Perinatal loss: Response from author

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Abstract:

I appreciate this opportunity to have a dialogue about perinatal loss, subsequent pregnancies, and the state of our science in these areas. The writer thoughtfully questions several important points inherent in my study (reported in September/October 2003 JOGNN).

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Article:

I appreciate this opportunity to have a dialogue about perinatal loss, subsequent pregnancies, and the state of our science in these areas. The writer thoughtfully questions several important points inherent in my study (reported in September/October 2003 JOGNN).

Definitions of perinatal loss vary in scope and breadth, depending on the context in which the definition will be used. Not everyone agrees with any one particular definition. Of utmost importance is the need to provide a clear definition so that judgments can be made about the comparability of information, or in this case, the generalizability of the findings. Most people would agree that there is a difference between a spontaneous perinatal loss (miscarriage, ectopic pregnancy, stillbirth, or neonatal death) and an elective termination of pregnancy (ETP) (elective abortion, selective termination). This is not to say that ETP is not difficult, or is not experienced as a loss. However, there are differences in the circumstances that lead to the loss, especially regarding decision making.

For this reason, the sample criteria for my study included only spontaneous loss so that the roots of the anxiety in pregnancy after loss could be as clearly isolated as possible. It was imperative for the loss groups and no-loss groups to be as similar as possible (see my letter to the editor, January/February 1999 JOGNN). Thus, the women in both groups should have obstetric histories

as alike as possible, so that any differences found could be attributed to the perinatal loss (the primary difference between groups).

Indeed, exclusion of women with a history of elective abortion does limit the generalizability of the findings. I was remiss in not stating this additional study limitation in my report. Clinical practice and research methods do not always match, due to necessary decisions regarding designs for internal (control) and external validity (generalizability). These research decisions generally increase one type of validity as they decrease the other. Therefore, judgments must be made by the researcher to design the strongest study possible, given the inherent limitations of sample size, methodology, and other factors. Because our empirical knowledge of pregnancy after perinatal loss is still limited, our studies must be carefully planned so as to learn as much as possible from each of them.

Although I agree that we need to know what pregnancies after elective abortions are like, we are still trying to understand what pregnancies after spontaneous loss are like. I believe that these two kinds of pregnancy need to be studied both separately and together. In the study under discussion here, I chose to limit my sample as I did to minimize confounding variables and thus clarify interpretation of the results.

More research is clearly needed to expand our inquiry and understanding. I am pleased to say that my current longitudinal study on pregnancy after perinatal loss may answer questions the writer has asked. All participants in the current study have had spontaneous loss and some also have had elective abortions; I hope to look for similarities and differences within and between the participants across their pregnancies. I agree that researchers and clinicians need to understand all pregnancy situations so that we can provide optimal care. This requires the careful and systematic testing of questions and the building of knowledge. Validation, evidence building, and careful interpretation of findings will all contribute to our knowledge of pregnancy experiences in our diverse society.

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