. In contrast to this, O'Leary and Thorwick (2006) suggested that women with a history of early losses get past their loss milestone and then do not know what to expect because they have never experienced pregnancy beyond that point. The findings of Keith (2005) and Hense (1994) indicated that great uncertainty and anxiety exist in the subsequent pregnancy after stillbirth particularly surrounding the end of pregnancy, labor and birth, and the reliving of past trauma. It

is crucial that nurses understand the experiences of women during their pregnancies in order to provide care responsive to their needs. Therefore, the purpose of this study was to describe and understand women's PAL experiences from 25 weeks gestation to birth.

## REVIEW OF LITERATURE

Perinatal loss occurs to approximately 2 million women each year in the United States (Gutmacher Institute, 2006). This rate is approximate due to inconsistent reporting criteria and requirements by states across the country, but in all estimations, perinatal loss is a frequent event. Losses through miscarriage, stillbirth, and neonatal death often trigger intense emotional responses including grief and depression (Bennet, Litz, Lee, & Maguen, 2005; Klier, Geller, & Ritsher, 2002). Embarking on a new pregnancy, which happens in the majority of cases, requires courage and hope (Hense, 1994; O'Leary & Thorwick, 2006).

Women in PAL have higher levels of pregnancy anxiety than similar women without a loss history at 17 to 28 weeks gestation (Côté-Arsenault, 2003) and in the latter half of pregnancy (Armstrong, 2002; Armstrong & Hutti, 1998). Qualitative studies of women's PAL experiences provide evidence that these women generally manifest decreased confidence and an increased sense of vulnerability. Descriptors of PAL are indicative of anxiety and concern rather than the mood swings, enjoyment, and anticipation that many women use to describe pregnancy (Murkoff, Eisenberg, & Hathaway, 2002). Themes from one study of PAL provided additional descriptors of women's stressful pregnancy experiences: "expecting the worst," "weathering the storm," "gauging where I am," "honoring each baby," and asking that others "support me where I am" (Côté-Arsenault & Marshall, 2000). Anxiety during pregnancy has also been found to have a negative impact on parenting. Anxious mothers demonstrate greater concern about their new baby's health and more difficulty with differentiation from the child as compared to women without a loss history (Theut et al., 1992). Greater disorganized attachment in the offspring after PAL was found by Hughes, Turton, Hopper, McGauley, and Fonagy (2001).

Previous pregnancy loss affects the experience of subsequent pregnancies.

Emotions and concerns across pregnancy after loss were reported by women who were on PAL support group lists. Key emotions were anxiety, fear, and hope (Côté-Arsenault, Bidlack, & Humm, 2001). Concerns ranged from the health of the baby to the effect another loss would have on the family. Findings reported here illustrate the known effects of perinatal loss on women's responses to pregnancy and subsequent parenting. Describing and understanding the events in pregnancy is a first step toward developing effective caring interventions for these mothers.

In this same sample, findings from the first half of pregnancy revealed that prior to viability, women were vigilantly watching every sign and symptom of pregnancy and worrying about how to interpret these signs (Côté-Arsenault, Donato, & Earl, 2006). The process of interpreting signs led to fluctuating worry and over time, increasing confidence that the pregnancy might proceed successfully. This process relates to the metaphorical image of a seesaw shifting positions in response to the opposite forces of worry and confidence. Women attempt to balance their emotions using several strategies: (a) seeking reassurance from care providers, spouses, family and friends, support groups, and the baby; (b) being hypervigilant; and (c) relying on internal beliefs. What is not known is how PAL women experience pregnancy after viability and whether

events in pregnancy change in this latter half of gestation. No other published reports of longitudinal PAL experiences post 24 weeks were identified in the review. This study reports women's experiences of pregnancy from 25 weeks gestation through birth.

## METHODS

Women were recruited from prenatal providers in central New York or through community and Internet canvassing with recruitment flyer postings from 2001 to 2003. Reported here are the findings of a qualitative component of a multiple-triangulated longitudinal study; that is, one that combined two or more types of triangulation: methods, data sources, and analyses (Burns & Grove, 2005).

The inclusion criteria at the beginning of the larger study required that women meet the following: (a) be 17 weeks gestation or less, or not have felt fetal movement; (b) have a history of one or more spontaneous pregnancy losses (ectopic, miscarriage, stillbirth, or neonatal death); and (c) be able to speak and read English. Pregnancy calendars were provided at the first data collection session (at 10-17 weeks). Calendars were chosen as a data collection method to increase the accuracy of women's reports of their pregnancy events and thoughts by reducing the need for recall (Burns & Grove, 2005). Data were obtained from these pregnancy calendars, field notes written by the Principal Investigator (PI) and research assistant at the time of survey completion for the larger study (30-35 weeks and postpartum), and any additional communication between the researchers and participants (e.g., phone calls or e-mails) that occurred when arranging for the next quantitative data collection.

The Events in Pregnancy (EiP) calendars were designed on 9 × 11.5" card stock to be nondirective with blank daily squares and two pages per month of open space labeled "Other Thoughts or Events." Preprinted stickers were provided to increase the ease of reporting common pregnancy discomforts, prenatal visits and testing, phone calls to the care provider, and stressful events. The EiP was pilot-tested with nine pregnant women who found it easy to understand and who provided ideas for additional stickers that were incorporated into the final calendars. Reminders to write on EiP calendars were sent to women by mail, e-mail, or telephone (their preference) every 1 to 4 weeks. Calendar pages were copied for data and the women kept their own calendars as keepsakes.

## ANALYSIS

Thematic data analysis was done through an iterative process of reading and rereading the calendar pages from 25 weeks to birth and the field notes for each participant. To increase the trustworthiness of the findings, each researcher read the calendars independently using different approaches. One researcher read calendars in order of participant number and pulled out all key quotes, while the second read half of the calendars and noted her overall impressions. The team met and identified preliminary themes through extensive discussion, memoing, and note taking. Each author then returned to the rest of the data to further verify and refine the themes (Lincoln & Guba, 1985). At the third meeting, the researchers recognized that the initial themes fell into two main categories: sense of security and preparing for baby. Original themes were condensed into subthemes as the relationships among them emerged and saturation of each was reached. Recognizing that the widely varying length of entry is a matter of personal style, the researchers were careful to note not only how much was written but also what was said and what was *not*

said by comparing and contrasting across women. Clarification and honing of themes continued through the writing and quotation selection processes during manuscript preparation.

## RESULTS

### *Sample*

The sample of 69 women who provided pregnancy calendars were 21 to 42 years of age ( $M=30.4$ ;  $SD=5.11$ ); well-educated ( $M=14.88$  years;  $SD=2.58$ ); primarily married (72.5%; 14.5% partnered); and mostly White (88.4%; 5.8% African American; 6% other). Income ranged from \$0 to more than \$120,000 (median category \$60,000-\$79,000 with 55% of the sample with incomes below this range); 83% described themselves as somewhat to extremely religious.

The sample's obstetric history included 2 to 13 pregnancies per woman ( $M=4.18$ ;  $SD=1.99$ ); 0 to 5 live children per woman ( $M=1.0$ ;  $SD=1.0$ ); and 1 to 7 losses per person ( $M=1.97$ ;  $SD=1.29$ ) totaling 133 losses in the sample. Gestational age of losses was diverse, including losses from 3.5 to 40.5 weeks gestation and 5 neonatal deaths ( $M=11.06$  weeks;  $SD=5.24$ ); years since last loss ranged from 0 to 13 years ( $M=2.17$ ;  $SD=2.49$ ).

### *Overall impressions*

From the 25th week of pregnancy on, a shift occurred for most women in this sample from focusing on the pregnancy and worrying that it might end to a restrained expectation that this baby may survive and there might be a newborn to care for. The following calendar quotes from a woman who had had one miscarriage at 16 weeks in a previous pregnancy are representative of labile emotions over time experienced by many. To further clarify quotes, the week of gestation the statement was made was noted in parentheses (27) as was the day within that week when applicable (27-4).

I feel a bit anxious about 'feeling' anything to do with this pregnancy, so I just wait to get good results [from glucose tolerance test] ASAP. (27)

Feel anxious about today's appointments, although I am excited to see baby again! ... I hope there is good news on kidney-ureter issue [questionable hydronephrosis seen on ultrasound] (27-4). [Later that day] I feel good about the appointment, and so much safer since the baby is getting big and could survive if born early.

[Baby's movements have been] only rolling and subtle pokes (28), [but then 2 days later], strong kicks started again. I've been feeling sad that our son died. I think that this as a reality has made me more aware of our loss. (28-2)

These weeks are slipping by so easily now – it is no longer the struggle to get another week finished. (30)

I realize that each morning when I wake up I lie still waiting for the baby to move around ... I have come to understand that there is a part of me that cannot believe this child will be born alive and OK ... Does everyone carry this disbelief, or is mine different because I am thinking of death? I dreamed of a dead bloody baby several nights but then I felt lots of movement. (31-1)

One year ago, I saw the positive pregnancy test that ended in the death of our son. I feel sad, somewhat alone in my awareness of the date's significance, and scared that I could lose this baby. Rationally, I know there is no reason for another loss ... but why was there a loss in September? I hate not having a reason ... That scares me, even as I feel an active baby inside me. (31-3)

After a busy weekend with lots of kicks and movement, I felt very few active movements and had an overwhelming feeling of dread ... I feel better having gone in [to the office to be checked]. [My husband] was very worried—this scare really woke up our fears of loss once again. It's really hard not to 'know' what normal is. (32)

Feeling a bit tense about cord accidents these days. I need to feel baby move or I find myself anxious and thinking negative thoughts. I am excited, but terrified. How could I survive another loss? I cannot imagine life with this child, but I certainly cannot imagine life without it either. (38)

### *Themes*

Two main themes of late pregnancy were identified: Precarious Pregnancy Security and Prudent Baby Preparations. Precarious Pregnancy Security addressed the ever-present background worry these women felt (e.g., "Cannot shake that nervous feeling"). This theme also included the mounting evidence that the pregnancy was secure, the baby was alive based on fetal movements, and the baby was growing appropriately. The Prudent Baby Preparations theme reflected women's careful consideration of the kinds of preparation for the infant they felt comfortable doing as they approached their due date.

**Precarious pregnancy security.** As the pregnancy progressed, women generally reported feeling more hopeful that their baby might be born alive; they remained cued in to their physical symptoms, especially fetal movement, and they had more frequently scheduled prenatal visits and tests, particularly ultrasounds. While most women experienced an increased sense of security that the pregnancy and baby would likely be fine, this security could easily be shaken, as the opening quote (under *Overall Impressions*) attests. Another woman with a questionable abruption wrote: "Very scary with the bleeding and pain. While I was at the hospital I didn't want to take the monitor off—at least that way I knew the heartbeat was OK. Mixed emotions about going home—comforting to be in the hospital where every tiny detail can be monitored and micromanaged." (32)

The first subtheme, "Informed Awareness," indicates the primary mechanism through which the women gained reassurance. Informed awareness was maintained through active self-care, assessing fetal movements, and the frequent monitoring by care providers at prenatal visits and with ultrasounds. As one woman said in her seventh month, "Going more frequently to doctor's helps stress level at this point in pregnancy so very happy to be pregnant but truly ready to have this baby. So that I know she will be safe."

Regular feedback from the baby, self, and care provider contributed to a sense of security through having as much data as possible. The high frequency of prenatal visits dictated by care

providers nearly eliminated phone calls between appointments. “Starting to have NST 3×/week—nothing wrong on NST, but makes me feel better. My MD says I can have as many as I want—it is so helpful that he is supportive and understanding.” (34) Another woman had a specific concern: “Could not see the [umbilical] cord and right now that is a pretty big deal to me. He seemed a little exasperated by my worries, but reassured me that I can have a US [ultrasound] done at any time if there was something I was worried about.” (26)

Medical visits provided comfort and data but most relied on fetal movement as the most frequent barometer of fetal well-being during this part of pregnancy. Among the many comments: “My friend at work lost her baby. I am still worried about losing mine—feeling the baby move reassures me.” (26) “It feels so good to feel her move in my belly. She reminds me all day she is there.” (27) “I feel constant/consistent stronger movements which is making me feel better.” (27) “Baby moves a lot and for the most part I am not as nervous as I have been.” (30) The women are aware of how important their baby’s movements are to them—truly a life-line.

A fairly consistent list of ongoing pregnancy discomforts was reported by all women through stickers or handwritten complaints: heartburn, difficulty sleeping, constipation, appetite (both “huge” and “none”), headache, and being very tired. Unlike earlier in the pregnancy, the discomforts are simply statements about being pregnant rather than a reflection of the baby’s status; pregnancy and baby seem to be evaluated separately at this point.

“Varying Emotions,” the second subtheme, refers to the wide range of women’s emotions including their worries and concerns, or the lack thereof, about the security of the pregnancy and the baby. Approximately half of the women’s calendars had comments about their worry and reports of stressful events that caused high anxiety. The other half, however, provided no evidence of worry about the pregnancy. Some women had very difficult personal lives that superseded any pregnancy concerns: for example, domestic violence, economic worries about the basics of food, clothing, and shelter for themselves and their children.

Women’s emotions varied day-to-day and over time, fluctuating between worry and calm, excitement and anxiety. Some women’s history of loss contributed to their emotions as these two women’s words illustrate: “I keep thinking about how excited I am but nervous that something could always go wrong.” (25); “I am definitely excited about having this baby, but I still find that I have negative thoughts, like worrying about stillbirth. And then I worry about worrying about it.” (30) Some women monitored their own emotions and others remarked that when they had a scare, they realized that the worries were right there, just under the surface. “I go from—ouch stop moving, get this baby outta [sic] me to—OMG [Oh my god] the baby hasn’t moved in a while, I hope everything is OK. Guess it really is true that I am not going to feel confident that all is going to work out well until I can hold and see this baby in my arms.” (41)

For women with a history of later or multiple loss, anxiety may remain high or increase as the due date and anniversaries of past losses approach. “Even though we’re in the home stretch and everything looks great at my appointments, I still have negative thoughts on occasion, like there could be complications, a stillbirth, SIDS, etc. I wish I could let go of the garbage and experience pure joy!” (34) One mother with multiple losses including a 40-week stillbirth stated at 31 weeks, “I am much more anxious than I was, as I go further along.”

Other women's emotions seem to be more related to normal hormonal changes related to being pregnant: "This month has been a roller coaster of emotions. I cry at the drop of a hat, and I cannot get a good night's sleep. I feel just 'BIG', no other way to put it." (25-27). A few women are feeling free of worry: "I'm starting to feel a lot better. Not as stressed out. I'm dealing with being pregnant a lot better. I'm enjoying being pregnant." (27)

**Prudent baby preparations.** The majority of women commented on their thoughtful decisions to move ahead with preparations, indicating that there would likely be a baby to love, take care of, and be part of the larger family and community. Prudent Baby Preparations occurred in several realms: physical, emotional, and social. Reluctance or resistance to preparing in all three areas generally decreased over time, but a few women had nothing visibly prepared for the baby prior to its birth. Some preparations encompass all three arenas, such as childbirth classes where couples received instruction to prepare mentally, practice physical skills, and exchange information with other pregnant couples.

The physical aspect of Prudent Baby Preparations concerns the material needs for the safe care of the baby, a place for him/her to sleep, clothes, and diapers. Many expectant mothers were engaged in shopping, the receipt of gifts, and setting up a space with traditional items felt to be necessary to care for an infant. Most women in this sample, however, delayed any physical preparations for a baby until 30 to 36 weeks gestation. As time went on and they were still pregnant, most came to accept that they must have some items but were not ready to fully prepare a place for the infant in their home or to emotionally invest in clothing, furniture, and basic hygiene products. The emotions associated with gathering and organizing a future baby's things varied from the desire to have her "ducks in a row" (31) to the excitement of having "begun nesting!", to being completely overwhelmed, incapable, and often reluctant to prepare anything but the bare minimum. The following field note at 34 weeks illustrates such reluctance: "Husband has painted one room, has one piece of furniture in the nursery; might bring up the crib on the weekend. Not anxious to do this. She has bought nothing 'Baby only needs a few things, right?' [she asked rhetorically]. Doesn't want anything but a couple of diapers." There were also many women who never mentioned preparing for baby at all on their calendars. One woman's entries demonstrate the process she went through over a period of weeks:

Registering for baby shower gifts today was very stressful—I realized how unready I am and how real things are becoming. It took me four hours to select 20 items (including small things like sheets & clothes). I am so worried I selected items that are unsafe. (30)

I worked on getting the baby's room ready, but got stressed out so I stopped. (34)

Worked on the baby's room. I felt better now that things are in order. (35)

Emotional readiness for a new baby requires opening oneself up to the reality that the baby will really be born. This emotional preparation can be scary when there is fear of another loss. Fewer than a third of the subjects made reference to the mental and emotional processes they underwent to resolve the fact that a baby was most likely coming. The prospect of a baby brings with it varied emotions for the expectant mother. Many women use words like excited, anxious, and

impatient when they write about the baby's looming birth. Hope and fear seem almost inextricably linked for the woman experiencing pregnancy after loss. "Is this baby *ever* coming? I sound like every other mother to be, I know ... but it feels so close, yet forever. I feel ready—and scared that if we don't do this *soon* there may be a problem ..." (39)

Investing in the physical needs of the baby is closely connected to a woman's emotional investment in the baby. "Everything is going good, but I'm still not 100% confident. Feeling pretty confident but won't make big purchases for the baby until she's actually here." (32) Clearly the monetary investment and physical presence of baby items represents more than just making ready what the baby needs. The actual preparation makes the baby a reality and decreases the emotional cushions that the women have built around themselves. None of these preparation steps are taken without prudent consideration to the message they send, "I can start thinking about having a baby!" (30)

Most of the entries focused on excitement tempered with doubt and fear. "Starting to get excited knowing there's only 8 weeks left before the baby comes. I find myself excited, falling in love w/ baby, but still apprehensive. While I feel mostly secure knowing my baby's increased chance of survival at this stage, now I am concerned w/ having a healthy baby." (32) Around the 35th week of gestation, many women began to discuss their feelings regarding the arrival of the new baby in a more earnest manner. Some women with other children included their thoughts about the child's reaction as well. "I'm hoping he [her son] will accept her. So far he screams when he sees anything pink." (39) Interestingly, not much mention was made of the father's emotional state with regard to the baby's arrival. Childbirth or baby care classes were mentioned by some; these classes foster one's emotional preparedness through knowledge and projection into the future with labor, birth, and early parenting.

Women in the study mused on what the child would be like. However, the ultimate hope was that the baby would arrive alive. "The reality of having a child is setting in ... I'm hoping for a quiet, contented baby—though when it comes down to it, any sort of baby—fussy, loud, poopy—as long as she's healthy, would be fine by me." (30)

A new baby usually comes into an extended family and broader community and is often the focus of anticipation and excitement. The social preparation for baby that the participants engaged in included social rituals and interactions with others while pregnant. Eighteen women mentioned that they were having showers, but only a few women said they had named the baby or used the baby's name in their calendar. One woman at 25 weeks stated that she had thought of names but had not discussed them with the baby's father. Once the pregnancy is visible it becomes a social event, as one mother learned:

Several people today at church asked me about the baby's room and if I had needed any baby clothes/items. I haven't given it any thought. I'm too scared to take that step. I don't want to 'jinx' myself, or pull the stuff out and something happens and we don't bring the baby home. (28)

Another woman and her husband had not recognized how their own behavior could affect those around them:



We also decided that since we haven't shown outwardly to other people how happy we are it may be worrying mom. We sat down and came up w/ a list of baby things we'll need and if we could decorate what we would like. Hopefully we will seem more normal to mom and stop her from worrying. (27)

Women experiencing PAL often feel vulnerable to inconsiderate outsider remarks. Lack of awareness and understanding is most likely the reason for such remarks.

Went for like 2 weeks when I didn't think he was moving as much as he should. People made comments that they didn't think I was big enough. Drove me to tears. I don't understand why women say things that would upset another person. Why do they share horror stories? (27)

I am so tired of everyone just assuming that I am happy, overjoyed and full of excitement. I am none of these things. I am dreading this C-section. A co-worker asked me why I found out the sex of the baby. (John and I are the only ones who know it.) I was honest and told her I thought it would help me feel close to this baby, so that when it died I would have already had a name picked out and known this child as a son or daughter. She just looked at me like I was insane. Nobody gets it. (28-33)

With hospital personnel, insensitivity can be especially upsetting as the nature of the health profession requires that health care professionals be sensitive and knowledgeable about all aspects of health and illness. One couple with a history of several losses at different gestational ages received this response during an ultrasound. "Ultrasound tech said to me, 'Oh, you've only had one fetal loss.' Thank God my husband was there—I was so shocked, I couldn't even respond! People can say the dumbest things!" (28)

Maternal preparations for the anticipated baby were complex and multidimensional. These preparations were not always easy, but the reality of the time constraints and the rotund physical awkwardness of pregnancy seemed to push women to do some preparation in all three arenas.

## DISCUSSION

Events in Pregnancy calendar entries and field notes from mid to late pregnancy provide insights into the thoughts and activities of women pregnant after loss. They were focused on the security of their pregnancies and the reality that they were truly going to have a baby; however, their expectations were restrained by their fear of another loss.

Women in the latter half of pregnancy have restrained expectations due to continued fear of another loss.

The women reported frequent, steady feedback from fetal movement and prenatal surveillance that helped keep their anxiety and worries subdued and provided them informed awareness. Fetal movement was felt by all and became the gold standard of baby's current safe status. The frequency of prenatal visits was definitely greater than the routine recommended visits for low-risk pregnancy (every 4 weeks initially; then every 2 weeks, 32-36 weeks, then weekly)

(Simpson & Creehan, 2002). However, few women reported requesting more frequent appointments than their care provider suggested. This is in contrast to what was seen in an early pregnancy study (Côté-Arsenault et al., 2006).

Many discomforts were reported by study participants in the latter half of pregnancy, but these symptoms were stated as fact, an expected part of pregnancy. These calendar entries were simply reports of how the women were feeling, which is unlike findings from early pregnancy when each sign and symptom was interpreted as a potential barometer of the status of the pregnancy and baby (Côté-Arsenault et al., 2006). This seems to be another indicator of decreased anxiety in the latter part of pregnancy.

Emotional fluctuations emerged as a subtheme and contributed to the women's precarious sense of security. Pregnancy is not a stagnant state; there are numerous physical changes that influence emotional and social adjustments (Rubin, 1984). Any emotional comfort that was gained at any point in pregnancy had to be readjusted by these women when another physical or social change took place. It is not surprising, therefore, that PAL women continually worked to maintain a balanced perspective about themselves and the future with this baby.

Based on the calendar and field note data, physical preparations for baby seemed to be delayed in this group of women. It is likely that these women avoided getting physical things for the baby as a way to protect themselves in case of a negative outcome. Clinicians should ask women pregnant after loss about their preparations for baby such as nursery setup, showers, and fantasies about when the baby comes. If preparations are few or none, the clinician should ask the woman whether she thinks this is related to her past losses. A clinician response that explains that these behaviors are not uncommon among other women with a history of past loss could open up further discussion.

Care providers should ask women pregnant after loss about their preparations for baby.

Emotionally preparing to have a new baby is one of the major tasks of pregnancy; preparing to be its mother is another (Mercer, 1995; Rubin, 1984). The women in this sample were not successful in becoming a mother to their lost babies, making their preparation in this pregnancy perilous. Moving forward to accept their new role requires letting go of the many defenses (e.g., guarded emotions, avoidance of preparation, focus on the pregnancy rather than on the baby) that these women constructed to protect themselves emotionally from another major disappointment. Their personal struggles need to be acknowledged and supported by family, friends, and care providers. The challenges of being pregnant after previous perinatal loss are not generally recognized in our society (Côté-Arsenault & Freije, 2004), so it is no wonder that the emotional risks for these women are not acknowledged. Having conversations with care providers about their hopes and fears would provide a safe, social opportunity for women to gain recognition for the unique aspects of their pregnancies. Care providers need to know each woman's story of loss, acknowledge their reality that pregnancy does not insure a healthy baby, recognize that restrained expectations for this pregnancy are normal, and acknowledge milestones such as past death dates of other babies and the positive milestones for this baby in this pregnancy.

The longitudinal qualitative methods used for this study yielded extensive data from 25 weeks gestation to birth. While challenging to analyze, the data also provided new insights into pregnancy after loss never before examined. The relatively unstructured data collection methods revealed what women chose to share but also left questions about the interpretation of behavior or activity frequencies. For example, activities such as baby naming and baby showers could be rarely mentioned because they were not specifically suggested on calendar stickers or because they were avoided as one form of coping in PAL; the researchers cannot determine which is the case from these data. The sample was socioeconomically diverse, generally well-educated, and the racial composition mirrored the larger community; however, greater racial and educational diversity would be needed for broad generalizability of the findings. Greater inclusion of minority women and fathers should be a goal for future work in this area. In addition, supportive interventions for women in PAL must be developed and tested so that clinical guidelines are available and evidence based.

The study reported here addresses the late pregnancy experiences of women with previous perinatal loss. The evidence indicates that women are still uncertain about the safety of their babies but that fetal movement is extremely reassuring. Frequent prenatal visits provide a steady flow of information about the status of the pregnancy and increased security. With a better understanding of PAL, clinicians can have a positive impact on women's prenatal experiences.

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