Perinatal loss: the mother's experience of grief, resolution, and subsequent child.

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PERINATAL LOSS:
THE MOTHER'S EXPERIENCE OF GRIEF, RESOLUTION, AND SUBSEQUENT CHILD

A Dissertation Presented
By
Deborah L. Davis

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

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Dedication

To my grandfather, Alvin Samuel Tostlebe
and in memory of my grandmother, Pearl Childress Tostlebe
and their infant son, John
ABSTRACT

PERINATAL LOSS: THE MOTHER'S EXPERIENCE OF GRIEF, RESOLUTION, AND SUBSEQUENT CHILD

SEPTEMBER, 1986

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In the last decade there has been an increased awareness about maternal grief following the death of a baby around the time of birth. As the necessity to grieve and emotionally recover from this loss is recognized, many obstetricians advise women to wait 6 to 12 months before attempting another pregnancy. There were several purposes to this dissertation: (1) to explore the nature of grief resolution for mothers who experience perinatal loss; (2) to explore mothers' perceptions of the effects of perinatal loss on their relationship to the subsequent child; and ultimately, (3) to determine whether grief resolution or the passage of time mediate the effects of a perinatal loss on the mother-subsequent child relationship. Twenty-four mothers who had experienced perinatal loss were interviewed with the Perinatal Loss Interview, a structured, open-ended interview developed for this study. All 24 mothers also had at least one child born subsequent to the perinatal loss. Grief resolution was described by the mothers as an acceptance and integration of the loss as well as a diminution of the intense feelings of grief. Likewise, unresolved mothers feel like
they have not accepted their loss, and still have intense feelings of grief, mostly sadness, yearning, and regret. However, regardless of grief resolution or the passage of time since the loss, 20 of the 24 mothers spontaneously mentioned feelings of overprotectiveness and replacement with the subsequent child. Overprotectiveness appears to be a result of feeling intensely vulnerable to having a baby die—since it happened once it can and probably will happen again. Replacement feelings, with few exceptions, appear to be a result of the mother never having the opportunity to get to know the baby who died— the mother tends to superimpose the subsequent child’s traits onto her image of the baby who died since this is her best guess as to what her baby would’ve been like. Thus, rather than specifying the number of months a mother should postpone subsequent pregnancy, doctors might be wise to educate the mother about grieving and the feelings she is likely to have about the subsequent child as a result of having had a baby who died. With this information, and being the best judge of her own needs and emotions, the mother can be left to decide for herself how long to postpone another pregnancy.
# TABLE OF CONTENTS

DEDICATION ....................................................................................... iv  
ABSTRACT .......................................................................................... v  
LIST OF TABLES ................................................................................ ix  

Chapter

1. **INTRODUCTION** ........................................................................ 1  
   The Grief Reaction ........................................................................... 5  
   The Effects of Perinatal Loss on Parenting of Subsequent Children ................. 15  
   Variables that Affect Grieving ....................................................... 19  
   Hospital-Based Interventions for Bereaved Parents ................................. 30  

2. **METHOD** .................................................................................. 44  
   Subjects .......................................................................................... 44  
   Procedure ....................................................................................... 59  
   Design ............................................................................................ 60  
   Coding the Perinatal Loss Interview .................................................. 73  
   Data Analyses ................................................................................ 84  

3. **RESOLUTION** .......................................................................... 92  
   The Resolved Mothers .................................................................... 93  
   The Unresolved Mothers .................................................................. 98  
   The Resolution Indicators ............................................................. 104  
   Resolution and the Passage of Time ............................................... 132  

4. **EXPERIENCES SURROUNDING THE LOSS: MAKING MEMORIES** ...... 140  
   Contact with the Baby ................................................................... 141  
   Momentos of the Baby ................................................................... 154  

5. **GRIEF RESOLUTION AND FEELINGS ABOUT THE BABY WHO DIED** ... 171  
   Anger ............................................................................................. 173  
   Sadness .......................................................................................... 180  
   Bittersweet ..................................................................................... 184  
   Neutral ........................................................................................... 189  

6. **DOCTOR ADVICE** .................................................................... 203  


vii
VII. MOTHERS' PERCEPTIONS OF THE EFFECTS OF PERINATAL LOSS ON THE RELATIONSHIP TO THE SUBSEQUENT CHILD

Overview ................................................. 220
Overprotectiveness, Resolution, and Time .................. 229
Overprotectiveness and Subsequent Child Variables ...... 234
Summary and Discussion of Overprotectiveness .......... 239
Replacement Feelings, Resolution, and Time ............ 254
Replacement Feelings and Subsequent Child Variables ... 258
Summary and Discussion of Replacement Feelings ....... 259

VIII. SUMMARY AND CONCLUSIONS ................................................. 272

Grief Resolution ............................................ 272
Parenting of the Subsequent Child ......................... 277
A Normal Developmental Model of Grief for Perinatal Loss ............................................. 279
Practical Applications ....................................... 282
Directions for Future Research ............................. 287

APPENDIX

A. Mothers' Verbatim Statements on Resolution and Feelings about the Baby who Died ............ 291
B. Glossary .................................................. 298

BIBLIOGRAPHY .................................................. 301
## LIST OF TABLES

1. Maternal Obstetric Histories ............................................. 48
2. The Babies Who Died: Baby Histories ................................. 53
3. Subsequent Children: "Subsequent Child Variables".............. 57
4. Variables Assessed by "Perinatal Loss Interview" ............... 62
5. Time Since the Loss, Resolution, Feelings about Baby's Death, and Maternal Satisfaction with Contact and Momentos .................................................. 174
6. Doctors' Advice to Mothers: Advice Received, How Many Months Mothers Decided to Wait, Actual Number of Months Between Loss and Subsequent Birth, and Mothers' Opinions about Doctor Advice .................................................. 205
7. Time, Resolution, and Maternal Feelings of Overprotectiveness or Replacement with the Subsequent Child .................................................. 230
A century ago in this country, many parents experienced the death of one or more of their infant children. Presently, the death of a baby is not a common event: Infant mortality has decreased from 20 per 1000 live births to 11.2 per 1000 live births in this decade alone, a sharp contrast to rates a century ago (Hittelman, et al., 1985). With the development of modern medical procedures and technology, many preterm and sick newborns, who several decades ago would have perished at birth, are now surviving infancy. Thus, expectant parents, having faith in modern medicine and little exposure to infant death, are not likely to seriously consider the possibility that their infant may die. Parents naturally assume that a healthy baby will be born to them and if sick, that their baby will survive (Borg and Lasker, 1981).

Parents can also exercise much control over the introduction of children into their lives. With effective methods of birth control and women moving beyond the realm of homemaking and child rearing, parents are likely to carefully plan when and how many children to have. So in addition to assuming they will have a healthy baby, many parents make a conscious decision to have a child and carefully plan the pregnancy; these parents have a great emotional investment in each pregnancy having a positive outcome (Harmon and Graham-
When a pregnancy ends in stillbirth or neonatal death, the parents' expectations have been cruelly violated, their emotional investment dashed (Borg and Lasker, 1981). To add to the tragedy, bereaved parents often find themselves isolated in their grief as those around them are unable to grasp the meaning of this loss (Kennell and Trause, 1978). Fortunately, in recent years, there has been an improvement in the quality of care bereaved parents receive from health professionals (Harmon and Graham-Cicchenelli, 1985; Harmon et. al., in press). These improvements include interventions aimed at (1) encouraging the parents to acknowledge their baby's existence and (2) validating their feelings of loss and despair (Whitfield, et. al., 1982; Ewy and Ewy, 1984; Glick en et.al., 1986).

One intervention that is often overlooked is the advice given to parents about when to conceive another pregnancy. Losing a baby is a devastating experience and yet, after a loss, many women have a very strong desire to become pregnant again. To try again, to embark on another pregnancy is to risk another loss. There are probably many thoughts and emotions that motivate these women to try again; among them may be the desire to fill their empty aching arms and the hope that there will be a different outcome this time.

In the past, obstetricians simply considered the time necessary for physiological recovery and advised women to start trying to become pregnant after 2 menses. Recently, with increased awareness about grief following perinatal death and the necessary psychological
recovery following a loss, many obstetricians have begun advising women to wait 6 - 12 months. Considering all the psychologically important interventions a doctor can implement for bereaved parents, advice about how long to wait before conceiving another pregnancy seems inconsequential. However, there is speculation that if a mother has not resolved her grief for her dead baby before conceiving another baby, she may increase her risks for parenting dysfunction; perhaps the mother should postpone another pregnancy so that she may fully grieve her loss. If she becomes pregnant too soon, her grief may be suspended during that pregnancy, but return after the baby's birth and thus compromise her relationship to the new baby (e.g., Bowlby, 1980; Rowe, et. al., 1978; Klaus and Kennell, 1982). While this advice to wait is based on concern for both physiological and psychological recovery from pregnancy and loss, many doctors disagree or are not sure about what is the best advice to give to their patients (Harmon, personal communication, 1985). In practice, the number of months a mother is advised to wait varies greatly among physicians. 

Friedman and Gradstein (1982) advise that the optimal waiting period should not focus on waiting a certain number of months, but rather should depend on the individual and her personality, past experiences, desire to be a parent, and support network. In fact, the most critical factor in determining whether a mother is ready for another baby may simply be whether she has mourned her loss and is ready to move on with her life (Friedman and Gradstein, 1982; Bowlby, 1980). Being able to help a woman determine when she is ready for
another pregnancy may be an invaluable support that a doctor can provide, both for grief work and parenting a subsequent child.

This dissertation is a descriptive study of the mother's experience of having a baby that dies at or around the time of birth, and what it's like to then have another baby and raise this healthy child born subsequent to the perinatal loss. Because of the speculation in the literature about how mothering may be compromised if grief is not resolved before the birth of a subsequent child, the main questions posed by this dissertation are (1) What is the meaning of "grief resolution" following perinatal loss?; (2) What is the relationship between grief resolution and parenting a subsequent child?; and (3) Does the passage of time play a role in resolution or quality of parenting a subsequent child?. The practical application of this information lies in what constructive advice doctors can give mothers about how long to wait before trying to conceive a subsequent pregnancy. Should the mother wait until she has resolved her grief over her loss or is there a certain number of months that is ideal to have between perinatal loss and subsequent birth? Thus, the 3 foci of this study are (1) grief resolution following perinatal loss, (2) the passage of time, and (3) parenting a subsequent child.

Data will be obtained from maternal self-report during the Perinatal Loss Interview, an interview designed for this study. Women interviewed will be mothers who, within the past 10 years, have experienced stillbirth (fetus greater than or equal to 20 weeks gestation) or death of a neonate (within 28 days after birth).
Each mother will be asked to describe (1) the events surrounding her baby's death, the emotions experienced, and support received after the loss, as well as her current perspective on her baby's death and her definition of grief resolution and the ways she feels resolved or unresolved; (2) the passage of time between events of the loss, trying to conceive again, feeling better, and birth of the subsequent child, as well as advice the mother received from her doctor on how long to wait before conceiving another pregnancy, and her opinion about the advice she received, how long she actually waited, and why; and (3) her experiences with and feelings about raising a healthy child born subsequent to her loss. All the variables examined by the Perinatal Loss Interview were chosen based on the literatures on pregnancy loss, grieving, clinical interventions following loss, and parenting dysfunction due to grief or depression.

The following is a review of the literature on (1) the normal grief reaction and resolution, particularly with regard to mourning a fetal or neonatal death; (2) pathological or unresolved grief; (3) the effects of perinatal loss and grief on parenting of subsequent children; and (4) variables and interventions that affect the grieving process.

**The Grief Reaction**

After the death of a loved one, mourning is a healthy process of coming to terms with the loss (Bowlby, 1980). When part of one's
existence is invested in loving another person, if that loved person goes away or dies, one will feel deprived, reduced, and afraid of the new adjustments that must be made (Jackson, 1974). Grieving is the process by which one gains control over these painful emotions and finds a new way of living for the future. Through this process, grief is resolved as one learns to continue on as a whole person rather than as one who is permanently diminished (Jackson, 1974).

Grief is a definite syndrome with psychological and physical symptoms (Lindemann, 1944). In Lindemann's (1944) classic study of adults who had lost a close relative, he reported a number of symptoms which were experienced by a vast majority of the bereaved. Psychological symptoms include preoccupation with thoughts of the deceased, irritability, restlessness, guilt, and intense feelings of distress. Physical symptoms included shortness of breath, tightness in the throat, lack of strength, exhaustion, sighing, empty feeling in the abdomen, and loss of appetite. These symptoms of distress commonly occur in waves lasting 20 to 60 minutes.

There may also be changes in personality brought out by emotional stress, the feelings of anxiety and despair (Jackson, 1974). A fastidious person may become careless; an outgoing person may become withdrawn; an even-tempered person may be quick to anger (Wolff and Simons, 1985).

For parents, grieving is necessary after a stillbirth or neonatal death. Women mourn the death of their newborn whether the infant lived for 1 hour or 2 weeks, weighed 3,000 or 580 grams, and whether
the pregnancy was planned or unplanned (Kennell, Slyter, and Klaus, 1970). Mothers grieving the loss of a neonate may in fact experience the same grief reaction as described by Lindemann (1944). Women who have lost a neonate report depression, preoccupation with the loss, crying spells, sleeplessness, loss of appetite, and other symptoms considered to be part of the normal grief reaction (Jensen and Zahourek, 1972). About half of mourning parents report illusions of seeing or feeling the presence of the child (Hollingsworth and Pasnau, 1977). The feelings of grief peak at 3 months and progressively decline from 6 to 12 months after the loss (Hollingsworth and Pasnau, 1977; Helmrath and Steinlitz, 1978; Harmon, Glicken, and Siegel, 1984). And the grief reaction is as great for a fetal death as for the death of a newborn (Peppers and Knapp, 1980).

The Phases of Grief

Bowlby (1980) and Kubler-Ross (1969) outline the phases of grief through which parents must progress upon the loss of a child. Progression through each phase can take days or months, even years, and at times parents may vacillate between phases. Thus, these phases are by no means distinct or irreversible, but they give organization to an otherwise bewildering emotional experience.

The first phase of grief is shock and numbness. The parents feel stunned and the reality of their infant's death may not sink in for several days. The second phase includes episodic denial and searching and yearning for the dead infant. Parents may wonder if the dead
Infant is really someone else's and that their baby is somewhere, alive and well. If fetal demise has been diagnosed before delivery, the mother may still believe that she can detect fetal movement. After delivery and/or the infant's death, a period of searching and yearning occurs, during which there is a desire to recover the lost infant. The parents are preoccupied with images of the baby and often dream about the infant. Perinatal death presents a complication to this phase in that the searched-for person is the infant who was fantasized about and idealized during pregnancy. The discrepancy between the idealized infant and the realized dead infant is especially agonizing as perinatal death transforms the expectation of joy to the horror of sorrow (Kennell and Klaus, 1982).

As parents work through denial, searching, and yearning and start grasping the reality of the death, they will begin experiencing feelings of anger, guilt, failure, and resentment (Bowlby, 1980; Higgins, 1977; Harmon and Graham-Cicchinni, 1985; Borg and Lasker, 1981). Feelings of failure and inadequacy tug at the parents as they wonder if they are able to produce a healthy baby. Diagnostic terms such as incompetent cervix and blighted ovum can add to feelings of failure and inadequacy (Jiminez, 1982). Parents feel resentment toward others who seem to effortlessly produce healthy babies despite unhealthy habits during pregnancy (Berezin, 1982). Parents may also feel angry at fate, God, or each other (Borg and Lasker, 1981). Guilt is anger directed at the self and may arise from parents wondering whether it was something they did or did not do before or during
pregnancy or delivery that caused the infant's death (Tatelbaum, 1980). Or parents may direct anger toward medical staff, blaming their obstetrician, delivery room nurses, or neonatologists for the death of their baby. Hospital staff who deal with angry parents must recognize that parents are ventilating anger about their infant's fatal illness or death and to not take attacks personally or behave defensively. In fact, directing rage toward doctors and nurses is a healthier option than self-directed anger because directing anger toward oneself may lead to self-destructive behavior or later, chronic depression (Berezin, 1982; Tatelbaum, 1980).

These first phases of grief which involve numbness, denial, and anger, are all forms of protest against the reality of the baby's death. As the parents work through feelings of denial and then anger, there is a growing realization that the baby is gone and what might have been cannot be recovered. Finally the parents become resigned to the baby's death and enter a phase of grieving characterized by disorganization. The bereaved parents may still feel anger and guilt and even occasional denial as they fluctuate between yearning for the baby and accepting the death (Bowlby, 1980). Eventually as the parents begin to really accept the death and attempt to integrate the changes it has wrought, they can reinvest their interests in activities and relationships. In this way they begin to reorganize their lives and to experience feelings of resolution.
Resolution

Ultimately, the healthy grieving process leads to resolution (Bowlby, 1980; Kubler-Ross, 1967). Resolution is the acceptance of the loss and its integration into life that goes onward: Acceptance comes after dealing with the feelings of denial, anger, guilt, depression, isolation, etc., feelings which can still exist but the parent has found new meaning in life and looks to the future with hope instead of despair (Ewy and Ewy 1984). One sign that a parent feels resolved is when the parent has regained interest in activities, relationships, and new challenges, rather than dwelling on the past and what was lost (Jackson, 1959; Hollingsworth and Pasnau, 1977; Bowlby, 1980; Harmon and Graham-Cicchinelli, 1985). Another sign of resolution is the reorganization of the image of the lost infant (Bowlby, 1980). In the psychological relationship between the bereaved and the deceased, changes are necessary such that memories of the deceased are realistic, do not substitute for other relationships, and do not evoke painful emotions (Rubin, 1984). The resolution of grief is clinically important for it indicates emotional health: The parent has accepted the changes death has wrought and she is ready to move on with her life (Helmrath and Steinitz, 1978).

The literature on grieving emphasizes the importance of "letting go" of the deceased, reducing the emotional investment in the lost loved one. Klaus and Kennell (1982) assert that mothers who become pregnant prior to completing their grief work, have not relinquished their emotional investment with their dead baby and therefore find it
very difficult to attach to the new baby. Grief resolution has also been considered a fairly speedy and final accomplishment: Lindemann (1944) reported that grief subsides after a month or two, and in Kubler-Ross's (1969) stages of grief, resolution is the desired "end" of the grief reaction. In contrast, recently compiled evidence suggests that acute grief often exceeds one year and in some sense, grief may never end (Parkes, 1970; Kowalski, 1984). Holidays and anniversaries surrounding the baby's life and death may be accompanied by sadness for years to come (Higgins, 1977). After many years, the bereaved can continue to "miss" the deceased. Peppers and Knapp (1980) refer to the feelings of grief over perinatal loss which never disappear as "shadow grief". Kowalski (1984) confirmed the existence of "shadow grief" in mothers 15-30 months post-loss but unlike Peppers and Knapp (1980), proposed that "shadow grief" is not a burden these mothers must bear but is a bittersweet memory of the child they never really knew, a memory which they cherish.

As many parents report this phenomenon of shadow grief, it must be considered a normal part of grief resolution. Resolution does not mean withdrawal of emotional investment in the lost infant: parents never forget their infant who dies and will always have feelings of grief over the loss (Bowlby, personal communication, 1985). In resolution, the bereaved parent retains the memories of the deceased but gradually gains a perspective on these memories such that they are less intense and evoke a sense of well-being rather than guilt, anger, or depression (Rubin, 1984; Wolff and Simons, 1985). The parent is
able to regain interest in daily living and to focus on the future with recognition that it is different than what was hoped for (Helmrath and Steinitz, 1978; Harmon and Graham-Cicchinelli, 1985).

Unresolved Grief

There is a myriad of problems that can arise when parents have difficulty resolving their grief. Pathological or unresolved grief is often a precipitant to problems in many aspects of living. Unresolved grief can result in 1) feelings of depression, anger, and guilt, 2) onset of diseases such as ulcers, asthma, rheumatoid arthritis, 3) either overactivity or withdrawal, 4) self-destructive behavior which endangers social or economic existence, and 5) severe alterations in relationships, including compromised parenting of current or future children, and marriages which until the loss were stable and satisfying (Lindemann, 1944; Kaplan, et al., 1973; Klaus, 1984; Tatelbaum, 1980).

Indications. Unresolved grief is the exaggeration or distortion of the normal grieving process (Lindemann, 1944; Jackson, 1974; Bowlby, 1980). Bowlby (1980) classifies pathological mourning into 2 main types: chronic mourning (referred to as distorted by Lindemann, 1944) and prolonged absence of conscious grieving (also referred to in the literature as delayed, inhibited, or suppressed). The main difference between these 2 variants lies in the bereaved's level of daily functioning and the degree of awareness of the connection between intense emotions and the loss. In chronic grieving, the
bereaved acknowledges that the death occurred but fails to accept the death and move on; in absent grieving, the bereaved fails to acknowledge feelings of grief or loss.

**Chronic mourning.** In chronic mourning, the bereaved experiences intense and prolonged feelings regarding the loss and her life remains disorganized and unfocused. The parent is preoccupied with the loss and often incapacitated by intense guilt, anger, depression, and other emotions associated with normal grieving. In chronic mourning, grief remains a prominent aspect of life for years after the loss. For instance, the parent may continue to be preoccupied with the image of the baby, talk about the baby as if he still existed as an integral part of their lives, or fantasize that he will return someday to live with them. The mother may believe that if she does not constantly remember the dead baby, no one will (Peppers and Knapp, 1980). This failure to accept and integrate the loss and reorganize the relationship with the deceased are marked signs of the lack of resolution these parents experience (Rubin, 1984; Bowlby, 1980). This lack of resolution often leads to depression (Zahourek and Jensen, 1973). In general, symptoms of chronic grief include morbid brooding, preoccupation with reunion, lack of redefining goals or investment in the future, talk about the deceased in present tense, overvaluing objects that belonged to the deceased, overidealization of the deceased, and denying feelings of ambivalence, guilt, and anger (Ewy and Ewy, 1984; Tatelbaum, 1980).

**Absent grieving.** In absent grieving, the parent is seemingly
unaffected by the loss, shrugs it off as inconsequential; this underreaction can indicate prolonged numbing where the parent refuses to acknowledge the reality of the loss (Bowlby, 1980). The parent is able to organize her life but she experiences a variety of physical symptoms or psychological difficulties such as inexplicable episodic depression or interpersonal problems. Life remains organized, not due to an ability to cope with the loss, but rather due to the parent remaining oblivious to the loss. Indeed, an absence of grief rather than intense grief may indicate family disorganization and conflict (Caplan, Mason, and Kaplan, 1965). Common symptoms of absent grieving include chronic physical problems, emotional withdrawal, overwork, substance abuse, self-destructive behaviors, compulsive behaviors, preoccupation with death or suicide, and severe anniversary reactions (Tatelbaum, 1980).

Many of the symptoms listed under chronic mourning or absent grieving may be experienced by parents progressing normally through the grieving process. Parents may in fact for several weeks or months after the loss show an absence of grief and then progress into chronic mourning; other parents may oscillate back and forth between chronic and absent grieving (Bowlby, 1980). However, one year is considered a cutoff point: After one year following a loss, if these symptoms persist, unresolved grief may be indicated (Ewy and Ewy, 1984; Gorer, 1965; Helmrath and Steinitz, 1978; Stringham et al., 1982; Parkes, 1970).

The contrast between mothers who have resolved their grief and
mothers who have not resolved their grief is illustrated in a study by Kowalski (1984). Kowalski (1984) found that of mothers 15 - 30 months post-loss who were coping poorly, most still felt anger, guilt, and a sense of failure, most still had episodes of crying, and they could not think of anything positive about the experience. These mothers had mostly turned their anger toward themselves in self-destructive ways and they experienced low self-esteem and depression. On the other hand, mothers who coped well had very little anger and had been able to create something positive from the experience. Thus, after the first year since the baby's death, the presence of anger and depression differentiated the grieving experiences of these two groups of mothers. In general, professional help is indicated if parents are either defensive, i.e., extremely apathetic and unresponsive to the loss, or destructive, i.e., extremely angry, guilty, or depressed (Jackson, 1974).

The Effects of Perinatal Loss on Parenting of Subsequent Children

One way that parents exhibit the effects of perinatal loss is to insist on having no more children (Wolff, et al., 1970). The risk of having to go through another pregnancy whose outcome may also be tragic is too much for some parents to bear. But many parents wait less than 6 months to become pregnant again, replacing the lost child by having another (Friedman, et al., 1963; Bowlby, 1980). Because many parents go on to have a new baby soon after a perinatal loss, it
is important to examine the effect of such a loss on a subsequent pregnancy and the ensuing parent-child relationship.

It seems likely that having a baby die will color the mother's experience with subsequent pregnancies, perhaps making her more anxious that something could go wrong again. It seems equally likely that if she gives birth to a healthy baby, her relationship to that baby could be affected by her experience of losing a previous baby. The literature cites several negative effects of perinatal loss on parenting of subsequent children, all speculated to involve unresolved grief. Although there are no systematic studies, it seems likely that the effects of perinatal loss on parenting can be exacerbated by unresolved grief, and likewise be mitigated by resolution.

One way that parents who have lost a baby may increase their risk for parenting disorders with a subsequent child is to become pregnant before they have resolved their grief. Indeed, having a new baby is considered by many to inhibit rather than facilitate grief resolution. For example, Rowe et al. (1978) found that mothers with a surviving twin or subsequent pregnancy less than five months following the baby's death are at higher risk for prolonged grief than mothers who wait at least 6 months before becoming pregnant. Becoming pregnant before grief work for the dead baby is completed can have the effect of suspending grief during anticipation of the next baby, only to have grief return soon after birth (Bowiby, 1980). Then, at a time when parents should be relating to and concentrating on the new baby, they find themselves consumed with thoughts and grief for the dead baby.

A pronounced form of this interference with attachment to the new baby is when the parents view the baby as a replacement for the dead infant (Davidson, 1977; Cain and Cain, 1964; Schneiderman, 1979; Posnanski, 1972). Here, the parents may have difficulty focusing on the new baby as an individual separate from the dead baby, even imagining that the new baby is a return of the dead baby (Bowlby, 1980). Or if the parents retain an idealized memory of the dead infant, the subsequent child grows up inferior by comparison to the "perfect" (though dead) sibling (Peppers and Knapp, 1980). Thus, Bowlby (1980) recommends parents wait one year before conceiving again so they can reorganize their image of the dead infant and retain it as a memory distinct from their new infant. However, waiting a certain number of months to become pregnant again is no guarantee that the parent-infant relationship will be unaffected by the loss. Any parents who do not completely mourn the death of their baby are at risk for having problems with parenting a subsequent baby.

As unresolved grief can affect functioning and interpersonal relationships, unresolved grief can similarly influence the relationship between a mother and a new baby born subsequent to a pregnancy loss. Unresolved grief, either chronic or absent, resulting in depression and other compromises in normal functioning can render a parent emotionally unavailable, which can have a serious depriving effect on the development of children born subsequent to the loss.
(Emde, 1980; Richardson, 1974). Or parents may displace their feelings of inadequacy, guilt, and sadness onto the child, making him or her a scapegoat (Dunlop, 1979). Guilt may be heightened by feelings of disloyalty to the deceased infant when a new baby arrives and requires love (Wolff and Simons, 1985). Or, the parents may still be in such need of emotional support that it may be difficult for them to be supportive of their children (Berezin, 1982).

Another effect of perinatal loss is the parent becoming overprotective of subsequent children for fear of losing them too. Known as the "vulnerable child syndrome" (Green and Solnit, 1964) this reaction often produces parents who are hypervigilant and children who have difficulty with separation/individuation issues.

Finally, the mother who gives birth to twins, one of whom dies, is at high risk for unresolved grief and resulting disruptions in parenting. The most difficult death to mourn is the perinatal death of a twin when the other twin is alive and well (Rowe, et al., 1978). Everyone downplays the death of the twin and focuses on the healthy baby while the mother is left alone with thought of the dead twin for years to come (Lewis, 1980; Wilson, et al., 1982). The presence of a living twin in no way lessens the grieving process. The mother needs to be able to acknowledge and openly express her feelings about the loss of the one twin so she can complete her grief work and concentrate on the living twin (Wilson, et al., 1982). She may also need help in working out feelings of blaming the surviving twin for the demise of the other or being angry at the baby for being so
healthy and needing all the loving attention babies need (Borg and Lasker, 1981). If the mother does not complete her grief work, the surviving twin may grow up either feeling he has to be very ambitious to make up for the loss, or he may give up that struggle and withdraw (Dunlop, 1980).

**Variables that Affect Grieving**

There are many variables which affect the course of grieving the loss of a fetus or neonate. But first, it is important to recognize that there are a number of features of perinatal loss which make grieving inherently difficult.

Grieving the loss of a fetus or neonate is very different from grieving the loss of a spouse, parent, child, or other loved one. One basic difference is the length of acquaintance with the deceased. The parents' attachment to their unborn child can begin even before conception as they begin to fantasize about their future offspring, including fantasies about physical features, personality characteristics and talents they hope to find and encourage in their child (Benedek, 1962; Klaus and Kennell, 1982). When a pregnancy is conceived and when fetal movement occurs, these feelings of attachment to the child are heightened in the parents (Harmon et al., 1982). But because the infant was not a person of long acquaintance, it is difficult for friends, family, and even professionals to consider the baby's death a traumatic loss of a loved one, or to imagine the
parents' feelings of grief over the loss of someone who they have not been able to see, touch, or handle except maybe briefly (Kennell and Trause, 1978). This attitude can make parents feel that their grief is unacknowledged, unjustified, or unnatural, feelings which do not facilitate grief work. Additionally, because the child's life is so brief, there are very few memories associated with the loved one and no one with whom those few personal memories can be shared (Lewis, 1979; Jiminez, 1982).

Other unique features of perinatal loss which can make the grieving process very difficult for parents include: 1) Because the infant never became a person to be loved in his own right, the parents may not have separated their idealized notions of the potential of the infant from the real baby and may have more difficulty letting go of this "perfect" child who never made any demands (Jiminez, 1982; Peppers and Knapp, 1980); 2) The loss of the idealized infant can represent a loss of self to the parents (Furman, 1976); 3) The rituals designed to support the bereaved, eg., funeral, memorial services, mourning period, are not present upon the death of a fetus or newborn (Goldberg and Minde, 1983; Schneiderman, 1979; Lewis, 1979); and finally 4) With the death of a parent or a friend, you have lost a part of your past, but with the death of a child, you have lost a part of your future (Ewy and Ewy, 1984). Losing a part of one's future is an aspect of perinatal death that makes it particularly difficult to get on with life following such a loss.

Besides those variables which make mourning any perinatal loss
difficult for all parents, there are also variables which may influence the course of grief for individual parents. There are a number of speculations and few studies in the literature which try to address the variables that discriminate between mothers who cope well and mothers who cope poorly following the death of an infant. Variables emphasized in the literature as affecting parental grief include 1) childhood events regarding separation and loss, 2) perinatal events surrounding the loss, 3) availability of social support systems, particularly the reaction of others to the parents' grief and the quality of the marital relationship, and 4) hospital based interventions. In general, it seems that these variables influence grieving by either facilitating or exacerbating the normal feelings of loss, anger, guilt, failure, despair, and isolation. Indeed, these variables in combination with extent of these feelings may be used to indicate resolution: Kowalski (1984) used these variables and feelings to classify mothers 15-30 months after a perinatal loss according to how well they were coping. Compared to mothers who were coping poorly, mothers who were coping well had a better marital relationship, larger support system, more supportive friends, and stronger religious beliefs (another form of support) as well as lesser feelings of failure, anger, and guilt.

Childhood Events Regarding Separation and Loss

Parents who may be particularly vulnerable to problems coping with the death of an infant are those parents who felt rejected during
childhood or had childhood experiences with separation or loss, particularly of a parent. Bowlby (1980) proposes that the way a person responds to loss is determined to a large extent by how her needs for love, comfort, and attention were responded to during infancy, childhood, and adolescence. The healthy response to loss is to dwell on memories, to express yearning, anger, sadness, and to cry. Children who experience discontinuities in caretaking or are not permitted to cry or seek comfort, may grow into adults who tend to bottle up feelings or bear unhappiness alone. The tendency to bottle up feelings can lead to absent grieving as grief is inhibited; the tendency to bear sorrows alone can lead to chronic mourning as the feelings of grief are exacerbated. Indeed, many bereaved have reported how damaging it was for friends and relatives to tell them to quit being so sad and pull themselves together; being told this as a child is likely to be equally if not more damaging, the result being an adult who cannot let herself grieve or rely on others for support (Bowlby, 1980).

Perinatal Events

Generally it is assumed that more intense grieving is associated with later stages in pregnancy (Kirkley-Best, 1981). But other variables modify this factor, such as, how long the parents had been trying to become pregnant, prognosis for future pregnancy, and whether they already have any children (Lewis, 1980). If the parents have previously given birth to a healthy child and there are no fertility
problems, they may not feel such a sense of failure as parents who do not have any living children or parents who experience infertility problems. Circumstances of the pregnancy can also affect the grieving process. For example, if the pregnancy was unwanted, the mother may feel guilty that her wish to not bear this child somehow caused the baby to die (Bowlby, personal communication, 1985). Circumstances of perinatal care and delivery may play a role in giving the parents someone, even themselves, to blame for the death, exacerbating normal feelings of anger or guilt. For example some unfortunate mishap may have occurred which the parent thinks could have caused the death, making them bitter and angry at themselves or others (Bowlby, 1980). Finally, the cause of death can exacerbate feelings of guilt or failure. For example, if there were uterine or placental abnormalities, the mother may feel guilty, that maybe there was something she should have done or not done to prevent the condition. Or if the infant was born with genetic anomalies, the parents may feel a great sense of failure in that their bodies and/or genes are defective, making them fearful that they cannot bear a healthy child (Borg and Lasker, 1981).

When the infant dies before birth, there is a unique set of problems for the grieving process. First, the mother must cope with the fact that she is carrying a dead baby inside her body. Because our society considers a corpse to be a disgusting thing, the mother has to deal with feelings of contamination and horror (Lewis, 1980). Obstetricians are reluctant to induce labor because of the
complications that can arise if induction is unsuccessful. To perform an unnecessary cesarean section is also risky. Secondly, if a mother carries a dead baby for too long (2 weeks or more), she may have difficulty mourning the death. For one thing, it is easy for the mother to suspend her feelings and deny the baby’s death while she appears overtly pregnant. Until the baby is born, the mother holds on to the hope that the child is still alive and she may need a lot of reassurance that there was nothing that could be done at birth, that the baby was indeed dead for a while before birth (Grubb, 1976). In addition, the mother may become withdrawn, perhaps remaining withdrawn even after the birth of the next child (Lewis, 1980).

Social Support

Social support systems, including friends, relatives, and hospital staff, are a major factor that can help parents cope with a loss (Jackson, 1974; Helmrath and Steinitz, 1978; Yates, 1972; Schnederman, 1979; Kowalski, 1984). The most treasured friends are the ones who can talk with the parents about the baby (Schnederman, 1979). Without such support, parents are likely to have difficulty resolving their grief (Davidson, 1977; Lewis, 1976).

Kowalski (1984), in a study of social support systems for grieving mothers, found that at 15 - 30 months post-loss, mothers who were coping poorly had small social support systems, were not religious, and had not attended college. On the other hand, the mothers who were coping well had large social support systems, had
close relationships with husbands and friends, were religious, middle class, well educated, and had good medical care. Kowalski (1984) proposes that for her sample there was a relationship between having a large support system and being educated and middle class: middle class, educated mothers are more achievement oriented, hopeful, and resourceful in finding support for coping with their grief than uneducated, lower class mothers.

Although social support can be a key to the bereaved parents' survival, many parents experience difficulties with the reaction of others and the marital relationship.

Reaction of others. A major variable that affects the parents' grieving process is the reaction of others, particularly the behavior of hospital staff. Until recently it was not widely recognized that parents will and should grieve the death of their newborn. The subject was avoided and in order to not upset her, the mother not allowed to see the infant. Often the mother was not even given adequate follow-up medical care, much less psychological follow-up (Peppers and Knapp, 1980).

The grieving mother who cries loudly and continuously is upsetting to staff and other patients. While this behavior is normal grieving behavior and accepted in other cultures, it is not culturally acceptable behavior in the United States (Zahourek and Jensen, 1973). While the intensity of the mother's feelings has at least been recognized, the father's attachment to the infant and need to grieve the loss has been completely ignored. These traditional attitudes
toward perinatal death has resulted in the parents being faced with a non-event and nothing tangible to mourn; parents feel isolated and the grieving process is not facilitated (Lewis, 1976). In fact, pediatricians and obstetricians who have chosen specialties that deal with new life may be particularly inadequate in dealing with death, much less acknowledging and encouraging the parents' need to do so (Knapp and Peppers, 1979).

In general, the reaction of others serves to isolate the parents with their grief; this isolation plays a significant role in inhibiting the grieving process. More specifically, Davidson (1977) observed that the grieving process is thwarted by hospital practice and by the reaction of others in 3 major ways: (1) The grieving process is thwarted in the searching-yearning phase of grief when the mother asks to hold and see the baby and attend the funeral and is denied those requests so she "won't get upset". But not being able to see the baby or attend the funeral only makes the affirmation process, dealing with the reality of the death, more difficult and agonizing. And difficulty accepting the reality of the death leads to pathological grieving (Bowlby, 1980). For example, one mother described how after being denied contact with her baby, she began weighing vegetables and kitchen utensils in order to find something that approximated the length and weight of the baby. A rolling pin fit the bill and she cradled it and cried (Davidson, 1977). On the other hand, mothers who are allowed to see and hold their infants are given confirmation of what the baby looked and felt like and are able
to reorient themselves far more quickly than mothers denied contact (Kirkley-Best and Kellner, 1982). Those who think holding the infant might make the mother too attached should be reminded that the mother who has carried the baby in her womb for months has already "held" and felt an attachment to that baby (Kirkley-Best, 1981; Kennell and Klaus, 1976).

(2) The grieving process is thwarted when the mother is feeling angry, resentful, and guilty about the death and is reaching out for support. Due to their own anxieties or lack of empathy, people don't know how to acknowledge the loss and be supportive by helping the mother think out angry, difficult questions like "Why me?".

(3) For similar reasons the grieving process is thwarted when the mother is feeling disorganized, sad, and depressed. There is not social recognition of the parents' need to mourn a perinatal death and family and friends expect them to recover quickly. In fact, couples inexperienced with this kind of loss are surprised at their depth of feeling, or the fact that acute grief lasts 6 to 12 months (Helmrath and Steinitz, 1978; Stringham, et al., 1982). These expectations for minimal grief, as well as neonatal death being an uncomfortable topic, isolate the parents, leaving them to grieve alone and wonder if they are being unreasonable in their grief. Because the mother is discouraged in her attempts to grieve and thereby feel released from her loss, the reorientation phase of grief is delayed. Instead of being encouraged to experience and express her grief, the mother is left to dwell on the baby and her loss. In addition, the mother may
dwell on her loss because she believes that if she doesn't remember this baby, no one will (Peppers and Knapp, 1980). Unable to complete her griefwork and focus on living for the future, she remains depressed and disoriented.

**The marital relationship.** Another factor that determines how well mourning proceeds is the relationship between the parents. If mother and father proceed through the stages of grief at the same pace, they can derive a lot of comfort from each other (Bowlby, 1980). A recent study by Forrest (et al., 1982) indicates that along with a social support system, an emotionally supportive husband is crucial: socially isolated women whose marriages lack intimacy have a higher incidence of psychiatric symptoms within 6 months after the loss. Similarly Kowalski (1984) found that women who have good marital relationships and large support systems are the ones who cope well 15 - 30 months after the loss. However, there are a number of problems parents can run into: (1) differences in the experience of losing an infant, (2) differences in pace of grieving, (3) differences in expression of grief, and (4) differences in societal expectations for the mother and father.

(1) One factor that may make it difficult for mother and father to support each other is differences between the parents in how they experience perinatal loss. Perinatal loss is usually more deeply felt by the mother because of the physiological attachment during pregnancy and hormone response to childbirth (Helmrath and Steinitz, 1978; Friedman and Gradstein, 1982). Additionally, the mother loses a child
who exists for the present since she is confronted with the physiological reality of a baby moving and living inside her, while the father loses a future child whose existence is more abstract (Jiminez, 1982). In any case, both parents need a lot of support in dealing with the death of an infant, including acknowledgment of their need to grieve the loss and reassurance of their "wholeness" and worth (Furman, 1976).

(2) Perhaps due to differences in the experience of losing an infant, parents often grieve at different rates. For instance, if one parent is still in the phase of denial and the other parent is depressed or angry, they may have great difficulty comforting each other (Kubler-Ross, 1969). Or if one parent is expressing anger and guilt while the other is reaching resolution, they may feel very impatient with each other.

(3) Another major difficulty that parents often experience in their relationship is that they have different ways of expressing their grief. Since men in this society are taught that crying is an unacceptable expression of emotion, many fathers will find it difficult to cry, even in front of their wives. When the mother is spending a lot of time crying, her husband may worry that she is overreacting and feel it is his duty to cheer her up. Meanwhile, the mother may not be able to understand why he won't cry, why he always tries to be so cheerful. While she can hardly get anything accomplished, he may dive into work, spending more time at the office in order to escape the tension and sadness at home. From her
perspective it may seem like he is not grieving the death of their baby, that it hardly even bothers him. So she gets more upset, then he tries to be more cheerful, and the tension mounts (Glicken et al., 1986).

(4) Another problem the couple may face is that in this culture, the father is expected to return to normal particularly soon after his baby's death. The additional expectation that the father provide emotional support for his wife makes it very difficult for him to express his grief. If he withdraws, the strain on the marriage can be great (Lewis, 1980). Of the 40 families studied by Kaplan, et al. (1973), 28 reported marital problems 3 months after their child's death. However, in a study by Harmon, Glicken, and Siegel (1984), about half of the couples reported that the death of their baby drew them together. The improved outcome for couples experiencing death of a baby in the latter and more recent study may be a result of improvements in hospital practice since 1973. If hospitals have revised practices in order to facilitate grieving in both parents, it makes sense that marital problems might decrease.

**Hospital-Based Interventions for Bereaved Parents**

Hospital-based intervention is necessary and helpful to parents who experience stillbirth or death of a newborn (Queenan, 1978; Lewis, 1979). Support from hospital staff can be crucial in facilitating parental grief (Lippman and Carlson, 1977). Unfortunately,
traditional hospital practices have not been supportive of parents who are grieving the death of a fetus or neonate. This lack of support can be attributed to the fact that neonatal death is an uncomfortable topic for most people. Friends and relatives don't know what to say and have difficulty understanding the parents' grief. Hospital staff are not immune to this reaction. Doctors and nurses have a high investment in delivering a live, healthy baby and may feel helpless, guilty, and a sense of failure following perinatal death. So they avoid the patient to avoid facing those feelings, compounding their problems and contributing to the mother's feelings of isolation (Zahourek and Jensen, 1973; Yates, 1972). In order to be helpful to the parents with their grief, medical staff must grapple with these feelings and understand appropriate grieving (Zahourek and Jensen, 1973; Solnit and Green, 1959; Kowalski, 1980; Lippman and Carlson, 1977). By handling the event tactfully, constructively, openly, doctors and nurses can facilitate a healthy mourning response, i.e., help the parents to acknowledge the reality of their loss and to express their feelings about it (Hildebrand and Schreiner, 1980; Kennell and Trause, 1978; Cohen, et al., 1978; Lewis, 1979).

In recent years, many hospitals have vastly improved their treatment of parents who experience the death of a fetus or neonate (Harmon and Graham-Cloichinelll, 1985). Given the toll that pathological grief may take on the parents and their relationship with each other and subsequent children, it is important to examine hospital-based interventions that promote healthy grieving.
Recognizing the Depth of the Loss

A first step in providing support for parents who experience perinatal loss is to recognize the parents' emotional investment in the unborn child. Stillbirth or death of a neonate is a profound loss because during pregnancy, in preparation for parenthood, parents can begin their attachment to the baby. They often have fantasies about the baby's potential and the effect the baby will have on their lives (Kirkley-Best, 1981; Friedman and Gradstein, 1982). Although the parents never "knew" the baby in the way that we normally think of knowing someone, the baby and their hopes and dreams for this child had become incorporated into their lives and thus, the baby's death represents a deeply felt loss. Secondly, parents appreciate being recognized as parents as indeed they are and have considered themselves to be for the past 7 to 9 months (Stanko, 1973).

Listening

Listening is one of the best forms of support for grieving parents (Helmrath and Steinitz, 1978; Yates, 1972). Yates (1972) interviewed mothers who experienced stillbirth in order to discover their needs and how hospital staff could meet them. All expressed an overwhelming need to talk about the stillbirth and to not be left alone. Careful listening is particularly important if fetal demise has been diagnosed. Before labor and during delivery, mothers who are carrying a dead baby can be greatly helped by being given the opportunity to discuss their feelings and fears. Talking and
expressing emotions will prevent the mother from withdrawing. Parents will also need reassurance that the baby is not rapidly decomposing and that labor is often easier (Lewis, 1980).

**Use of Sedatives**

Whenever medically unnecessary, parents should not be given sedatives as this will dull the grief response as opposed to facilitating it. Parents who hide in the fog of sedatives will have greater difficulty resolving their grief than parents who experience the intensity of their grief (Kennell and Trause, 1978; Hildebrand and Schreiner, 1980; Dunlop, 1979).

**Sensitivity to the Special Situation**

The parents should be given the option of having a private room, away from the maternity ward (Schwiebert and Kirk, 1981; Harmon and Graham-Cicchinelli, 1985). Husbands should be encouraged to spend the night with their wives. Unlimited visiting allows the parents to be together during their time of great need (Kennell and Trause, 1978). The mother's chart or door should also be flagged somehow so that hospital staff can easily identify her special situation. Flagging these mothers would reduce an all too common problem of staff inaccurately assuming the woman has a healthy baby and inappropriately approaching her about nursing her baby or renting an infant car seat.
Helping Parents Collect Memories

Memories of a loved one are also important for grief work (Lewis, 1979). Although painful, dwelling on memories of the deceased is a way for the bereaved to experience a gradual goodbye to the loved one. If memories are avoided, the gradual goodbye is never completed and the parent cannot focus attention on the future and the living (Hollingsworth and Pasnau, 1977). But with an infant who dies before or shortly after birth, there are few memories for the parents to think and talk about and fewer people with whom to share those memories. The parents may become obsessed with going over the details of the pregnancy, the birth, the baby's short life, which others may find distressing. So, the parents become isolated in their grief, both from wanting to protect others from distress as well as themselves from acute awareness of their loss (Lewis, 1979). However, the parents should be encouraged to go over and over the details surrounding the baby as it is a way to dwell on the few memories they have of this child (Solnit and Green, 1959). Parents should not be made to feel guilty or morbid for wanting to know all the details about the baby's birth, illness, and condition. These memories, however few, are meaningful and collecting them (as well as objects such as baby's footprints, lock of hair, photograph) can aid grief and be treasured even after grief resolution (Stringham et al., 1982).

There are a number of specific ways parents can be helped to collect memories including holding the baby, naming, and having pictures, an autopsy, and a funeral.
**Holding the baby.** To see and hold the baby is one important way for parents to gather memories and say goodbye to their baby. It is important that medical personnel encourage the parents to see and hold the baby, explaining its helpfulness for the grieving process (Cohen, et al., 1978; Kennell and Trause, 1978; Kennell and Klaus, 1976; Kowalski and Bowes, 1976; Lewis and Page, 1978). If parents resist, a doctor or nurse can offer to be with the family and/or hold the baby for them; the staff's acceptance of the child often makes the family feel less morbid or frightened (Furlong and Hobbins, 1983). Parents need to be able to spend as much time with the baby as they wish and especially be reminded that they may see the baby again (Harmon and Graham-Cicchinelli, 1985). Having contact with the baby confirms for the parents the fact that there was a baby, lets them see the baby as an individual, and gives them something tangible to mourn (Davidson, 1977; Kirkley-Best and Kellner, 1982). Even if the baby is macerated or malformed, if parents are prepared, they will be more comfortable and often will find a positive body feature on which to focus (Harmon and Graham-Cicchinelli, 1985). Hildebrand and Schreiner (1980) report that they have never encountered parents who regret having seen their baby. On the other hand, many parents who were still having difficulty coping with their infant's death months or years later wished that they had seen and held their baby. Mothers who hold their infants are more willing to deal with the reality of the death, facilitating the mourning process. Seeing the baby also alleviates fears about the baby being a monstrosity, horribly deformed:
fantasies are usually much worse than the reality and parents are often relieved at how normal the baby looks (Kennell and Trause, 1978; Dunlop, 1979).

**Naming.** Parents should be encouraged to name the baby (Yates, 1972). Naming the baby is another way to acknowledge the baby's existence and individuality and also gives parents a way to refer to the baby (Kennell and Trause, 1978).

**Pictures.** Pictures should be taken and offered to the parents. If they do not wish to accept a picture, they should be informed that a picture will be taken and saved so they can collect it any time in the future (Harmon, et. al., 1986; Kennell and Trause, 1978). Along with pictures, other mementos of the baby such as footprints, a lock of hair, hospital ID bracelet, autopsy results, birth/death certificates, should be saved in a "memory box" to help the parents acknowledge their loss (Kirkley-Best and Kellner, 1982; Harmon, Glicklen, and Siegel, 1984).

**Autopsy.** Parents should be encouraged to give consent for an autopsy in order to determine the cause of death and whether there are implications for future pregnancies (Hildebrand and Schreiner, 1980). Permission for autopsy should be requested by the physician most familiar to the parents and after they have been counseled about grief reaction. A few months after perinatal loss, parents usually want to know as much as possible about causes of their baby's death (Hildebrand and Schreiner, 1980). Knowing the cause of death helps parents resolve any guilt they feel for the baby's death (Helmrath and
Steinitz, 1978). However, parents who resist giving permission for autopsy should have their wishes respected. In any case, parents should be explicitly and emphatically assured by the physician that the baby's death is not their fault (Hildebrand and Schreiner, 1980).

Funeral. Doctors and nurses should also encourage parents to arrange a private funeral for the baby (Kennell and Trause, 1978). Of the parents who elect to have the hospital dispose of the body, many later wish they had had some sort of private burial or memorial services (Stewart, personal communication, 1984). A service may help the parent grasp the reality of their baby's death and allow them to say goodbye (Glicken, et. al., 1986). Funerals or memorial services are also important because they acknowledge the parents' loss and their need for comfort and support. A funeral permits the parents to work through their grief in a socially acceptable pattern of behaviors. Enabling the parents to act out intense emotions, a funeral can also be therapeutic (Raether and Slater, 1977). And a funeral also allows friends and family of the parents to share their sorrow. For the parents, the presence of others is supportive as it makes them aware that others care enough to want to share this experience with them (Raether and Slater, 1977).

On the other hand, parents who do not have a funeral may give the impression to others that the loss was not significant. This impression makes it easy for friends and family to deny the importance of the loss and ignore the parents' need for support. Not having a funeral confirms the view that "after all, it was only a fetus,
really, and you can always have another baby". On the other hand, a funeral says "this baby was ours, it was special, and we mourn the loss". Then the parents may be more likely to receive support and permission to grieve (Kennell and Trause, 1978). And the presence or absence of a funeral or memorial service and ritual burial can be a significant factor in how well parents cope with their loss (Kowalski, 1984).

The baby's grave also provides the parents with a place where they can go to be with the baby and appropriately express their sadness. Often, parents who cremate their baby's body find it helpful to scatter their baby's ashes in a meaningful place. All of these ritualized gestures are likely to result in friends and relatives recognizing the loss as significant to the parents and giving them opportunities to be supportive. And parents who receive such support are better able to cope with the loss (Helmrath and Steinitz, 1978).

**Follow-up Care**

Parents who do not receive much support for their grief, which often happens very soon after the funeral anyway, often wonder why their feelings are so intense and whether they are being unreasonable or abnormal. Because death is permanent, the mother's feelings of emptiness can be overwhelming, and she may resort to denial for a while, thinking of the child as being alive, hearing a baby cry, wondering if the baby is comfortable in his grave (Hagan, 1974). These thoughts, feelings, and hallucinations are part of the normal
grieving process and parents need to be reassured that they are not losing their minds (Hollingsworth and Pasnau, 1977). For this reason, follow-up contacts by hospital staff or parent groups can be helpful to grieving parents. A simple phone call from a caring physician can result in a reduction of problems in mothers of stillbirths (Schreiner, Gresham, and Green, 1979; Elliot and Heiln, 1978; Harmon, Glick, and Siegel, 1984). And mothers who participate in supportive counseling are far less likely to show psychiatric disorder 6 months after the loss than mothers who do not receive such support (Forrest, et al., 1982). Thus, education about the grief reaction and referrals to support groups are 2 valuable follow-up interventions for grieving parents.

**Education.** Parents who lose a baby need to be educated about healthy grieving, what feelings and experiences to expect, the variety of responses considered normal, how to use resources, encouragement to express feelings, and reassurance that grief will run its course in time (Engle, 1964; Jackson, 1974). Education about grief also indicates to the parents that their caregiver acknowledges their feelings and recognizes the significance of the parents' loss, in itself an important source of support (Estok and Lehman, 1983). Besides hospital follow-up care and parent support groups, books can be a valuable educational resource. Books which discuss causes, feelings, and options surrounding pregnancy loss can be very helpful to grieving parents in ways similar to support groups, by recognizing and validating feelings the parents have about this ordeal (eg., Borg...
and Lasker, 1981; Schliebert and Kirk, 1981). The parents can be spared much anxiety by reading or being told that intense feelings of sadness, illusions of hearing the baby cry, and grief lasting 12 months are normal. Without this information, many parents feel that they must be abnormal (Hildebrand and Schreiner, 1980).

Couples also need to be educated about possible differences they may have in grieving styles so that they can have insight into each other's reaction and their relationship during this stressful period. Parents are often helped by counseling, particularly about the need for them to communicate openly with each other about their thoughts about the baby and their sadness (Friedman and Gradstein, 1982). If parents can communicate their feelings and thoughts, they may be able to understand and cope with each others' differing behaviors. This communication and understanding will enable them to be a great source of support and comfort for each other (Kennell and Trause, 1978).

**Referral to bereaved parent support groups.** A group of other parents who have experienced death of an infant can be a valuable source of support to grieving parents (Helmrath and Steinitz, 1978; Harmon, et. al., In press). Parent support groups take many forms and some parents find some formats more helpful than others. A good self-help parent group will facilitate parents' grieving process by acknowledging and validating the reality of the death and feelings and diminishing the guilt associated with the loss (Wilson and Soule, 1981). Harmon, et. al. (In press) recommend professional co-leadership by individuals who have not experienced perinatal loss.
This type of leadership provides objective facilitation, professional assessment of parents' psycho-social needs and follow-up, and allows leaders to share the difficulties and stress of facilitating the group in discussions following each meeting. Parents report that one of the most beneficial outcomes of participation in such a support group is renewed hope for the future as well as helping to improve communication between husband and wife (Wilson and Soule, 1981).

**Parenting Subsequent Children**

The interventions appropriate for preventing or interrupting the parenting disorders that stem from the death of a baby have not been specifically outlined or researched. Indeed, it is not clear as to which parents, what kinds of grieving experiences, or which supports used by the parents are related to onset or prevention of parenting disorders after the death of an infant.

One thing on which there is broad consensus is that parents should be counseled on delaying future pregnancies until grief is resolved. Soon after the death of a baby, some parents feel that the only way they will ever feel better is to have another baby, the sooner, the better (Berezin, 1982; Borg and Lasker, 1981). However, it is widely speculated that another pregnancy will only temporarily suspend grief, inhibiting its resolution. And as discussed earlier, unresolved grief may play a role in a number of parenting disorders. Waiting 6 months to 1 year before conceiving again may allow the parents to progress through the grieving process and reduce the
likelihood of parenting disorders with subsequent children. However, as Berezin (1982) and Borg and Lasker (1981) suggest, many mothers simply ache with emptiness until they can be filled with the hope of finally having a healthy baby.

Besides waiting many months to conceive again, there are undoubtedly other factors that play a role in reducing the likelihood of parenting disorder with subsequent children. Perhaps mothers should not be advised to wait a certain number of months but rather wait until grief over the loss is resolved, however long or short a time that takes (Friedman and Gradstein, 1982). In fact, whether a mother can handle the death of her baby in a way that is not detrimental to future children may depend on the kind of support and follow-up she receives, not how long she waits to conceive. Furthermore, the mother who has the resources and support to facilitate her grief may also be likely to have the resources and support to facilitate her parenting skills. Compared to mothers who lack supportive relationships, mothers who have supportive relationships may be least apt to succumb to a parenting disorder upon the birth of a new baby, regardless of when conception takes place.

The purpose of this research then is to address this issue of how long a mother should be advised to wait before she tries to conceive another pregnancy. Conclusions are based on the mothers' reports of their opinion of advice they received, how long they decided to wait and why, and especially, whether the mothers who had more time elapse between the loss and the subsequent child's birth, or mothers who felt
resolved by the time of the subsequent child's birth, were indeed less likely to experience the effects of perinatal loss on their relationship to the subsequent child.
CHAPTER II

METHOD

Subjects

Recruitment

Women were recruited from hospital medical records, perinatal loss support groups, and referrals from other mothers. Women, who within the past 13 months to 10 years experienced fetal demise (greater than or equal to 20 weeks gestation), stillbirth, or death of a continuously hospitalized infant within 28 days after birth, were sent a letter explaining the project. Each letter contained a self-addressed postcard on which the mother was asked to indicate whether or not she wished to participate in the study. When a woman met with the interviewer, she was asked to sign a consent form which addressed concerns about confidentiality and permission to not answer difficult questions. There were 2 main reasons for interviewing women who had lost a baby between 13 months and 10 years ago: (1) women for whom at least one year had passed since the loss were likely to have had time to gain some perspective on the experience; and (2) because new interventions for women who experience perinatal loss have been implemented during the past 5 years, interviewing women who lost a baby any time in the past decade would yield data on the variety of hospital and socio-cultural situations in which these mothers
experienced perinatal loss.

Thirty-one mothers were interviewed, 24 of whom were raising a child born subsequent to the perinatal loss. Since a large component of this dissertation was to look at the experience of subsequent pregnancy and raising a child born after a loss, the data analyzed is only that from the group of 24 mothers with a subsequent child. Other than 1) length of time since the loss occurred, 2) at what gestational age the baby died, and 3) raising a child born subsequent to the loss, there were no other restrictions placed on these mothers to qualify for inclusion in this study. Lack of restrictions means that the study lacks control over many variables, leading to wide variability among mothers' situations. However, because this is largely a descriptive, exploratory study, placing more restrictions on subject recruitment would have reduced the opportunity to explore differences among mothers in their reactions to perinatal loss and experiences with raising a subsequent child. For example, this study included 6 mothers whose subsequent child had major problems at birth, requiring some time (a week or less) in neonatal intensive care. Excluding these mothers would ignore the possibility that children born subsequent to perinatal loss might have problems at birth. Perhaps these children's problems at birth were due to their mother's high risk obstetrical history; but for whatever reason, in this sample, it was a reality that 25% of the subsequent children spent several days in a neonatal intensive care unit (NICU) sometime during the first month of life.
Mothers reported that their reasons for participating in the interview were (1) to contribute to research aimed at helping women through the experience of perinatal loss; (2) to help themselves by talking to someone who would listen; and/or (3) because they received the recruitment letter on or near the anniversary of their baby's death and took it as a sign that they should participate.

The Mothers

The mothers, at the time of their interview, ranged in age from 19 to 39 years. The average age was 31.6 years; the median age was 32.5 years. At the time of their loss, mothers ranged in age from 17 to 35 years. The average age at the time of the perinatal loss was 27 years, as was the median age.

Twenty-one mothers were still married to the father of the baby that died, 18 of whom reported the marriage to be satisfying and 3 of whom reported problems in the marriage. Two of the 18 mothers in satisfying marriages were unmarried when they became pregnant with the baby who died. Both married the father of that child: one during the pregnancy and the other 9 months after the baby died. Three mothers were divorced within 3 years of the baby's death after 4 1/2 to 7 years of marriage. These 3 mothers do not attribute the baby's death as causing the divorce although one mother recognized it as a catalyst for emphasizing problems that already existed.

Mothers' religious affiliations varied greatly. Among 24 mothers, 12 (50%) reported that they considered themselves to be
religious, 8 (33%) considered themselves to be somewhat religious, and 4 (17%) considered themselves to not be religious. Of the 20 mothers who consider themselves to be at all religious, 3 had no particular religious affiliation. Of the remaining 17 mothers, 10 religions were represented: 5 Catholics, 3 Baptists, 2 Lutherans, 1 Jew, 1 Protestant, 1 Presbyterian, 1 Methodist, 1 Christian, 1 Quaker, and 1 Unitarian.

Mothers' educational levels varied from completing 11th grade of high school to obtaining a Master's degree. Four mothers had high school educations, 13 mothers had attended college, and 7 mothers attended graduate school. Six mothers did not work outside the home, 9 mothers worked part-time (less than 20 hours per week), and 9 mothers worked full-time (20 hours per week or more).

Mothers' obstetric histories varied among problems of infertility, multiple losses, high risk pregnancies, as well as unremarkable histories before and since the baby's death. Maternal obstetric histories are outlined in Table 1 which lists each mother and her age, number of pregnancies, pregnancy outcomes, and fertility. The following brief descriptions of the obstetrical histories of these mothers indicates the difficulty many of these women encounter in their efforts to have a healthy baby.

The first 11 mothers listed in Table 1 each had one perinatal loss and no other pregnancy losses. Of these 11 mothers, only 7 had no problems with fertility and had uneventful subsequent pregnancies, including 2 mothers, Jane and Anya, who each had one living child born
<table>
<thead>
<tr>
<th>Mother</th>
<th>Age</th>
<th>Gravity</th>
<th>SAB</th>
<th>TAB</th>
<th>Perinatal</th>
<th>Pre-loss Children</th>
<th>Subsequent Children</th>
<th>Fertility Problems*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kara</td>
<td>31</td>
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<td>none</td>
</tr>
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<td></td>
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<td>boy</td>
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<td>none</td>
</tr>
<tr>
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<td></td>
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<td>unknown (10 wk),</td>
<td>none</td>
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<td>none</td>
</tr>
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<td>none</td>
</tr>
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<td>3</td>
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<td>girl, boy</td>
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<td>none</td>
</tr>
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<td></td>
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<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Sophie</td>
<td>34</td>
<td>2</td>
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<td>girl</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>yes</td>
</tr>
<tr>
<td>Lynn</td>
<td>33</td>
<td>2</td>
<td></td>
<td></td>
<td>boy</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>yes</td>
</tr>
<tr>
<td>Martina</td>
<td>32</td>
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<td></td>
<td></td>
<td>boy</td>
<td>girl</td>
<td>unknown (20 wk),</td>
<td>yes</td>
</tr>
<tr>
<td>Kelly</td>
<td>26</td>
<td>2</td>
<td></td>
<td></td>
<td>boy</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>sterile</td>
</tr>
<tr>
<td>Bess</td>
<td>33</td>
<td>8</td>
<td>1</td>
<td>2</td>
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<td>girl, girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Holly</td>
<td>35</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>girl</td>
<td>girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Dara</td>
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<td>5</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>boy, girl, girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Kitty</td>
<td>29</td>
<td>5</td>
<td>2</td>
<td></td>
<td>girl</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>yes</td>
</tr>
<tr>
<td>Rose</td>
<td>26</td>
<td>4</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>girl, girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Elaine</td>
<td>34</td>
<td>4</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Jess</td>
<td>34</td>
<td>3</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>girl</td>
<td>unknown (20 wk),</td>
<td>worry</td>
</tr>
<tr>
<td>Hannah</td>
<td>39</td>
<td>3</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Erin</td>
<td>39</td>
<td>4</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>boy, girl</td>
<td>unknown (20 wk),</td>
<td>worry</td>
</tr>
<tr>
<td>Cindy</td>
<td>21</td>
<td>3</td>
<td>1</td>
<td></td>
<td>girl</td>
<td>girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
<tr>
<td>Desi</td>
<td>31</td>
<td>3</td>
<td>2</td>
<td></td>
<td>boy</td>
<td>boy (adopt)</td>
<td>unknown (20 wk),</td>
<td>sterile</td>
</tr>
<tr>
<td>Meryl</td>
<td>39</td>
<td>8</td>
<td>2</td>
<td></td>
<td>unknown</td>
<td>boy</td>
<td>unknown (20 wk),</td>
<td>sterile</td>
</tr>
<tr>
<td>Peg</td>
<td>30</td>
<td>5</td>
<td>1</td>
<td></td>
<td>boy, girl</td>
<td>girl</td>
<td>unknown (20 wk),</td>
<td>none</td>
</tr>
</tbody>
</table>

* Fertility Problems: "none" = no problems; "worry" = concern about being able to conceive; "yes" = sought treatment for concerns; "sterile" = tubal ligation or ovaries removed.
** Anya's second pregnancy was with twins, a girl who died and a girl who lived.
previous to the loss. Another 1 of these 11 mothers, Luanne, had no problems with fertility but had heavy bleeding during the first trimester of her subsequent pregnancy. The remaining 4 mothers with one loss experienced both infertility and major problems during the subsequent pregnancy, including premature labor, gestational diabetes, and preeclampsia. One of these mothers, Kelly, had a tubal ligation following the birth of her subsequent child as her life would be in danger should she become pregnant again.

The second 11 mothers listed in Table 1, in addition to the perinatal loss, also experienced early (less than 12 weeks) pregnancy loss. Of these mothers with early pregnancy loss, 4 mothers had had one or more therapeutic abortions for their first pregnancies; 2 of these mothers, Bess and Holly, also had one and two spontaneous abortions (miscarriages) respectively following their perinatal loss. For 3 of these 4 mothers, Bess, Holly, and Dara, their first surviving child was born subsequent to these losses; the 4th mother, Kitty, had one living child born before the perinatal loss. Kitty sought treatment for infertility after her first child was born, as it took more than 2 years to become pregnant with the baby who eventually died. Bess, Holly, and Dara had no problems becoming pregnant, but Bess and Holly who both had miscarriages, also experienced bleeding early in the subsequent pregnancy.

Of the 8 remaining mothers with early pregnancy loss, all experienced at least one miscarriage. 2 mothers, Rose and Elaine, each lost their first pregnancy to miscarriage; Elaine then had one
healthy baby before her perinatal loss, and both mothers had no problems with fertility or during the subsequent pregnancy. Two more mothers, Jess and Hannah, each had one miscarriage following the perinatal loss, prior to the pregnancy with the subsequent child. Jess was concerned about fertility but both Jess and Hannah had uneventful pregnancies with the subsequent child. Two more mothers, Erin and Cindy, each had one miscarriage following the birth of their subsequent child. Erin had concerns about fertility but uneventful pregnancies; Cindy had no concerns about fertility but during her pregnancy with her surviving daughter Emily, she required complete bedrest after 32 weeks because of premature labor. Another mother, Desi, had 2 miscarriages, one before and one following the perinatal loss. After 5 years of trying to become pregnant again, Desi and Ric adopted an Infant son, Sam. When Sam was 5 months old, Desi had her ovaries and uterus removed because of massive ovarian cysts.

The remaining 2 mothers, Meryl and Peg, each had early pregnancy loss, but in addition, experienced multiple perinatal losses. Meryl, who never used birth control in 19 of her 20 years of having children, was toxemic during her first pregnancy but her daughter survived. After 2 miscarriages and nearly 10 years, she gave birth to another daughter who survived mild Rh disease. In the following consecutive 3 years she experienced 3 perinatal losses, all stillborn: 2 infants at 20 and 24 weeks respectively (sex unknown; she reports "I didn't want to know"), and a fullterm Infant boy who she saw and touched. This last pregnancy had been monitored carefully for Rh sensitivity so when
the autopsy reported that the baby died of Rh disease, she refused to believe it. She used birth control for a year because she realized "my body was not ready to carry a pregnancy successfully." Then after 2 years of trying to conceive, and at the age of 37, she accepted the possibility that she might never become pregnant again; a year later, she became pregnant. It was at this time she was told that during her last pregnancy, due to a laboratory error, fetal distress was not detected and that was why the baby had died of Rh disease. This subsequent pregnancy was also monitored closely for Rh disease and after 2 fetal transfusions, induced labor at 36 weeks gestation, and 16 postnatal transfusions, her son Cary survived. After Cary's birth, Meryl had a tubal ligation.

Peg, the other mother with multiple perinatal losses, has had no problems with fertility. Her first pregnancy, unplanned, ended in miscarriage at 15 weeks. Seven years later, when she and her husband decided they were ready to start their family, in the following 18 months she experienced 3 perinatal losses: a boy at 21 weeks, a girl at 20 weeks, and twin girls at 26 weeks. After these losses, like Meryl, Peg also waited a year for her body to recuperate before trying to conceive again. After 11 months she tried and conceived immediately. During the first trimester a cerclage was placed around her cervix to prevent premature dilation. She started bleeding at 32 weeks and was hospitalized for the following 6 weeks, after which her son Joel was born.

Meryl's and Peg's experiences with perinatal loss were more
numerous but not necessarily more difficult than for the other mothers who only had one baby die. Many of the mothers mentioned the following theme on surviving these tragedies, explained here by Peg:

"People say 'I don't know how you've dealt with all that, I never could!', but they could if they had to, they could. When something happens to you you have to deal with it or you go crazy I guess. And I just decided 'I'm going to have to deal with it.'"

The Babies who Died

Since Peg and Meryl had multiple perinatal losses, for them, the interview focused on their most recent loss. As Peg lost 2 twin girls, the deaths of a total of 25 babies became a focus of this study. These babies ranged in gestational age from 20 to 41 weeks. Of these 25 babies, 6 were very premature, being less than 30 weeks gestation at delivery; 8 babies were moderately premature, being 31 to 37 weeks gestation at delivery; 11 babies were fullterm, between 38 and 41 weeks gestation at delivery. Twelve of the babies were boys, 13 were girls. Most mothers chose to name their baby: all but 3 mothers named the baby; interestingly, the 3 mothers who did not name their babies delivered at 26 weeks or earlier. Table 2 lists each mother by order of the gestational age of her baby at delivery, sex of the baby, type of delivery, whether the baby was live or stillborn, and cause of death, including whether the mother believes her baby's death was preventable or not.

Of the 24 mothers, 6 delivered by emergency cesarean section; all of these babies were greater than 30 weeks gestation: 3 babies were live born and 3 were stillborn. The remaining 18 mothers
### TABLE 2

**THE BABIES WHO DIED: BABY HISTORIES**

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>G.A.*</th>
<th>SEX</th>
<th>DELIVERY**</th>
<th>BIRTH STATUS</th>
<th>CAUSE OF DEATH***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane</td>
<td>20</td>
<td>boy</td>
<td>vaginal</td>
<td>stillborn</td>
<td>? unknown</td>
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<tr>
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<td>girl</td>
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<td>stillborn</td>
<td>placental abruption</td>
</tr>
<tr>
<td>Lynn</td>
<td>25</td>
<td>boy</td>
<td>vaginal</td>
<td>live born</td>
<td>prematurity</td>
</tr>
<tr>
<td>Peg</td>
<td>26</td>
<td>girl A</td>
<td>vaginal</td>
<td>live born</td>
<td>prematurity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>girl B</td>
<td>vaginal</td>
<td>stillborn</td>
<td>twin-twin transfusion</td>
</tr>
<tr>
<td>Luanne</td>
<td>28</td>
<td>boy</td>
<td>Dx F.D.</td>
<td>stillborn</td>
<td>unknown</td>
</tr>
<tr>
<td>Anya</td>
<td>31</td>
<td>girl B</td>
<td>c/sect</td>
<td>stillborn</td>
<td>unknown</td>
</tr>
<tr>
<td>Sophie</td>
<td>32</td>
<td>girl</td>
<td>c/sect</td>
<td>live born</td>
<td>unknown</td>
</tr>
<tr>
<td>Kelly</td>
<td>32</td>
<td>boy</td>
<td>c/sect</td>
<td>live born</td>
<td>sepsis</td>
</tr>
<tr>
<td>Kara</td>
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<td>vaginal</td>
<td>live born</td>
<td>unknown</td>
</tr>
<tr>
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<td>boy</td>
<td>Dx F.D.</td>
<td>stillborn</td>
<td>cord accident</td>
</tr>
<tr>
<td>Kitty</td>
<td>37</td>
<td>girl</td>
<td>vaginal</td>
<td>live born</td>
<td>hydrocephaly</td>
</tr>
<tr>
<td>Desl</td>
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<td>boy</td>
<td>c/sect</td>
<td>stillborn</td>
<td>preeclampsia</td>
</tr>
<tr>
<td>Hannah</td>
<td>37</td>
<td>girl</td>
<td>c/sect</td>
<td>live born</td>
<td>unknown</td>
</tr>
<tr>
<td>Cindy</td>
<td>38</td>
<td>girl</td>
<td>Dx F.D.</td>
<td>stillborn</td>
<td>cord accident</td>
</tr>
<tr>
<td>Erin</td>
<td>38</td>
<td>girl</td>
<td>Dx F.D.</td>
<td>stillborn</td>
<td>unknown</td>
</tr>
<tr>
<td>Liza</td>
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<td>boy</td>
<td>vaginal</td>
<td>live born</td>
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<td>sepsis</td>
</tr>
<tr>
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<td>Dx F.D.</td>
<td>stillborn</td>
<td>cord accident</td>
</tr>
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<td>Rh disease</td>
</tr>
<tr>
<td>Sara</td>
<td>40</td>
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<td>vaginal</td>
<td>live born</td>
<td>sepsis</td>
</tr>
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<td>vaginal</td>
<td>live born</td>
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</tr>
<tr>
<td>Dara</td>
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<td>dwarf</td>
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<tr>
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<td>boy</td>
<td>vaginal</td>
<td>stillborn</td>
<td>sepsis</td>
</tr>
<tr>
<td>Holly</td>
<td>40</td>
<td>girl</td>
<td>c/sect</td>
<td>stillborn</td>
<td>unknown</td>
</tr>
</tbody>
</table>

* G.A. is gestational age of baby at birth.

** Delivery refers to circumstances by which the baby was delivered: "c/sect" is cesarean section, all emergency, with detected fetal distress; "Dx F.D." means the baby was diagnosed fetal demise before vaginal delivery; "vaginal" means that the baby was delivered vaginally; at G.A. 38 weeks or greater, problems were not expected.

*** If the mother believes that her baby's death was preventable, this is denoted by an exclamation point (!). If the mother wonders about the preventability of her baby's death, this is denoted by a question mark (?).
delivered vaginally. Before delivery, 7 of these mothers were told that their babies were dead; of the remaining 11 mothers, 4 were in labor with very premature, probably non-viable infants and death was expected: 3 of these very premature infants were stillborn, the other 2 were live born. The other 7 mothers were in labor with infants of 36 weeks gestation or greater and only Kitty was expecting her baby to die as ultrasound had determined that the baby was severely hydrocephalic. Of these older, vaginally delivered babies, 6, including Kitty's baby, were live born and only 1 was stillborn.

Of the 14 babies who were stillborn, for 5, the cause of death remains unknown. Of the remaining 9 stillborn babies, 1 died from placental abruption, 1 from twin-twin transfusion, 1 from Rh disease, 1 from maternal preeclampsia, 2 from sepsis and 3 from cord accidents. Of the 11 live born babies, for 2 the cause of death remains unknown. Of the remaining 9 live born babies, 3 died from complications of prematurity, 2 from sepsis, and 4 from congenital defects. Thus, in this sample, besides the unknowns, these babies died from a variety of causes. Of the 11 live born babies, 4 lived for less than 24 hours and 7 lived for 2 to 6 days.

Mothers were not asked whether they thought the death was preventable but all of them brought it up as an issue. Of the 24 mothers, 8 felt that their baby's death was not preventable, 10 thought maybe it was preventable but conceded that probably there was nothing that could have been done differently, and 6 mothers believed that yes, their baby's death was preventable, something should have
been done differently and their baby would be alive today. Of these 6 mothers who believe the death was preventable, 5 were full term babies and one was, at 37 weeks, nearly full term; 2 babies died from cord accidents, one from sepsis, one from maternal preeclampsia, one from Rh disease, and one from unknown causes. The mother of the baby who died from sepsis felt that if babies were routinely cultured for beta strep like they used to be, her baby's beta strep infection would have been treated before it overwhelmed his system. The other 5 mothers delivered stillborn babies for whom they believe fetal distress should have been detected. Four of these mothers felt that if their suspicions of decreased fetal movement had been investigated by their doctors, fetal distress would have been discovered, and their babies delivered before they died. The fifth mother whose baby was being monitored for Rh disease was the victim of a laboratory mistake: fetal distress was not detected and the baby died as a result.

The Subsequent Child

All 24 mothers had at least one child born subsequent to the perinatal loss, including Desi who adopted a son 5 years after her baby died. Of these 24 mothers, 6 had given birth to 2 or more subsequent children; the first subsequent child was focused on during the interview.

There are 4 "subsequent child variables" which were assessed as they may be relevant to the parenting of the subsequent child: (1) the child's current age; (2) the child's birth order among living
siblings; (3) the child's sex, compared to both the sex of the baby who died and the sex of other living siblings; and (4) health status during the first month of life. Table 3 lists each mother and outlines the data pertaining to her subsequent child with regard to these variables. Mothers are listed by order of current age of the child. In addition, the gestational age of the child at birth was included; only 3 children were born before term.

**Current age.** Subsequent children ranged in age from 5 weeks to 7 years. For data analysis, the 24 subsequent children were divided into 4 age groups: (1) Infants, less than 12 months old, of which there are 6 children; (2) Toddlers, 12 to 35 months old, 6 children; (3) Preschoolers, 3 and 4 year olds, 8 children; and (4) School age children, ages 5 through 7 years, 4 children.

**Birth order.** Of the 24 children, 13 are first born and the only living child. Interestingly, 6 or nearly half of these children's mothers feel that it is very likely they will not have any more children; 3 mentioned that they would like to have another child, and 4 mothers did not mention their plans. Of the remaining 11 children, 5 were first born but have 1 or more younger siblings, 5 are the youngest with 1 or 2 older siblings, and 1 child is in the middle, with one older and one younger sibling.

**Sex.** There are a total of 11 girls and 13 boys. Of the 11 girls, 5 are the same sex as the baby who died, 3 are the other sex, and 3 are of the other sex but have at least one sibling of the same sex as the baby who died. Similarly, of the 13 boys, 6 are the same
### TABLE 3

**SUBSEQUENT CHILDREN: SUBSEQUENT CHILD VARIABLES**

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>G.A.</th>
<th>SEX</th>
<th>COMARED TO LOSS</th>
<th>BIRTH ORDER**</th>
<th>NEONATAL PROBLEMS***</th>
<th>CURRENT AGE</th>
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<tr>
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<tr>
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<td>diff/+</td>
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<td>minor</td>
<td>7 yrs</td>
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</table>

* Sex Compared to Loss: Sex of subsequent child was either "same" = same sex as baby who died; "diff/+" = different but has living sibling who is same sex as baby who died; or "diff/0" = different and has no living sibling who is same sex as baby who died.

** Birth order of subsequent child among living siblings.

*** Neonatal Problems: "minor" in all cases refers to hyperbilirubinemia (newborn jaundice); "major" refers to the child being admitted to a NICU, problems include prematurity, meningitis, apnea, pneumothorax, heart defect, and severe Rh disease.
sex as the baby who died, 4 are the other sex, and 3 are of the other sex but have at least one sibling of the same sex as the baby who died.

Neonatal health status. Of the 24 subsequent children, 13 were healthy with no medical problems during the neonatal period. Another 5 were treated for hyperbilirubinemia, a fairly common condition also known as "newborn jaundice". However, the remaining 6 children were admitted to an NICU for a period between 1 and 7 days. These newborns suffered from a variety of critical conditions.

Of these 6 babies, 4 had problems that were acute, with no lasting effects determined. Bryn's baby was born with a pneumothorax (collapsed lung) which was treated without complication. Lynn's baby was born prematurely but after a week was healthy enough to be sent home. Both Sara and Anya's babies were born healthy and they both took the baby home. But Sara reports that when her baby, Gary, was 11 days old, she rushed him to the hospital because he was having spells of apnea, where he wasn't breathing and turning blue. After 3 days in the NICU, he was sent home as the doctors felt he was not in danger. Anya's baby, Jared, at 8 days of age was discovered to have meningitis for which he was admitted to the NICU and treated.

The remaining 2 babies were born with problems that have had lasting effects. Meryl's baby, Cary, was born with severe Rh disease and required 16 full body blood transfusions. Cary has a slight hearing loss and Meryl has concerns about other problems which may surface as he gets older. Luanne's baby, Molly, was born with a heart
defect and was under observation before she was sent home. Molly had surgery to correct part of the defect at age 18 months (1 month before Luanne's interview) and will have surgery again when she is 4 years old. Luanne reports that the prognosis is excellent, but she still worries.

**Procedure**

Upon receipt of the postcard from a mother, she was called and an appointment was made with her to be interviewed at her convenience at the Infant Behavior Laboratory at the Health Sciences Center. The interview lasted about 90 minutes or more depending on how much the mother elaborated on her feelings and experiences. The interview was conducted in a 19' x 11' carpeted and insulated playroom decorated with colorful wall hangings. There were 2 comfortable chairs against one wall of the room at a 90 degree angle to each other; between the chairs was a small table with water, cups, and kleenex. All interviews were video taped. A video camera was concealed behind a one way mirror. Each mother was informed of the presence of the video camera and assured that if she felt uncomfortable at any time, she could request that recording be stopped. As it was, only one mother expressed concern about being videotaped but once she was in the room, she felt comfortable with the idea. Interviewing guidelines included assuring the mother that crying (or not crying) was normal and OK, avoiding repetitive questioning, being sensitive to any difficulty a mother might have with any questions, reflecting answers to help the
mother clarify what she means, prompting, and making eye contact. The interviewer did not take notes during the interview so that she could be an empathic listener rather than a data collector for the mother.

Parts One through Four of the interview were administered in numerical order, and the questions in each are arranged in a specific sensible order. But, mothers often would address issues as they came to mind. For instance, while talking about support received from her husband, the mother might talk about how and when they decided to try to conceive another pregnancy. Thus, during this discussion, the mother might provide answers for 3 different questions in different parts of the PLI. Later, when these questions come up in the PLI, they needn't be asked again, although it was often helpful to mention at that point, "you mentioned earlier that..." and proceed with the next question on that page. So the administration of the PLI is loosely structured, to both meet the needs of the data collection and to fit the mother's own flow of thoughts and feelings.

At the end of the interview, the mother was asked if there was anything else about her experiences that she considered important and would like to talk about, and she was encouraged to ask questions of the interviewer.

Design

There were 4 main factors that were examined: (1) The experiences surrounding the death, including those which the mothers consider helpful or unhelpful, the emotions felt, and support received
after the loss; (2) Grief resolution, including the mothers' definition of resolution and how each mother indicates and perceives her degree of resolution; (3) Passage of time, particularly the number of months since the loss and number of months between the death of the baby and birth of a new baby; and (4) Subsequent child, including the mothers' experiences and feelings about subsequent pregnancy and giving birth to a healthy child after the loss, and her perceptions of the effect of the loss on her feelings and experiences with parenting a healthy child. Table 4 contains a full listing of the variables examined under each of the 4 main topics. These variables are both (a) the specific experiences mothers were asked to describe and (b) the measures by which experiences surrounding the loss, resolution, and subsequent child were assessed in each mother.

**Perinatal Loss Interview**

The Perinatal Loss Interview (PLI) is a structured open-ended interview especially designed for this study. Each of the 4 global factors mentioned above is addressed by a specific set of questions: Part One of the interview focuses on experiences surrounding the loss which are mentioned in the literature as facilitating or inhibiting the grieving process for perinatal loss; Part Two focuses on the mother's feelings and perceptions of resolution, including those variables which are considered to be indicators of resolution; Part Three focuses on the passage of time, that is, the number of months that passed between significant events such as the loss, birth of a
TABLE 4

VARIABLES ASSESSED BY THE "PERINATAL LOSS INTERVIEW"

(1) Experiences Surrounding the Loss:
(a) support network, including spouse, family, friends, professionals
(b) religious or sophisticated philosophical beliefs
(c) contact with the infant, momentos
(d) burial and memorial rituals
(e) cause of death; post-hoc: preventability
(f) infertility and other pregnancy losses
(g) feelings of grief experienced, eg., anger, guilt, failure

(2) Grief Resolution Indicators
(a) frequency of thoughts about the baby
(b) anniversary reactions
(c) feelings about the baby and baby's death
(d) current emotional reactions to the loss
(e) current feelings of grief, i.e., anger, guilt, failure
(f) outlook/ thoughts about the future
(g) recognizing anything positive about the experience
(h) answering the question "why me?"
(i) thoughts of what baby would be like now if baby had lived
(j) self-report on feelings of resolution

(3) Passage of Time
(a) number of months since loss
(b) number of months between loss and trying to conceive again
(c) number of months between loss and birth of subsequent child
(d) doctor's advice about waiting to conceive and mother's opinion

(4) Subsequent Pregnancy and Child
(a) experiences during pregnancy, labor, delivery
(b) feelings during pregnancy, labor, delivery
(c) experiences with child
(d) feelings and concerns about child
(e) feelings and concerns about being a mother, raising this child
(f) maternal perception of effect of perinatal loss on parenting of subsequent child
(g) maternal perception of effect of perinatal loss on relationship with subsequent child

(5) Subsequent Child Variables
(a) current age
(b) sex
(c) birth order
(d) neonatal health status
subsequent child, and being interviewed; and Part Four of the interview focuses on the mother's perceptions of her experiences with and feelings about the child born after the loss, and how she feels the loss has affected her experiences with subsequent pregnancy and child. In general, the PLI contains specific but open-ended questions. Particularly in Part Three, and in the other parts to a lesser extent, for many issues, the data are confined to the mother's responses to specific questions. For instance, not every mother could be expected to spontaneously mention what she decided to do with the baby's body, or how often she thinks about the baby, or how it felt to try to conceive another pregnancy, or how many months elapsed between the loss and birth of the subsequent child. But, in general, the questions in the PLI are (a) catalysts to get each mother to talk about her experience as well as (b) insurance that information on each issue is obtained from each mother.

**Part One.** The grief facilitating and grief inhibiting variables which the interview explores are based on those variables which are emphasized in the literature as having an effect on how well a mother is able to cope with a perinatal loss. Many of these variables were found by Kowalski (1984) to discriminate between mothers who were coping well and mothers who were coping poorly 15 to 30 months after a perinatal loss. These variables were examined by questions in 7 domains: (1) support networks, including spouse, family, friends, and professionals; (2) religious or sophisticated philosophical beliefs; (3) contact with the infant and mementos collected; (4) burial and
memorial rituals; (5) cause of death; (6) experience with infertlllity and other losses; and (7) feelings of grief experienced (see Table 4).

Questions pertaining to the first domain (support) include:

"Who was the most helpful and supportive to you after the death of your baby?"

"What would you change about the way the hospital handled things?"

"After the baby died, were you able to talk to your spouse about your feelings?"

Questions pertaining to the second domain (religion) include:

"Do you consider yourself to be religious?"

"Do you have any ideas about why you think this happened to you?"

Questions pertaining to the third domain (contact/momentos of baby) include:

"Did anyone encourage you to see, touch, or hold the baby?"

"How do you feel now about being/ not being able to see/touch/hold your baby?"

"Did you receive/save a photo of the baby?"

Questions pertaining to the fourth domain (burial/memorial rituals) include:

"What did you decide to do with the baby's body?"

"Did you have a funeral/ memorial service?"

Questions pertaining to the fifth domain (cause of death) involve
those where the mother was asked to explain the circumstances preceding and immediately following the baby's death, and including:

"Do you feel you understand the medical reasons for your baby's death?"

Questions pertaining to the sixth domain (other losses and infertility) include obtaining obstetrical histories from the mother and questions such as:

"How long after the baby's death did you start try to become pregnant again?"

"How did you decide to become pregnant?"

"How did you feel about trying to become pregnant?"

Pertaining to the seventh domain (feelings of grief) the mother was asked to describe any feelings of anger, guilt, failure, isolation, suicide, and depression. In addition she was asked if she had any other strong feelings after the loss of her infant.

In this section of the Perinatal Loss Interview, although specific questions were asked of each mother, the mothers were free to elaborate and go off on tangents as it can be assumed that they would talk about issues which were relevent to their experience. And in fact, there was one issue, not asked about in the PLI, that every mother talked about spontaneously: their belief about whether or not their baby's death was preventable. Thus, this variable was placed post-hoc under the fifth domain (cause of death) and considered in data coding.

Part Two. The second purpose of the interview was to assess a
mother's degree of grief resolution. In the literature on grief resolution, there are a number of issues which are considered to be "resolution indicators". Thus, concerning these issues, a set of questions was designed. These questions address issues about the effect of the baby's death on current functioning, a major indication of degree of resolution (Bowlby, 1980), as well as feelings about the baby and the baby's death, and the investment in memories/relationship to the dead infant, parameters used by Rubin (1984). Thus, the following resolution indicators, which are listed in Table 4, were utilized and can be categorized as follows:

How often the mother thinks of the baby and whether these thoughts intrude on normal functioning:

(a) "These days, how often do you think about the baby? "Do thoughts about the baby keep you from doing things you would like to do or get accomplished?"

(b) "Are there times of the year that are harder for you than other times?"

The affect associated with thoughts of the baby:

(c) "Can you describe the feelings you have when you think about the baby and the baby's death?"

(d) "Do you still have crying spells or notice other reactions when you think about her/him?"

(e) "Do you ever still feel angry/guilty/a sense of failure?"

Thoughts about the future:
(f) "How do you feel when you think about the future and what it might bring?"

Putting the experience into perspective:

(g) "Have you been able to make anything positive come out of this experience?"

(h) "Do you have any ideas why you think this happened to you?"

(i) "Do you ever think of what the baby would be like now if s/he had lived?"

The above issues can only be speculated to be indicators of grief resolution for a perinatal loss in light of the differences between perinatal and other losses. Since the "Indicators of resolution" above are only speculated to indicate resolution, and since the whole interview is based on self report, it seemed most reliable and valid to ask the mothers about their own definition of resolution and whether they felt resolved in their grief:

(j) "Do you feel any resolution about your grief over your baby's death?"

"Can you describe those feelings?"

Part Three. The passage of time was measured by obtaining the dates on which the baby died, the mother's report of when she began to feel better, when she decided to try to get pregnant again, and when the subsequent healthy baby was born. In addition, the mother was asked what advice she received from her doctor about how long to wait before trying to conceive another pregnancy, how she felt about that
advice then, and how she feels about it now.

Part Four. To assess the mother's perception of her experiences with and feelings about subsequent pregnancies and children, a third set of interview questions are based on the Prugh (1983) Five Questions approach for identifying high risk mother-child relationships. In addition, some questions are based on those used by Harmon and Culp (1981) with which they assessed the differences in development of the relationship between mothers and their fullterm or preterm infants, the relationship between mothers and their preterms being at higher risk for dysfunction. Questions cover 5 basic domains:

1) Experiences during pregnancy, labor, and delivery:
   "How often and for what reasons did you visit your obstetrician during this pregnancy?"
   "Were there problems during this pregnancy?"
   "How was labor and delivery?"

2) Feelings and concerns during pregnancy, labor, and delivery:
   "While you were pregnant, what feelings did you have about the pregnancy?
   "How did you feel during labor and delivery?"
   "At the time of birth, did you have any concerns about the baby?"

3) Experiences with the child since birth:
   "Have there been any problems with this child since birth?"
   "How often and for what reasons have you visited a doctor
with this child?"

4) Feelings and concerns about the child since birth:
   "How did you feel when you saw the baby for the first time?"
   "What concerns have you had about this baby since birth?"
   "Is raising this child easy, difficult, or a combination?"

5) Feelings and concerns about being a mother:
   "What does it mean to you to be a mother?"
   "Do you feel differently about yourself since (first healthy child after loss) was born?"
   "Do you have any concerns about how you are raising (child born after loss)?"

In addition, Part Four assesses the mother's attributions of her feelings and experiences with subsequent pregnancies/children to the loss of a baby. Thus, several questions directly ask the mother to report her feelings about the baby in relation to the previous loss. These questions attempt to determine the effect of the baby's death on the following:

1) Feelings during pregnancy and birth of subsequent child/ren:
   "At the time of this baby's birth, did you think about the death of ________ (baby that died)?"

2) Rearing/parenting of subsequent child/ren:
   "Do you feel you have treated or raised this child differently as a result of your experience with the death of ________?"

3) Feelings for and relationship with subsequent child/ren:
"Do you feel your relationship with this child has been affected at all by your experience with the loss of ______?

The only questions pertaining directly to the mother's perception of the effect of perinatal loss on parenting a subsequent child are nonspecific and open-ended. The interview avoids asking specific questions about issues such as the replacement and vulnerable child syndromes hypothesized to affect children of bereaved parents. Without direct questions, the mothers were free to spontaneously talk about those issues with which they are dealing; in this way their answers were not affected by the interviewer's bias, and the effects of perinatal loss on subsequent children are seen through the mother's perspective. In addition, throughout the interview, if the mothers would spontaneously describe feelings and experiences with their subsequent child, including attributions to the perinatal loss, this was considered data on parenting a subsequent child.

Data on child variables were also considered as they may mediate the effects of the perinatal loss on a mother's experiences and feelings about a healthy child born subsequent to the loss, i.e., current age of the child, the birth order of the subsequent child among healthy siblings, whether the sex of the child is same or different from that of the baby that died, and medical problems during the first month of life (See Table 4).
Reconstructive Recall

During the interview, the mothers' answers to questions about the events and emotions at the time of the loss were not likely to be objectively accurate, especially since for half of these mothers, perinatal loss occurred more than 4 years earlier. But retrospective recall is valuable in that the mothers (1) recall the events and emotions which remain most salient to them and (2) the perspective through which they presently view those events and emotions is one through which they have chosen to incorporate the experience into their lives. In this way, recall is retrospectively "reconstructed". Hence, their reports indicate the overall impact of perinatal loss on their lives, not just the immediate effects; their present interpretation and reconstruction of the past reveals the current impact of the loss on their lives.

Criterion Validity

To establish criterion validity, ideally the mothers who participate in the interview would be given a battery of questionnaires to confirm the interview's ability to predict those questionnaire results. But there are no established questionnaires that correspond to the interview, comprehensively addressing a mother's experiences concerning or related to perinatal loss. For this study, criterion validity was explored by seeing how well the information obtained corresponds to findings in professional and lay literature about mothers who experience perinatal loss.
Content Validity

Content validity asks to what extent does the Interview obtain pertinent information about the experience of perinatal loss. Many of the interview questions are designed to reflect the professional literature on grieving, resolution, interventions for facilitating grief for perinatal loss, and experiences with subsequent children. Other questions were taken from maternal interviews developed by Prugh (1953), Harmon and Culp (1981) and Glicken, et. al. (1986) to assess the mother's feelings about pregnancy, pregnancy loss, and parenting. In addition, books written for parents such as "When Pregnancy Falls" (Borg and Lasker, 1981), "Surviving Pregnancy Loss" (Friedman and Gradstein, 1982), and "After a Loss in Pregnancy" (Berezin, 1982) were used as resources for designing questions, both for their insight into the woman's experience of perinatal loss as well as their discussion of interventions that facilitate grieving.

Construct Validity

Construct validity refers to how well the Interview obtains the true meaning of the experience of perinatal loss, resolution, and experiences with subsequent pregnancies/children. The interview questions are open-ended so that mothers are encouraged to talk freely and each mother can be a guide as to what was important in her own experience with perinatal loss; the very last question asks the mother if there is anything else she would like to share about her experience that she considers important but was not addressed during the
Interview. It must be assumed that mothers who volunteered to be interviewed are the best tellers of their own story. Rather than trying to objectively assess each mother's experiences and emotions, the data collected reflects the mother's own perception of her experience and the perspective she has acquired.

Pertaining to both content and construct validity, the appropriateness and comprehensiveness of the interview questions became apparent when administered to the mothers who participated in this research. The mothers' circumstances of perinatal loss varied greatly: gestational age of the fetus ranged from 20 - 41 weeks; cause of death varied from prematurity to congenital defects to unknown. The mothers talked for 1 1/2 to 3 hours and reported that they felt the scope, depth, and length of the interview was appropriate.

Coding the Perinatal Loss Interview

Since the purpose of this study was to both assess and describe, some questions were designed for assessment, others to gather qualitative descriptions of experiences and feelings. Assessment questions were coded in order to assess the mother's experiences, i.e., what happened, what she did and felt, or what she did not do or did not feel. Each question has 3-tiered answers under which a mother's response can be categorized. For example to the question, "Were you able to see, touch, or hold your baby?", the 3 categories
are (a) "No, or contact fleetingly"; (b) "only able to see or touch"; (c) "able to hold". In addition, each category of answer was assigned a score of 1, 2, or 3. For example, for questions pertaining to experiences surrounding the loss, the scores are assigned according to the degree to which the categorized answer is associated with high (=3), medium (=2), or low (= 1) grief facilitation. In this way, for each mother, the interview yields assessments on questions within the 3 main topics, i.e., reflecting to what extent (i.e. high, medium, low) the mother's experience is considered to be (a) conducive to grief facilitation, (b) reflective of resolution, or (c) indicative of positive experiences with a subsequent pregnancy/child. It is important to note that the coding is nominal; the numbers assigned to the categories do not reflect true interval measurement. This 3-tiered nominal method of coding is used by Harmon and colleagues for their maternal interview data (see Harmon and Culp, 1981).

Besides assessment, the interview data also describe the mother's experience. The descriptive questions, questions that tap the mother's insights about a given experience adds to the richness of the data. Usually, answers to descriptive questions were not categorized and coded but rather, added insight into assessment data on the grief experience, the meaning of resolution, and what it's like to give birth to and raise a healthy child after experiencing a perinatal loss. For example, to the assessment question assessing resolution "Have you been able to make anything positive out of this experience?" (yes = 3; maybe = 2; no = 1) is the descriptive question describing
this aspect of resolution: "What positive things have you recognized?" (Insight into resolution, no categorization of answers).

Some descriptive questions were coded in order to add to the assessment of their corresponding variable. For example, assessment of the mother's contact with the infant is modified by her degree of satisfaction with the contact. Thus, answers to the descriptive question "How do you feel about being able to see/touch/hold your baby?" can be categorized and coded (satisfied = 3; mixed or neutral = 2; dissatisfied = 1) and used as additional information to assess the mother's contact with the infant. Again, these scores are nominal and do not reflect interval measurement of degree of satisfaction or emotion.

As discussed in the section Introducing the PLI, the Interview is structured but open-ended so that mothers were free to follow the flow of their own thoughts rather than the order of the questions in the interview. Thus, a mother could be coded on a certain issue by assessing all statements she made pertaining to an issue. A good example of this is that often, mothers would talk about how something about circumstances surrounding the baby's death still made them angry. Any mother who made this statement could be considered "still angry" and coded as such. Another implicit coding scheme concerns "gratuitous denial". Gratuitous denial is when someone brings up an issue and then denies that they have any concern about it or that it applies to them. Small children are blatant users of this tool, such as when a parent innocuously approaches a child and the first words
out of the child's mouth are "I didn't eat any of that candy." Of course, where before there was no suspicion, the parent's first thought is, "Aha, that child consumed some candy." Thus, during the interview, whenever a mother brings up an issue without being asked about it, and then denies it, she was coded as "wrestling" with that issue. For instance, a mother who describes a situation and then adds, "...but I'm not upset about it..." is considered to be a mother who probably is upset about it. Perhaps she is trying not to be upset, or wishes she wasn't. Or perhaps it is too painful or embarrassing for her to admit to herself or to the interviewer that she is upset. Coding for gratuitous denial particularly applies to the vague, open-ended questions about the effects of perinatal loss on parenting a subsequent child, where a mother who mentions an issue may deny that it applies to her.

**Coding Part One**

Part One of the interview investigates variables pertaining to experiences surrounding the loss which may affect maternal grieving (see Table 4). Each variable has a corresponding set of questions for which the answers given were used to assess each mother. Each answer was categorized and coded according to whether the answer is associated with low (= 1), medium (= 2), or high (= 3) grief facilitation. As discussed previously, some examples of experiences considered to be facilitative of grief work include an available support network, contact with the baby, and a collection of mementos,
including a photograph. An example of coding is as follows: To the question "Did you see, touch, or hold the baby?", since contact with the infant is considered to facilitate grief, mothers' answers were categorized and coded as follows:

3 = mother held the baby;
2 = mother saw or touched the baby but did not hold;
1 = mother did not have contact with the baby or had contact only fleetingly.

For descriptive questions that concern feelings associated with any experience,

3 = positive feelings
2 = feelings that are neutral (neither positive nor negative) or mixed (positive and negative)
1 = negative feelings

Coding Part Two

In order to assess a mother's degree of grief resolution, her answers to the resolution indicators were examined. Each resolution variable has a corresponding set of questions for which the answers given were used to assess resolution in each mother. Answers expressing a relatively low degree of resolution on a given question received a score of 1 for that question; answers expressing a relatively moderate degree of resolution received a score of 2; answers expressing a relatively high degree of resolution received a score of 3. In theory, mothers who are relatively resolved may still
have strong feelings of loss associated with the experience, but these feelings are held in perspective and do not intrude on getting on with life and looking toward the future. Mothers who are relatively unresolved may still harbor ideas of what life would be like if the baby had lived, thoughts of the baby may intrude daily, and there may be less feelings of optimism for the future than in mothers who are relatively resolved. A mother who still harbors feelings of anger, guilt, or sense of failure may be relatively unresolved in her grief; a mother who cannot find anything positive about the experience of losing a baby also exhibits a facet of lack of resolution. In addition, the mothers were asked about their perceptions of grief resolution and to what degree they feel resolved.

Some examples of the categorization and coding of answers to resolution questions are as follows:

(a) "Can you describe the feelings you have when you think about the baby?"

3 = bittersweet, happy and sad, peaceful
2 = sad, lonely, depressed
1 = angry, guilty, a failure (i.e., destructive feelings)

(b) "Have you been able to think of anything positive about your experience [of losing a baby]?"

3 = yes
2 = somewhat, try to
1 = no
Coding Part Three

Part Three of the PLI involves the passage of time and doctor's advice pertaining to how long the mother was advised to wait before trying to conceive a subsequent pregnancy. The passage of time is assessed in terms of the number of months that passed between events of loss, feeling better, trying to conceive, conception, birth of a subsequent child, and the interview itself. Maternal age at the time of the loss and the interview was measured in years. Then, after these data were compiled, histograms were constructed to form groupings of mothers. Grouping the mothers according to passage of time between events and age is a parsimonious way to handle "time" as a variable in data analyses. Examples of the actual categories constructed for this sample are as follows:

Time between loss and trying to conceive again, i.e., "wait":
1 = wait 1 - 3 months
2 = wait 4 - 6 months
3 = wait 7 - 19 months

Time between loss and birth of subsequent child:
1 = 15 months or less
2 = longer than 15 months

Time since the loss (time between loss and being interviewed):
1 = 13 - 32 months
2 = 41 - 60 months
3 = 71 - 119 months

Resolution according to birth of subsequent child:
1 = felt resolved after child's birth
2 = felt resolved before child's birth

Doctor's advice is assessed in terms of how many months the mother was advised to wait before trying to conceive another pregnancy and how she felt about the advice, both then and now. Doctor's advice received was coded as follows:
3 = no specific advice received
2 = wait less than 6 months
1 = wait 6 months
0 = wait longer than 6 months

How the mothers felt about the advice then and how they feel now is coded separately as follows:
3 = thought it was good advice
2 = thought it was OK advice
1 = thought it was bad advice

Coding Part Four

In order to assess the quality of the mother's experiences with and feelings about the first subsequent pregnancy and child born after the loss, questions pertaining to the mother's experiences, feelings, and concerns were coded according to whether her answers are positive (=3), neutral or mixed (=2) or negative (=1). An example of the coding of answers for an "experience" question such as, "How was labor and delivery?" is as follows:
3 = a positive answer such as "easy and fast";
2 = a neutral answer such as "average length, what I expected",
or a mixed answer such as "fast but painful",
or planned induction or Cesarean section;
1 = a negative answer such as "long and painful"
or emergency induction or Cesarean section.

Coding for a "feelings" question such as "What feelings did you have during the final weeks of the pregnancy?" is as follows:
3 = a positive answer such as "happy and excited";
2 = a neutral answer such as "no big deal, felt OK",
or a mixed answer such as "anxious but happy";
1 = a negative answer such as "anxious and impatient".

Coding for a "concerns" question such as "What concerns have you had about baby since birth?" is as follows:
3 = mentions fear of death, loss, severe illness
2 = mentions mild concerns, eg., mild illness, annoyances
1 = none

Coding of questions pertaining to mothers' perception of the effects of perinatal loss on parenting and relationship to subsequent child were done in 2 ways. First, to direct questions about the effects of perinatal loss, eg., "Do you feel you have treated or raised [child] differently as a result of your experience with the death of a baby?", the coding is simply:
3 = no
2 = unsure
1 = yes
Then, this kind of question was followed by asking the mother to elaborate, "in what way?", and issues that were mentioned by the mothers were coded as follows:

3 = does not mention, i.e., this particular mother did not raise this issue

2 = mentions but denies, i.e., gratuitous denial

1 = mentions and acknowledges that this applies to her and her child

Finally, the mothers' verbatim descriptions of what they perceive as the effects of losing a baby were examined for insight into the feelings and experiences the mothers report about subsequent pregnancy and parenting a healthy baby.

Child Variables

The data collected on the healthy child born subsequent to the loss was coded as follows, with the higher score indicating less speculated risk for parenting difficulties such as overprotectiveness or replacement child syndrome:

(a) birth order among living children

3 = later born

2 = first born, with siblings

1 = first born, only child

(b) gender of child

3 = different from baby that died

2 = same as baby that died, has living sibling of same sex

1 = same as baby that died, no living siblings of same sex
(c) age of child

4 = school age: greater than or equal to 60 months
3 = preschooler: 36 months to 60 months
2 = toddler: 12 to 35 months
1 = infant: less than 12 months

(d) neonatal health

3 = healthy
2 = minor illness (e.g., hyperbilirubinemia)
1 = critical illness, admitted to NICU

Interrater Reliability

The interviewer was responsible for coding all interviews from videotapes. To insure the reliability and objectivity of the interviewer as rater as well as of the coding system, another rater also evaluated 10 interviews to compare coding with the interviewer/rater. The second rater was an R.N. who coordinates the perinatal mortality unit at the University Hospital; she specializes in talking with mothers whose baby has just died at birth. The degree of disagreement between the scores obtained by both raters was used to highlight segments or guidelines of the coding system that were not clear or objective. The first 3 interviews which were coded for reliability ranged from 77% to 80% agreement. Questions on which the 2 raters disagreed were reviewed and the coding system and their understanding of it was clarified. For the remaining 7 interviews, reliability ranged from 91% to 100% for an average agreement of 96%.
Data Analyses

Because this study is largely descriptive, much of the data are reported in terms of frequencies and patterns that emerge among the variables and across mothers. Since the coding is nominal, scores received on the different questions under a given variable cannot be meaningfully summed or averaged. Thus interview questions must be handled individually in statistical analyses.

As the data is presented in terms of frequencies in discrete categories, and each mother is represented in only one category under each variable, the Chi square test is appropriate to test the significance of relationships between variables. But, because of the small sample size, in all of the 2 variable comparisons made, more than 20% of the cells have expected frequencies of less than 5. This condition violates a rule for application of the Chi square distribution, but is corrected by use of the analogue of the Fisher's Exact test (Siegel, 1956). The Fisher's Exact test finds the significance of a relationship by taking the marginal totals and enumerating all possible configurations of cell frequencies. All of the configurations that are less probable than the observed configuration are accumulated; this accumulation then determines the exact probability of obtaining the observed configuration. For example, if the probability of the observed configuration is \( p = 0.5000 \), this means that given the observed marginal totals, 50% of the possible configurations are less probable than the one observed; this
probability would indicate a nonsignificant relationship between 2 variables. For this study, any \( p < .0550 \) was considered significant, and \( p > .0549 \) but \( < .1000 \) was considered marginally significant.

The Perinatal Loss Interview is a comprehensive interview on the mother's experience of perinatal loss, grief, resolution, and what it's like to conceive another pregnancy and parent a child born subsequent to the loss. Because interview questions must be analyzed individually and since there are so many questions in the PLI, only a select batch of questions was chosen for data analyses for this dissertation. Since the foci of this dissertation were (1) grief resolution, (2) the passage of time, including doctor's advice on this issue, and (3) parenting a subsequent child, these issues were also the foci of data analyses.

Grief Resolution

An objective measure of grief resolution following perinatal loss is not available. Grief resolution is vague yet central to issues of surviving pregnancy loss and perhaps affects parenting of subsequent children. Thus, answers to "resolution indicators" questions were examined in order to make some conclusions about the nature of grief resolution following perinatal loss. This study represents only a rough attempt to assess and define grief resolution. Each mother's perception of her own grief resolution was assessed. Self-report of resolution was then correlated with scores received on the 9 resolution indicators listed in Table 4, questions which assess the
mothers on behaviors and emotions of the bereaved which are cited in the literature as being indicative of resolution. By determining these relationships, the mother's subjective perception of resolution can be tied into behaviors and emotions as assessed by the grief resolution indicators. For example, there may be a strong relationship between maternal perception of resolution and the mother being able to make something positive out of her experience, while there may be a weak relationship between maternal perception of resolution and how often the mother thinks about the dead baby. After determining which resolution indicators discriminate between mothers who report a high degree of resolution and mothers who report a low degree of resolution, resolution can be described in terms of what behaviors and emotions these mothers use to perceive and define resolution following perinatal loss. These relationships may help to define what constitutes grief resolution following perinatal loss.

In addition to defining grief resolution, 2 questions which address 2 different issues categorized under the experiences surrounding the loss, which are listed in Table 4, were analyzed for relationships to resolution. For instance, the interventions in hospitals such as encouraging contact with the infant, or the availability of support, or the burial and memorial rituals may affect maternal grief resolution, thus indirectly influencing parenting of a child born subsequent to a loss. If so, then these experiences could be viewed as important for both the mother and indirectly, the subsequent child.
Three criteria were used to choose the 2 questions which address the 2 experiences surrounding the loss to be statistically analyzed: (1) the potential meaningfulness of a variable's relationship with resolution or parenting a subsequent child, (2) amount of variability in answers displayed between mothers, indicative of differences among mothers in their experiences or feelings for a given issue, and most importantly, (3) relevance of an issue, i.e., the amount of importance mothers place on a given subject as having significantly affected their experience or emotions. Relevance of an issue was largely be judged from what the mothers report they would change about their experiences surrounding the loss, what helped or didn't help them through the experience, and what events elicit their strongest emotions concerning the loss. Additionally, observations of how much affect is shown, how much detail is given, and how much time is spent on the subject played a role in confirming importance of a given issue.

Thus, to answer questions about the nature of grief resolution following perinatal loss, the relationships examined were between self-report of resolution and 12 variables, including the 9 resolution indicators and 2 experiences surrounding the loss, and the following variable, passage of time.

**Passage of Time**

Time was measured in months. Passage of time was examined for both it's relationship to resolution and parenting a subsequent child.
To see if the passage of time plays a role in feelings of resolution, self-report of resolution was correlated with time since the loss, that is, the number of months between the loss and the mother's interview. To see if the passage of time mediates the effects of the loss on parenting a subsequent child, the parenting variables were correlated with both time since the loss and time between the loss and birth of the subsequent child. The other variables classified under "passage of time" involved the advice the mother received from her doctor about the passage of time, i.e., how long to postpone trying to conceive another pregnancy. Relationships examined were between (1) what advice the mother received, (2) how she felt about the advice at the time it was received, (3) how she feels about the advice now, (4) how long she actually waited before starting to try and conceive another pregnancy.

**Parenting a Subsequent Child**

Mothers were only asked 3 questions which were considered catalysts for getting them to talk about the effects of the loss on the subsequent child. One question was rather specific, the question about their thoughts of the baby who died shortly after the birth of the subsequent child. The other 2 questions were very nonspecific and open ended, (a) a question about the mother's perceptions of the effect of the loss on her relationship to the subsequent child, and (b) a question about her perceptions of the effect of the loss on her parenting of the subsequent child. Since there were no questions
about specific issues on parenting a subsequent child, issues that the mothers mentioned in answering the above questions or at any time during the interview, were sorted out for common threads that ran through the mother's experiences and perceptions. Any issue that was mentioned by more than 60% of the mothers was described and correlated with response to either the perception of effects of the loss on parenting or relationship to the subsequent child.

But only 2 of these "specific parenting variables" were actually chosen for further statistical and descriptive analyses. The criteria used for choosing the 2 specific parenting variables were (1) variability among mothers, because if nearly all the mothers feel a given way, then it's obvious that feelings of resolution and the passage of time do not mediate that specific parenting variable; (2) relevance of an issue, i.e., what has affected or concerned the mothers most about parenting or relating to a subsequent child and do the mothers attribute their feelings or behavior to their experience with perinatal loss; and (3) that the 2 specific parenting variables be conceptually discriminable and statistically independent. Then these 2 specific parenting variables were correlated with (1) current feelings of resolution, (2) feelings of resolution at the time of the birth of the subsequent child, (3) time since the loss, and (4) time between the loss and the birth of the subsequent child. In this way the variables of resolution and time were tested for their relationship to the effects of the loss on the subsequent child. In addition, subsequent child variables were examined for their mediation.
of the effects of the loss on that child. When considered relevant, the age, sex, birth order, and neonatal health status of the subsequent child were correlated with the specific parenting variables.

For all variable considered in this dissertation, besides descriptive data and correlational analyses, verbatim reports of these mothers' experiences were considered valuable in illustrating the mothers' perceptions and emotions. And as each mother has a highly unique set of circumstances and experiences, individual case examples are an important way to present the data. Case examples both illustrate and make sense of the complexity of the relationships between the relationships between grief resolution, time, and parenting a subsequent child.

In summary, although the PLI covers a broad range of topics, only certain questions were considered for data analysis. To explore these questions about resolution, parenting a subsequent child, passage of time, and doctors advice, the data analyses are carried out on the following relationships:

(1) Maternal self-report of grief resolution and its relationship to
   (a) the 9 indicators of resolution assessed in the PLI,
   (b) the passage of time since the loss;
   (c) 2 experiences surrounding the baby's death,
(2) Maternal self-report regarding 2 specific parenting variables and their relationship to
   (a) perception of effects of the loss on either parenting
or relationship to the subsequent child
(b) maternal self-report of grief resolution, both currently
    and just after the birth of a subsequent child,
(c) the passage of time since the loss and
    time between the loss and subsequent birth
(d) subsequent child variables which may mediate effects of the
    loss
(3) Maternal self-report of the advice she received from her doctor
    about how long to wait before conceiving another pregnancy and its
    relationship to
    (a) how she felt about the advice when she received it,
    (b) how she feels about that advice now, and
    (c) how long she actually waited before trying to conceive
        another pregnancy.
Each mother was asked "Do you feel any resolution of your grief over your baby's death?" Mothers who said "yes" in reply to this question were classified as resolved; mothers who said "no" or "not really" were classified as unresolved. Every mother was able to understand what was meant by resolution, as indicated by (1) the readiness with which the mothers answered this question, and by (2) their explanations of their own feelings of resolution or lack thereof (Kelly was the only mother who could not explain her unresolved feelings). Exactly half of the mothers in this sample reported that they felt resolved, and half of the mothers reported that they felt unresolved. Appendix A contains the verbatim responses of the mothers to the question about resolution, listing the resolved mothers' responses first, followed by the unresolved mothers' responses. In comparing the two groups of mothers on their responses, for simplicity and to make specific points, some statements will be quoted only partially, but the reader can refer to Appendix A for fuller statements on resolution.

The validity of the classification of mothers as "resolved" or "unresolved" according to their self-report was evident in both (1) the similarities among resolved mothers and similarities among unresolved mothers in the way they described feelings of resolution
and (2) the contrast between resolved and unresolved mothers in the way they described feelings of resolution or lack thereof. When describing their unresolved feelings, 10 of the 12 unresolved mothers reported that they felt better than they used to, but none of them could readily admit that they felt resolved. In this and other ways, there are distinct differences between the resolved and unresolved mothers in how they reported their own degree of resolution. The main discrepancy between unresolved and resolved mothers is the level of acceptance of their baby's death. Of the 12 unresolved mothers, 11 mothers either implicitly or explicitly expressed a lack of acceptance of their baby's death. Kara was the only unresolved mother who implicitly accepted her baby's death. She reported feeling "at peace." But she also mentions, like many of the unresolved mothers, "I wish it had never happened." On the other hand, all 12 resolved mothers described resolution in terms of reaching some sense of acceptance. Only 2 of the 12 resolved mothers, Meryl and Cindy, mention that they still wish it had never happened, which doesn't sound like acceptance, but Meryl nevertheless feels "...it's just accepted... It's alright."; and for Cindy, acceptance takes the form of feeling good that the baby is "alright... she doesn't have to suffer...."

The Resolved Mothers

Like Meryl above, 3 other resolved mothers actually explicitly
stated their acceptance of their loss. Liza expressed acceptance in a way typical to these mothers when she talks about her feelings of resolution:

"At this point, mostly just acceptance that this was part of my life and he's gone."

Like Cindy, 7 other resolved mothers expressed acceptance implicitly: Desi says "I feel peaceful"; for Bryn, "it's OK"; for Jessie and Sara, finally, the loss is "just something that happened"; for Rose, acceptance is expressed when she explains, "...It's all over. I can't bring her back, that type of thing, resolved." For Elaine, resolution means moving on, not being afraid to have another baby; for Kitty resolution means feeling emotionally distant from the event: she says "...It's just a memory now, like I'm thinking about somebody else."

Although all resolved mothers had reached some sense of acceptance of their baby's death, resolution had many different facets for these mothers. All 12 resolved mothers also described one or more of the following as contributing to their feelings of resolution: an integration of the loss into life, not asking "why" anymore, finding the positive, finding comfort in religious beliefs, and a reduction in painful grieving feelings.

Four mothers, Jessie, Sara, Liza, and Anya, describe the feeling of integration of the loss into their lives. Here, Jessie describes both acceptance and integration as playing a role in her resolution:

"Her life and death feel like a very integrated part of my life right now and not something I could or would change, just something that happened and I'm going to cope with it."
I don't feel as though it's limiting any more, it's just part of my life."

In explaining her feelings of resolution, Sara talks about how integration into her life as well as not asking "why" anymore means that the loss is not such a central part of her life:

"Finally... stopping to ask 'why' all the time. Instead of being on your mind all the time, it becomes part of your history. You know, you don't meet new people and discuss your dead baby any more. I mean, [now] I actually know people that don't know that I've lost a baby..."

For Meryl, though still recognizing that it was a tragedy, resolution means focusing on the positive:

"...there are alot of good things that came out of it; in a lot of ways I think I came out of it a better person. That's not the way I want to come out a better person but, everything's OK now, it's alright."

For Jane, acceptance was aided by religious beliefs:

"I feel that God gives us the children he wants us to have and so through that I was able to accept that that was not the one he wanted for me to have. So I was able to accept what had happened to me in a very short amount of time."

Cindy and Desi were also comforted by their religious beliefs, as Cindy says,

"Now I feel like I just know God took care of her and she's alright... she's in Heaven, she is a little angel."

Of resolution, Desi says, "It's a relief." Sara mentions that resolution includes not asking why all the time, as well as not feeling wracked with guilt. This theme of resolution meaning a reduction in painful feelings of grief was mentioned by 8 of the 12
Resolved mothers—Cindy, Sara, Desi, Rose, Anya, Bryn, Elaine, and Liza. Anya says simply, "Just gradually over time... it was not nearly as painful."

Although resolved mothers no longer feel intense, overwhelming grief and they feel an acceptance and integration of the loss into their lives, none of these mothers say that they feel no pain or have forgotten about their baby who died. Although she feels better, Cindy admits that she can still feel the yearning for her baby:

"I don't feel pain anymore, not like I did. Sometimes I do, sometimes I want her."

Kitty came closest to feeling "like I've forgotten", but even Kitty had a "good cry" before she came in for the interview. Perhaps it is an acceptance of the loss that makes it less painful. Liza expresses this point of view when she says,

"...it's such a part of my life to think of him and be sad that it's not the level of emotion or feelings, it's just acceptance."

Similarly, Rose describes how the grieving feelings are not gone, but they are more comfortable:

"Even when I feel grief it's not a desperate feeling, it's kind of a comfortable feeling... it's always up and down but resolved means I can look at her picture and not burst into tears."

But Rose goes on to make the point that resolution does not mean forgetting:

"But it's definitely not like I've put her in a closet and closed the door or anything like that."
Desi also feels that the loss is less painful although it took her a while to let go of the painful feelings and realize that resolution doesn't mean forgetting. She describes how she used to feel about the role of her grief in remembering her baby:

"...that tormenting is over but I still love him, he's not forgotten. That's another thing I was afraid of. I thought, I've got to keep this up [grieving] so that I don't forget him. I don't want anybody to forget him. But you don't have to be miserable to remember."

Although resolved mothers accept their loss, none of them say they are glad that their baby died; in fact, when describing their resolution, half still express varying degrees of regret that it happened: Cindy and Rose each still feels an occasional yearning for her baby, and Sara, Liza, and Bryn still recognize that it's a sad thing, Meryl and Cindy still wish it never had happened. Regrets and sadness are still acknowledged but they are not overwhelming. No longer feeling overwhelmed may lead to the overall acceptance that the baby is gone that makes all these mothers feel resolved in their grief. This acceptance in the face of wishing it hadn't happened or seeing it as a sad thing is expressed by Rose:

"It's like I know she's dead and I can't get her back. I don't have those real 'Oh I can't stand it- get her back here!' [feelings] like I could pull her out of the air if I had enough faith, if I gritted my teeth hard enough or whatever. I don't have those feelings anymore- It's like, well, she's gone. [Although], every once in a while I do.... The subject is pretty much closed, there's nothing to say, it's all over. I can't bring her back, that type of thing, resolved."

Thus, resolution for the resolved mothers means not being
overwhelmed by intense grief and involves feelings of acceptance, but not that you feel happy about it or forget the baby who died. Sara eloquently sums up the feelings of integration and acceptance, tempered by soft feelings of sadness and remembrance:

"... It isn't part of my [everyday] conversation. It just happened to me and I'll always be sad and I'll always have one less child."

The Unresolved Mothers

In contrast with the resolved mothers who no longer feel intense grief and have all reached some sense of acceptance of their loss, all of the unresolved mothers are to some extent still feeling intense grief and are not able to accept or integrate their loss. Some feel they will never accept the loss and that there is no such thing as resolution, and some feel they are working toward acceptance and resolution. Interestingly, 3 unresolved mothers, Sophie, Bess, and Holly, explicitly expressed their unresolved feelings in terms of not accepting the loss. For the other mothers, lack of acceptance was implicit, and expressed in terms of still having intense emotions of grief, regret, sadness, or anger.

Of the 12 mothers who are unresolved, 5 (Peg, Sophie, Hannah, Erin, and Martina) seem to think that resolution does not really exist, that one can never accept the baby's death and still remember. To them, resolution means accepting and forgetting, and they believe they'll never do either.
Erin expresses her doubts that she'll ever feel resolved when she says,

"I don't know that there is resolution. I just feel like I've met a happy medium of how I'm going to deal with it."

She feels like she has moved on, but reluctantly, with the pressures of raising her other children and the recognition that she can't bring Barbie back:

"I'm going to deal with it because I've got other children at home and life goes on and I can't bring her back. I've tried. When she first died, I tried my best. But there was no way I was going to get that little baby out here. So I just kind of moved on."

But then, she elaborates more on trying to bring Barbie back, as if she is still wondering if there was something she missed, something she could have done to bring her baby back:

"I knew I couldn't but I tried my best to bring her back. I screamed at the doctor to do something, I tried mouth to mouth on her, put her up to my lips to try to suck out that little life in her."

Martina and Peg both acknowledge that their grief is not as intense as it used to be, but both mothers imply that it's still too intense to ever think they can feel resolved. Martina says,

"There's no final phase of grief, I know that. It's just not as hard as it used to be. It's a lot easier to sit and talk about and think about him and every time you talk about him and think about him you don't go into a hysterical fit."

Thus, Martina gives the impression that she is feeling closer to hysterical than calm, which indicates the continuing intensity of her feelings. Peg is trying to cope with it but she is still too
"bothered" to see that she'll ever be resolved:

"I'm at a point where I can think about them, it doesn't bother me like it used to. Certain things bother me but generally- I don't know how you can ever really resolve something like that in your mind."

Similarly, Sophie points out that she'll probably never accept the loss but will learn to cope with it;

"I don't think I'll ever completely accept it but it's kind of a gradation- you never really get over it but you hopefully learn to cope with it better."

Hannah too has not accepted the loss and doesn't see resolution as an outcome of this experience because to her resolution means you forget about your baby who died:

"...I'm never going to be happy about losing her. So I'm never going to just totally put it away and say 'That's over and done with and I'm never going to think about it again' or 'I'm just going to go on and be strong and never cry about it'. I don't feel that way at all... When people say that [resolved] it's almost like you're saying you forgot."

Of the remaining 7 unresolved mothers, 2 unresolved mothers (Bess and Luanne) just state that they feel unresolved but don't mention whether resolution is an Impossibility or not. Of these 2 mothers, Bess comes the closest to feeling like resolution is Impossible when she says,

"I don't think I've reached a state of acceptance. I've put the loss of the baby in its place in my life, but I don't think I could say I've accepted it. Because accepted it means you go along with it."

Here Bess's definition of "acceptance" involves a sense of collusion over the baby's death. None of the mothers in this sample
feel they will ever collude over their baby's death. But the unresolved mothers, particularly the ones who don't think they'll ever feel resolved, seem to feel that acceptance means collusion, that it's OK the baby died. Meanwhile the resolved mothers can feel acceptance without feeling like they agree that it's OK the baby died.

Luanne also doesn't say whether she thinks she'll ever feel resolved but it is clear from her statement that her feelings of grief are still too intense for her to feel acceptance and resolution:

"It will always be there, I'm sure, even in 50 years I'll still remember. I'm not grieving like you do right afterwards. But you still have sadness and pain. It still bothers me but not everyday."

The remaining 5 unresolved mothers acknowledge that they see resolution as an eventual outcome of their grieving: 3 of these mothers, Kara, Kelly, and Holly, feel they are working on resolving their grief, while 2 mothers, Lynn and Dara feel stuck.

Similar to Erin above, Dara mentions that she has moved on because of her other children and "things go on" and not necessarily because she was ready to move on. But Dara is still stuck on feeling like she is very upset by the loss and her lack of resolution is related to her continuing intense emotional reactions to the loss. She gratuitously denies that she has a "psychological hang-up" which likely indicates that she indeed feels "hung up" or stuck in her grief. She says,

"Obviously we've had more kids and pulled our lives together and things go on. I think there's times when I still have some work to do in terms of my own reactions but I wouldn't say it's been a psychological hang up. I think I've been
pretty honest with myself and it's OK to cry."

Lynn recognizes resolution exists but feels stuck where she is, unresolved:

"I feel that a lot has been resolved but I'm sure there's still some that needs to be resolved... but I don't know how it's going to be resolved."

The other 3 mothers give the impression that resolution is something they are working toward. Kelly says simply, "I'm still working on it." Holly is starting to feel the acceptance and integration that comes with resolution but is still in transition:

"In some sense I feel it coming... I feel sort of an acceptance of the sadness, I'm not fighting it, or denying it, or overdoing it. I just feel like it's there and I'm getting towards integration- not something I want to deny or overuse or overdo it."

Holly's statement indicates that her acceptance is of the sadness of having a baby die. This leads to the speculation that perhaps it's not acceptance of the baby's death itself but acceptance of the sadness that leads to feeling resolved.

Kara is the only unresolved mother who described her unresolved feelings as some of the resolved mothers describe their resolved feelings:

"I feel at peace with him although that doesn't keep me from feeling emotional about it and having a tear now and then. I do feel OK about it and I still feel my love for him. I don't feel great that it happened to me, I wish it had never happened."

Kara still feels unresolved but she has the feeling of peace
mentioned by Desi, and the remnants of sadness and remembrance mentioned by so many resolved mothers. But as mentioned by so many unresolved mothers, she may feel that resolution means not "feeling emotional about it." In addition, when she says "I wish it had never happened" she implies a lack of acceptance. Resolved mothers may also mention that they wish things could have turned out differently, but still feeling emotionally raw may account for Kara's feeling unresolved.

To summarize, it appears that for these mothers, feeling unresolved is related to their intense emotions and lack of acceptance of their sadness or their baby's death. And not one of these mothers mentioned being at the point of integrating the loss into their lives. But similar to the resolved mothers, 10 of the 12 unresolved mothers explicitly mentioned that they have come a long way toward feeling better than they did at first. Although they are feeling better, they may feel a little too tender yet to feel resolved—those painful grieving feelings of sadness, yearning, and remembrance are probably still too sharp.

Half of the unresolved mothers are able to feel that resolution will be an outcome of their grief. But the vehemence with which the other half of these mothers claim that they will never accept the loss is probably a reliable indication that their feelings of grief are the sharpest. And maybe these mothers will never feel grief resolution. However, some of the resolved mothers, also at one point felt they would never feel resolved. This fact sheds hope that perhaps
eventually, all of these mothers will feel resolved. As Desi, a resolved mother pointed out, she used to think, "I've got to keep this up [grieving] so I don't forget him." Perhaps as the painful grieving feelings become less sharp and the memory stays strong, these unresolved mothers can recognize, as Desi says, "... that you don't have to be miserable to remember." In addition, as painful feelings become less sharp, perhaps acceptance won't seem like such a disloyalty to the baby who died. As Sara, a resolved mother admits, "I feel really really grateful that I had him for 3 days. And I didn't think I'd ever feel that way."

So, what makes some mothers have sharper painful feelings, feelings that they have not accepted the loss or never will? And what of the mothers whose loss occurred years ago and still feel unresolved? Is it possible that their grieving feelings are still too painful for them to feel like they can accept the loss? Or is it just a characteristic of some mothers to never feel resolution? The following sections on the relationship between resolution and a number of variables will illuminate those which separate the resolved from the unresolved mothers.

**The Resolution Indicators**

Besides the self-report question on resolution, a number of questions in the PLI pertained to variables which are cited in the
literature as being indicators of grief resolution. These variables include such things as how often the mother thinks about the baby, whether she thinks of how the baby would be now if the baby had lived, whether she looks to the future, all indications of whether the parent is moving on with life, or dwelling on the past and what was lost. In addition, the mothers are asked about their feelings associated with grieving, such as anger, guilt, and failure, and emotional reactions during the interview are observed. The mothers' responses to the direct, self-report question about resolution were correlated with responses to these indirect questions about resolution in order to find out the relationship between self-report of resolution and self-report concerning other indicators of resolution. Of the 9 indicators of resolution included in the PLI, only 1, "feelings about the baby", i.e., how the mother feels nowadays about the baby and the baby's death, correlates significantly with self-report of resolution. In fact, except for "feelings about the baby", there is virtually no relationship between the way these mothers think and feel about these traditional "resolution indicators" and their perception of their own resolution.

The following is a summary of how the mothers reported their thoughts and feelings with regard to the "resolution indicators" and each indicator's relationship to the mothers' self-report of resolution. More detailed summaries will be given to "feelings associated with grieving" as well as the 5 resolution indicators which displayed variability between mothers, such that no more than 11
mothers were found in a single category of a variable (all variables contained 3 or 4 categories). These indicators which displayed variability include "frequency of thoughts", "anniversary reactions", "emotional reactions" (observed and reported), "why me", and "feelings about the baby". The indicators "feel about future", "think of the baby as would be now", and "something positive" did not display as much variability among mothers. That a great majority of mothers felt one way on these three indicators is interesting in and of itself, but does not lend itself to much analysis of differences.

Feelings About the Future

Each mother (except Sophie, inadvertently) was asked how she feels about the future and what it might bring. None of the mothers felt pessimistic, and 17 (74%) mothers felt optimistic. The remaining 6 (26%) mothers held some reservations about the future, mostly due to worries about their subsequent children. Bryn, one of these mothers with reservations explains:

"When it first happened I was terrified of the future and couldn't stand the thought of bad things happening in my life. Well, now that it's been this many years (4 1/2) and nothing bad has happened in my life- Leslie's here, everything's been positive, it makes it much easier to deal with it, but I'm still afraid, I'm much more overprotective as far as Leslie goes."

Bryn illustrates the vulnerability these mothers feel, although, even the optimistic mothers do not escape feeling vulnerable to bad things happening. Jane, who is optimistic about the future and what it might bring, expresses her feelings of vulnerability when she says
about her surviving children:

"In my mind I always worry about them getting some unknown disease or something. Since then [the loss], I am very aware of death."

Jane goes on to say that she diligently makes doctor's appointments for annual check-ups to make sure she and the kids are OK and to have peace of mind.

As optimism does not protect these mothers from feeling vulnerable, it also does not discriminate resolved from unresolved mothers. Of the 17 optimistic mothers, approximately half, 9 (52.9%) mothers felt resolved, but approximately half, 8 (47.1%) mothers felt unresolved; similarly, half, 3 (50%) of the mothers who were not so optimistic, also felt resolved, half 3 (50%) mothers felt unresolved. The relationship between feelings about the future and feelings of resolution was nonsignificant (Fisher's Exact p = 1.000).

**Something Positive**

Each mother was asked if she had been able to see or make anything positive out of her experience. Of the 24 mothers, 3 (12.5%) mothers said no, 3 (12.5%) mothers said they tried to, and the majority, 18 (75%) mother said yes. These mothers cited positive things such as strengthened marriages, strengthened friendships, feeling stronger as an individual, having more empathy for women who experience the loss of a child, the ability to help others who experience loss, and even having the subsequent child, who likely would not have been conceived if the baby had lived. But finding the
positive did not relate with feelings of resolution. Of the 18 mothers who could find the positive, exactly half, 9 (50%) mothers felt resolved and half, 9 (50%) mothers felt unresolved. Likewise, of the 6 mothers who could not easily find the positive, exactly half, 3 (50%) mothers felt resolved and half, 3 (50%) mothers felt unresolved. Thus, there was no relationship between resolution and recognizing something positive (Fisher's Exact p = 1.000).

Thinking of Baby as Would Be Now

Each mother was asked, if she did not mention it spontaneously, and many did, whether she ever thought or wondered about what the baby would be like now if the baby had lived. The majority, 18 (75%) mother said yes, 2 (8.3%) mothers were not sure, and 4 (16.7%) mothers said no, that they just think of the baby as s/he was. Many of the mothers who said "yes" are reminded of this curiosity when they see children who were born at the same time their baby died, or in a pensive moment with their subsequent child as they realize the experiences they have missed with the child who died. Jessie expresses this when she says,

"With Katy I think of [Megan] alot, when I see Katy wearing things that were given to Megan or doing things that I had imagined Megan would do."

Again, this resolution indicator was as remarkable as "feelings about the future" and "something positive" in it's lack of relationship with feelings of resolution. Exactly half (50%) of the mothers in each category (9, 1, and 2 mothers, respectively) felt
resolved and half felt unresolved, indicating no relationship with feelings of resolution (Fisher's Exact p = 1.000). Thinking about what the baby would be like now is not particularly painful for these mothers; it is mostly a wistful, curious feeling that apparently is not related to these mother's perceptions of their grief resolution.

**Frequency of Thoughts**

Each mother was asked how often she thinks about the baby who died. Of the 24 mothers, 8 (33.3%) mothers reported that they think about the baby daily: 4 (50%) of these mothers feel unresolved and 4 (50%) feel resolved; 3 (12.5%) mothers think of the baby 1 to 5 times weekly: 2 (66.7%) of these mothers feel unresolved and 1 (33.3%) feels resolved; 8 (33.3%) mothers think of the baby once or twice monthly: 4 (50%) feel resolved and 4 (50%) feel unresolved; and 5 (20.8%) mothers think of the baby "hardly ever": 2 (40%) feel unresolved and 3 (60%) feel resolved. Thus, consistently across the "frequency of thoughts" groups, about half of the mothers feel unresolved and half feel resolved. Thus, for these mothers, resolution is nonsignificantly related to how often they think about the baby (Fisher's Exact p = 1.000).

Interestingly, some of the mothers who think of the baby daily point out that it has become a ritual rather than an obsession to think of the baby daily. For instance, Desi includes her deceased son Matthew in her nightly prayers, and Rose has a picture of her deceased daughter Jessica on the mirror in her bedroom where she sees it daily.
Both of these mothers feel resolved and none of the mothers in this sample feel that their thoughts of the baby intrude on their functioning.

Anniversary Reactions

Anniversary reactions are a phenomenon where the bereaved experiences feelings of grief on anniversaries meaningful with regard to the deceased. For example, the bereaved may find herself depressed annually on the date of the loved one’s death. Each mother is asked if there are times of the year that are harder than others. Of the 24 mothers, only 4 (16.7%) reported that they experienced no anniversary reactions; 5 (20.8%) mothers have an anniversary reaction once a year, all on the baby's date of birth. Sara describes what her baby's birth date is like for her:

"On the anniversary date we always try and do something, I mean, we don't try and be happy birthday or anything weird like that but we do something together as a family. I remember going to a pizza place [3 years after Jamie died, when Gary was just 2 years old].... and my husband and son were sitting there and I was getting Cokes for everybody and stopping in mid-stream as I was walking back to the table and realizing, 'There should be somebody else there. There will always be somebody missing, there will always be one less child in my life.'"

A majority, 15 (62.5%), of the 24 mothers experience more than one anniversary reaction per year. Of these 15 mothers, 8 experience anniversary reactions on 2 or more of the following discrete dates: baby's date of birth (5 mothers) or date of death (1 mother), and holidays such as Christmas (4 mothers), Easter (2), Memorial Day (2),
Thanksgiving (1) or Mother's Day (3). In addition, Jess also feels sad on her own birthday, Meryl thinks about how old Casey would have been at the first day of every school year, and Kelly feels depressed on the 27th of each month as her son died on the 27th.

Of the 15 mothers who experience more than one anniversary reaction per year, the remaining 7 mothers experience anniversary reactions during certain months or seasons rather than discrete dates: 5 of these 7 mothers have a hard time during the month of their baby's birth; of the 2 remaining mothers, Hannah, feels badly for a month before the baby's birthday, and Martina feels badly during the holiday season, starting with Thanksgiving and ending with the baby's birth date at the end of January. Erin describes how she feels during October, the month her baby died:

"In October, I'm real mellow and moopy and on her birthday it's like, we know it's that day. It's just like a signal in your body. And I'll break down and cry over nothing."

Liza, who feels badly during June, the month of her baby's birth and death, describes what that month is like for her:

"I dread June a little bit. I hope that I'll be in a situation for the rest of my life where I can just plan to always do something that will keep me kind of busy in June. But I think even if I do that I'll just have the reaction delayed or something. I don't know, it just always sneaks up on me. I really thought I'd be fine this year and I really had a lot of the same feelings again."

Both of these mothers illustrate how uncontrollable and even unexpected anniversary reactions are. Many of the mothers reported that the anniversary reactions become milder with the passage of time,
but others, like Liza, are often surprised by the intensity of their anniversary reactions.

Of the 4 mothers who reported that they experienced no anniversary reactions, 2 (50%) of these mothers feel unresolved and 2 (50%) feel resolved; of the 5 mothers who have one anniversary reaction per year, 2 (40%) feel unresolved and 3 (60%) feel resolved. Of the 8 mothers who experience a couple of anniversary reactions per year, half, 4 (50%) of the mothers feel resolved and half, 4 (50%) feel unresolved. Even among the 7 mothers who experience lengthy anniversary reactions, consistent with the other "anniversary reaction" groups, about half, 4 (57.1) feel unresolved and the other half, 3 (42.9%) feel resolved. Thus, resolution is nonsignificantly related to the number of anniversary reactions experienced (Fisher's Exact p = 1.000).

**Emotional Reactions**

Mothers were both observed during the interview for emotional reactions and asked what emotional reactions they still experienced. Of the 8 (33.3%) mothers who cried during the interview, the majority, 6 (75%) feel unresolved and 2 (25%) feel resolved; of the 7 (29.2%) mothers who teared up during the interview, about half, 4 (57.1%) feel unresolved, and 3 (42.9%) feel resolved; of the 9 (37.5%) mothers who did not tear at all, only 2 (22.2%), feel unresolved while the majority, 7 (77.8%) feel resolved. Thus, as could be expected, it appears that the majority of mothers who cry also feel unresolved in
their grief while the majority of mothers who do not shed tears also feel resolved in their grief. However, this relationship between observed emotions and resolution only tended toward significance (Fisher's Exact $p = .1194$). Perhaps with a larger sample size, this convincing trend could be confirmed as significant.

But because the mothers who did not cry during the interview may have been inhibited, in addition to observation, mothers were asked what emotional reactions to their baby's death they still experienced. Indeed, by looking at the relationship between observed and reported emotional reactions, it becomes clear that the mothers who do not shed any tears during the interview aren't always so composed when thinking about their loss. Of course, the 8 mothers who cried during the interview, all (100%) had to admit that they still cry or have physical reactions occasionally; likewise, of the 7 mothers who got teary-eyed, 4 (57.1%) reported that they still got choked up occasionally and 3 (42.9%) reported that they still have crying spells. But of the 9 mothers who showed no tears during the interview, only 1 (11.1%) never sheds tears and 1 (11.1%) just gets choked up every now and then. The remaining 7 (77.8%) of these mothers still have crying spells and/or physical reactions to their loss. The presence of this overt grieving behavior reported by mothers who showed none during the interview was remarkable. Indeed, the quality of the marginally significant relationship between observed and reported emotional reactions (Fisher's Exact $p = .0867$) discounts the relationship between resolution and observed emotional
reactions outlined above: observed emotional reaction is not a valid indicator of emotion because 88.9% of the mothers who show no reaction during the interview actually do still experience emotional reactions in private.

The relationship between resolution and emotional reaction thus can be more validly measured by comparing resolution and reported emotional reaction. Of 24 mothers, only 1 (4.2%) reported that she never shed tears over her loss, and she reports feeling resolved; 5 (20.8%) mothers reported that they get teary-eyed or choked up occasionally: about half, 3 (60%) of these mothers feel resolved and about half, 2 (40%) feel unresolved. Twelve (50%) mothers reported that they still cry occasionally about the loss: again, about half, 5 (41.7%) of these mothers feel resolved and about half, 7 (58.3%) feel unresolved.

In addition to crying, 6 (25%) mothers reported other physical reactions, such as intense anxiety in anticipation of the interview and feelings "In the pit of the stomach": once again, half, 3 (50%) of these mothers feel unresolved and half, 3 (50%) feel resolved. The relationship between resolution and reported emotional reaction to the loss was nonsignificant (Fisher's Exact $p = .8633$). Thus, resolved and unresolved mothers experience about the same range of emotional reactions with regard to their baby's death. It should also be emphasized that 75% of these mothers still have significant emotional reactions, i.e., crying spells or physical reactions to the death of their baby. And including mothers who just get teary-eyed, 95.8% of these mothers still shed tears over their loss.
Why Me?

Each mother was asked "Do you have any ideas about why this happened to you?" Mothers were classified according to their answer in 1 of 3 categories, negative ideas, just chance, or positive ideas. Of the 24 mothers, 5 (20.8%) mothers have negative ideas where they blame the doctors or themselves, feel they deserved it, or they just feel that life is cruel. Erin describes this point of view:

"I used to think it was my age. I really couldn't come up with an answer because I really never had bad things happen to me. I've been a fortunate person, I married a nice man, I have a wonderful family...So my life has been very good. When I used to say why me, I don't know if I ever got an answer and that's why I started blaming the doctor...now, I don't believe that. But that was my excuse then. [Now] I just feel like it was fate. Maybe my [deceased] girlfriend needed Barbie up there with her, I don't know, but it's kind of sad that God had to take my baby like that. You don't know what to think, but that's kind of where I've left it."

Here, Erin talks about first blaming herself, then blaming the doctor, and although she doesn't feel like she really has come up with a satisfying answer, she has left it at blaming God.

There were a total of 10 (41.7%) mothers who felt that it was just chance that this tragedy happened to them. Some of these mothers find comfort in that thought, even though it isn't much of a reason. For instance, Bess says,

"The only way I got through it at the time and the only way I can believe right now that why David died was it was purely an accident of nature and I really do believe that."

Some mothers believe it was just chance but recognize that some positive things arose from the experience. Kara expresses this point
of view:

"Certainly not to make me a better person although Nick and I have grown from it alot. Why does it happen to anybody—it just does."

A lot of these mothers started out with negative ideas and eventually realized that it was just random chance. Hannah describes this progression of her thinking:

"I think eventually I've come to the conclusion that things just happen. Events just happen in a certain way and we were one of them... At first I thought this weird thing happened and maybe I wasn't meant to be a mother and something like, I'd done something to deserve it. That's not a comfortable feeling at all."

Finally, there were 9 (37.5%) mothers who expressed positive ideas about why this happened to them. Some mothers felt that it was God's will and others felt that there was a positive reason why their baby died. Cindy talks about both:

"I just like to look at it as God decided that Nicole was too good to be on the earth and go through the things that we go through... And He knew that I was going to get divorced and He knows the future and maybe He figured that 2 kids would be too much for me to handle. I don't know, I just know that He knows what He's doing and maybe He thought that through this experience I could help other people."

Sophie has a philosophically sophisticated idea about why her baby Stephanie died, from which she has derived much comfort:

"Part of what I believe is that we exist as a soul or whatever, as an entity, before we are a body and it's like we decide how and when and to whom to be born and what kind of life to lead... we have a purpose for being born, almost like something or some things that we want to accomplish. And when those get accomplished, then we usually die... Stephanie needed to know that she was loved and she knew that the whole time I was pregnant and she knew that the 5
days she was here and she wanted to share that love with us and she didn't need to stay around any longer."

Jessie describes how she started with negative answers and eventually settled on positive answers to the question "why me":

"We have gone through hundreds of theories and I think that the resolution I've come to is that there isn't a particular reason and I don't feel as though we were singled out or we were being punished. I went through that for a while and I really felt guilty that I must've done something to deserve such a horrible thing. But I don't believe that anymore. I believe that it's just something, maybe her soul wasn't ready to-, maybe that was just as long as she was supposed to be with us. And I do believe that it changed things. I don't know that her father and I would've really developed a relationship and stayed together so it helps me to think that maybe that was part of the purpose."

The advantage to settling on positive answers to "why me" is that these mothers all derive comfort from those answers. In contrast, the mothers who are still wrestling with negative answers and some who have resigned themselves to "just chance" are not as comforted by those reasons for their baby's death. However, as with the other resolution indicators, this one was remarkable in it's inability to discriminate between resolved and unresolved mothers. Of the 5 mothers with negative ideas, 3 (60%) feel unresolved and 2 (40%) feel resolved; of the 10 mothers who believe it was just chance, 5 (50%) feel unresolved and 5 (50%) feel resolved; of the 9 mothers with positive ideas, 4 (44.4%) feel unresolved and 5 (55.6%) feel resolved. These data indicate that a mother's ideas about "why me" has a nonsignificant relationship with resolution (Fisher's Exact p = 1.000).
Feelings Associated with Grieving

Anger. Mothers were asked separately about feelings of anger, guilt, and failure with regard to the baby's death. Feelings of anger were most prevalent: All 24 (100%) mothers felt anger about the loss at one point and the majority of mothers, 17 (71%) still feel some anger. There are a variety of reasons that these mothers feel anger, and every mother gave several of these. But there were 2 general outstanding categories of reasons: (1) anger at the injustice of having a baby who dies and (2) anger at the circumstances surrounding the loss. All mothers, at least at some point, felt anger at the injustice of their baby dying. For instance, Bess describes her anger over the injustice of her baby's death, anger she acutely felt 8 months afterward and feels even now:

"Thanksgiving came and I was screaming mad, saying 'What do I have to be thankful for!' because I had lost David, then had a miscarriage and then I wasn't pregnant and was having trouble getting pregnant and I felt there was nothing to be thankful for- I had lost my baby and that was the cruelest thing ever. I felt so cheated that we had wanted that baby so badly and we were going to be such wonderful parents and then to have him taken away... I shouldn't have carried a baby full term and then not be able to keep him. The point is, he should be with us right now, we should all be together and he's still not with us so I think that part is always going to hurt because he'll never be with us."

Luanne expresses her feelings of Injustice by wondering why the baby who was "perfect" had to die while her other 2 surviving children were born with problems:

"He [the baby] didn't have anything wrong with him, [while] my daughter has a congenital heart problem and she just had surgery ... then my son just had surgery for craniosynostosis... so it still bothers me- why couldn't
Christopher have had all these problems since he had to die. The one that is perfect dies and the ones that aren't, you know, that's probably most of what I think about."

Many mothers feel anger about the injustice of them being the one, singled out, to have a baby that dies. These mother feel a lot of anger at pregnant women or mother with babies, particularly those who don't "deserve" to have a healthy baby. Desi, who still feels angry, also still feels the injustice:

"All these women who don't even want their babies or the ones who don't take care of their bodies can pop them out with no problem and practically no medical care. How come I couldn't do it."

Sophie, who also still feels angry, elaborates on this theme:

"I had wanted to be pregnant for, you know, it had been a conscious wish for like 10 years and if I'd see other people with babies, that was real hard. It was like how come they've got a healthy baby, or I'd see or hear about teenage moms or people that smoke and drink too much when they're pregnant and they have these perfectly healthy babies, and I had this perfectly healthy pregnancy and I ate all my proteins and my vegetables and vitamins and all that crap and Stephanie wasn't here. So it seemed real unfair."

As Sophie mentions, the resentment and envy toward pregnant women and mothers with babies was not confined to those that didn't "deserve" healthy babies. Many mothers were bothered by the sight of a pregnant woman or a baby as it reminded them of what they lost. Martina, whose anger disappeared at the birth of Robin, her subsequent child, describes her intense feelings of anger and resentment:

"I could not hold a baby. I didn't want to be around babies and anyone that had a baby, I wanted to shoot them. It was a terrible feeling. That's why I think [having] Robin has helped a lot because now I realize that I've got another one
and now other people can have babies too and it's OK, but back then it wasn't."

Elaine reports that she doesn't feel angry anymore but remembers why she couldn't tolerate seeing a relative and her newborn baby:

"My sister-in-law had had a baby and it was the third day [after my baby was stillborn] because my milk had just come in that day and I had forgotten that that was going to happen and I thought 'Oh, is this another torture thing here?' And she had called me and said she wanted to bring her baby over so I could see her baby and I remember saying 'I don't think that would be a good idea and I'll get to see your baby later.' And I remember thinking 'How could anybody do that?' but that was her way of trying to make things OK for me. That really stuck out, I was really looking at that and thinking 'Well now how did she get that baby and I don't have a baby?' And she couldn't breast feed and here I was with all this milk."

Many mothers also feel angry at a variety of circumstances which surround their loss. Mothers felt angry about what they considered to be inadequate medical care, that they were not encouraged to hold their baby at all, or didn't have more time with their baby, or receive a photograph. Typical of these mothers is Dara's expression of anger that she was not encouraged to see her baby, nor did she receive a photograph:

"I feel angry still that we didn't go up [to visit the baby]. I wish now we had... Nobody encouraged us to... We had planned to go up on the weekend and she died on Friday and it never occurred to us really to go up after she died. I'm a bit angry now that we didn't. (tears) I think my anger now is not in that it happened but now it's the things I wish I'd known to do then that I know I would do now."

More discussion of these mothers' feelings about contact with and momento of the baby will be continued in the sections on "Making
Memories" and "Feelings about the Baby".

Although these mothers' descriptions of their anger vividly illustrate how strongly that emotion touches them, there was virtually no relationship between anger and resolution. Of the 17 mothers who still feel angry, approximately half, 8 (47.15) feel unresolved and about half, 9 (52.9%) feel resolved. Similarly, of the 7 mothers who do not feel angry anymore, about half, 4 (57.1%) feel unresolved and about half, 3 (42.9%) feel resolved; the relationship between resolution and anger is nonsignificant (Fisher's Exact p = 1.000).

Guilt. Feelings of guilt, blaming themselves for the baby's death, were also prevalent: Of the 24 mothers, 21 (87.5%) felt guilty at some point; 14 (58.3%) mothers do not feel guilt anymore but 7 (29.2%) still do feel guilty. Cindy, who used to feel guilty, describes why it's so easy to feel guilt:

"It was the guilt that I have a baby inside of me, I'm the only person that could hurt or help that baby. What I consume in my body is what goes to that kid and I can't even know when something's wrong and I can't even act and get her out and take care of her. I mean, this is the inside of my body. That was the guilt. I just felt like people thought, 'Well, gosh, she was inside of you; didn't you know something was wrong? Couldn't you tell?'

Guilt is anger turned inward, and can be very destructive. Sara was asked by the doctors if she wanted to be present when they withdrew life support from her son. Her guilt involved her decision not to be there when he died:

"I failed him. I had all these hormones that were trying to be mothering and here was my big opportunity and I blew it. And everybody said, 'Well he didn't know if you were there or not.' But who knows? I felt like I really failed him...
I lived with that, for 2 years I beat myself up for that a million times over."

Sara goes on to tell how she finally worked through her guilt:

"I didn't even really deal with those feelings for probably a good year and a half. It was so painful to me that it wasn't until way towards the end of my real grieving time that I was even strong enough to cope with that. It was just admitting to myself that I had done this stupid thing—it was awful... I probably worked on it for 6 weeks where I was finally able to let myself off the hook for it. I'm able to objectively say I did the best I could in that situation. I would never do it again and a part of me still wishes I had done that."

Sara says she has worked through the guilt but she still wishes she had behaved differently, i.e., she's not totally "off the hook". She also refers to her mistake as "the stupid thing" and wishing she had "done that". She cannot say the words "held him as he died"; it is probably still too painful.

Unlike Sara, many of these women worked through their guilt by eventually turning their anger away from themselves and toward someone else, making their anger less destructive to their self-esteem. Desi describes her feelings of guilt which she managed to eventually work through by finding someone else to blame for Matthew's death:

"I felt guilty. But the only reason I blamed myself was because I was the only person who had contact with the baby so I must have been the reason why he died... I couldn't blame God because I needed Him too much to lean on so then finally after going to the [support] group I got to where I blamed the doctor and that's where I've stayed."

While none of the mothers who still feel guilty did anything to cause their baby's death, for some reason they still have nagging
feelings that there was something that they should've done differently. It is likely that losing a baby, a very stressful experience, emphasizes characteristically maladaptive ways of coping. So if a mother tends to feel guilt, she'll probably feel guilty about her baby's death. In fact Sara, who felt guilty about not being with her son when he died, describes this dynamic in herself:

"My initial reaction was of course 'What did I do? I know I must be responsible for this and what could it have been?' So I felt real guilty but I didn't know quite how to focus that guilt because I didn't know what I had done. I had a wonderful pediatrician who actually called me a month and a half later to make sure that I wasn't feeling guilty. And the neonatologist and obstetrician kept laying facts in front of me and saying, 'There is no way that you were responsible for this, you couldn't be responsible.' Yeah, they helped me through that. But the one thing I could hook on to, I did, I found the one real good one and nobody could take that away!"

And so, not able to feel guilty about why he died, Sara felt guilty about not being there with her son when he died.

However, feelings of guilt do not discriminate between unresolved and resolved mothers. Of the 24 mothers, the 3 who never felt guilt, 1 feels unresolved and 2 feel resolved; of the 14 who used to feel guilt, 8 feel unresolved and slightly less, 6, feel resolved; but of the 7 mothers who still feel guilt, 3 feel unresolved while 4 feel resolved. This relationship between resolution and guilt was nonsignificant (Fisher's Exact p = .7335).

Failure. Feelings of failure were not as prevalent as anger and guilt, but still, the majority of mothers, 17 (70.8%) felt failure at some point. Nine (37.5%) mothers do not feel failure anymore but 8
(33.3%) still do. Kelly describes how having a baby die can affect feelings of competence:

"I didn't feel I was a good mother, a good person, because I couldn't do this one thing right."

It's not surprising then that having another baby helped to make some mothers feel more competent, not failures. Erin illustrates this phenomenon with her remark:

"I felt failure as a child bearer but I got over that when I had a healthy little beautiful boy."

Even for Dara who lost a baby girl to a genetic anomaly which had a 25% recurrence rate, having a healthy son, and then 2 more healthy daughters vanquished her feelings of failure. She describes how she felt at their births:

"Excited, relieved, reassured that we could have a healthy baby was a big thing. With Laura, relief was the greatest, being able to have a normal female."

But some mothers are not even reassured by having a subsequent child who lives. As Bryn says, part of the need to have another baby is "I had to do it and do it right, by God!" However, although Bryn has a healthy 3 year old daughter, she still feels a sense of failure, and vulnerable to another perinatal loss:

"I'd always planned that I'd have 2 kids and now that she's gotten older I feel that I've had my 2 kids. I guess there's a part of me that says 'what happens if it happens again?' That's scary to me."

Other mothers still have feelings of failure because besides the perinatal loss, they have had other losses or complicated pregnancies.
Following Nicole's death, Cindy had a healthy daughter after holding off premature labor for 6 weeks and then her next pregnancy ended in miscarriage, "another failure". She says:

"About having babies, I feel like I'm not a pro, let me tell you! The thought of having another baby, trying again scares the hell out of me. Because of not just Nicole, but of all the things since. So I guess I do feel like I'm not the best baby producer."

For Anya, even having a twin survive and then having a healthy son after Rachel died did not quell her feelings of failure:

"Horrible feelings of failure— that I couldn't carry a pregnancy to term, that I couldn't keep 2 babies alive, that my body had bailed out on me. I had tried to do all the things you're supposed to do and it hadn't worked. My next pregnancy went fine but it was a one-baby kind of thing."

Thus it seems that Anya's sense of failure could only be overcome if she could carry twins to term.

Since Luanne's son Christopher died, she has given birth to 2 surviving children, a daughter with a congenital heart defect, and a son with a congenital skull defect. She describes her feelings of failure, feelings she understandably still has:

"Sometimes I really felt a lot of failure because both my kids have problems and so you know, you just feel like you haven't done anything right. I felt like I couldn't make a baby right!"

Surprisingly, of the 5 mothers who are infertile, or have had multiple perinatal losses, none still have feelings of failure, perhaps because their seemingly futile hopes for bearing a child have finally been realized. Even 7 of the 11 mothers who have had
miscarriages do not still feel like failures. In addition to Bryn, Cindy, Anya, and Luanne mentioned above, Holly and Hannah have had miscarriages which adds to their doubts about their reproductive success, Sara's feelings of failure go back to having failed her son by not being there when they disconnected life support, and Rose has a blood clotting disease which makes her feel like her body has "betrayed" her. Thus, the mothers who still feel failure don't all share similar reasons for feeling this way. Just as some mothers are prone to anger or guilt, similarly, for their own reasons, some mothers are more prone to feeling failure than other mothers.

Like anger and guilt, failure was not related to resolution. Of the 7 mothers who never felt failure, the majority, 5 (71%) mothers feel resolved while only 2 feel unresolved. Then for the 9 mothers who used to feel failure, there is a trend toward more mothers feeling unresolved: the minority, 2 (22%) feel resolved while the majority, 7 (78%) feel unresolved. However, for the 8 mothers who still feel failure, this trend is reversed and these mothers are not much different from mothers who never felt failure: the majority, 5 (62%) feel resolved while only 3 feel unresolved. In any case, this relationship between resolution and feelings of failure was nonsignificant (Fisher's Exact p = .1507).

The feelings of anger, guilt, and failure are not related to resolution perhaps because these emotions play an important role in making these mothers feel like they still have control over events in their lives. Feelings of anger, guilt, and failure are a result of
believing we have control and responsibility over what happens in our lives. If we did not feel control, we would not feel responsible or guilty or anger towards bad things that happen; we would feel helpless. For most of these women, feeling guilt, failure or anger may be better than feeling helpless, out of control. To give up those feelings could mean giving up control. Thus, holding on to these feelings of anger, guilt, and failure can be adaptive and does not preclude resolution, accepting the loss and moving on with life.

In summary, all of the above resolution indicators had virtually no relationship to maternal self-report of resolution. These resolution indicators could not discriminate between resolved and unresolved mothers. Thus, how these mothers think and feel about these issues concerning resolution plays practically no role in their perceptions of their own resolution. However, in bold contrast to all of these nonsignificant relationships is the significant relationship between self-perception of resolution and how the mothers feel nowadays about the baby and the baby's death. Thus, among the resolution indicators contained in the PLI, for these mothers, feelings about the baby are the most valid discriminator between mothers who feel resolved and mothers who feel unresolved.

Feelings about the baby

Mothers were asked how they feel nowadays when they think about the baby and the baby's death. According to their answers, mothers were categorized into 4 different groups: neutral, bittersweet, sad, and
angry. Mothers who describe feeling an absence of emotion were classified as feeling "neutral". Mothers who describe feeling sad on the one hand but positive, happy, or peaceful on the other were classified as feeling "bittersweet" (see Kowalski, 1984; Peppers and Knapp, 1980). Mothers who expressed sadness or longing, without mentioning positive or angry feelings, were classified as sad. Mothers who expressed any anger in response to the above question were classified as angry. It is also important to point out that many of the mothers expressed many different feelings about various issues surrounding their baby and their baby's death. Mothers were coded for feelings about the baby only with regard to their answer to this direct questioning about the baby and the baby's death. This direct questioning gave mothers a chance to characterize their own perception of their salient feelings about their baby who died. The following are statements made by mothers which typify each of the 4 classifications of feelings about the baby.

Anger is expressed by Erin:

"I feel angry that she didn't live, like with modern medicine, why didn't she live? ...I really wanted 3 children and my first one, if she'd lived, I'd have 3 children because I felt like by the time Wendy came along I was too old to continue. So sometimes I'm a little resentful to Barbie for doing this to me. It wasn't very fair of her."

Sadness is expressed by Hannah:

"I just think it's always going to be sad. Having a baby die is just never going to change into a happy experience. And I can't put it into, 'well, it means something or other and it was meant to be'- that just doesn't fit for me. So when I think about it, it's always going to be sad."
Bittersweet feelings are expressed by Jessie:

"I feel like I'll always be changed and I'll always remember her and be sad that she's not living with us but happy that we had her for a while and had the experience."

Neutral feelings are expressed by Bryn:

"There are times that I'll never forget him but there are also times when I am totally free of any memories."

Of the 24 mothers, 4 feel angry when thinking about the baby and the baby's death and all 4 of these mothers also report feeling unresolved. Of the 5 mothers who were classified as feeling sad, 4 of these mothers report feeling unresolved, while only 1 feels resolved. Thus, 8 out of 9 mothers with the negative feelings of anger or sadness associated with the baby also feel unresolved. Of the 11 mothers who feel bittersweet, 4 still feel unresolved, but the majority, 7, feel resolved. And all 4 of the mothers who report neutral feelings also report that they feel resolved. Thus, the trend for mothers with the more positive feelings (bittersweet or neutral) is that they are more likely to feel resolved than mothers with the more negative feelings (angry or sad). This relationship between resolution and feelings about the baby is highly significant (Fisher's Exact p = .0113).

In summary, with one exception, the resolution indicators assessed by the Perinatal Loss Interview are not valid indicators of resolution as perceived by the mother. In general, frequency of thoughts about the baby, anniversary reactions, emotional responses, optimism for the future, and gaining perspective on the loss do not
discriminate between mothers who report feeling resolved and mothers who report feeling unresolved. In fact, resolved and unresolved mothers were practically equally represented in various levels of these indicators. The only resolution indicator which discriminated between resolved and unresolved mothers was the mother's feelings when thinking about the baby and the baby's death. This relationship was highly significant, quite a contrast from the relationships between resolution and the other indicators.

There are several possible reasons for the lack of relationship between maternal self-report of resolution and these resolution indicators which are fairly widely accepted indicators of resolution of grief. (1) Perhaps the mothers' self report of their resolution is not valid. However, this is unlikely because of the consistent descriptions of resolved feelings among mothers who feel resolved and consistent descriptions of unresolved feelings among mothers who feel unresolved. In addition, these descriptions of resolved feelings were distinctly different from descriptions of unresolved feelings. (2) Perhaps none of these mothers are truly resolved, and so the indicators could not be expected to discriminate between the "resolved" and "unresolved" mothers. However, this is unlikely again because of the consistency among the 2 groups of mothers in their descriptions of their resolved and unresolved feelings. (3) Perhaps the mothers' self report of their feelings and behaviors with regard to the resolution indicators is invalid. However, then one would have to assume the self-report of resolution to be equally invalid, and
again, the resolved and unresolved mothers were so consistent within the 2 groups and so different between the 2 groups, that this possibility seems unlikely. Just as the mothers appear to be valid reporters of their feelings of resolution, it may be assumed that they are valid reporters of their feelings and behaviors with regard to resolution indicators.

The most likely explanation for the lack of relationship between resolution and resolution indicators may lie in the possibility that grief resolution over the death of a newborn is different than grief resolution for other losses. The difference could be a result of the differences in the grieving process this kind of loss and other losses. Reasons for differences in the grieving process include (a) the unexpected, untimely nature of perinatal death, (b) the lack of mourning rituals, (c) the lack of social support, (d) the lack of acknowledgment by others of the baby's existence, much less the loss, (e) the lack of memories with and of the baby, and (f) the fact that the mother never really got to know her baby as an individual, separate from her idealized notions of the potential of this child. If the grieving process is unique, then it seems likely that grief resolution over the death of a newborn would also be unique. And what these data indicate is that the traditional indicators of grief resolution are invalid when used to determine resolution over perinatal loss. These data indicate that the only indicator of resolution which coincides with self-perception of resolution is how the mother feels when she thinks about her baby and the baby's death.
Because this variable has such a strong relationship with resolution, "feelings about the baby" will be discussed later in terms of differences between resolved and unresolved mothers who feel angry, sad, bittersweet, or neutral. But first the discussion turns to a variable which mediates the relationship between resolution and feelings about the baby: the passage of time.

Resolution and the Passage of Time

Time is another variable considered for analysis of its relationship with resolution. The number of months since the mothers' perinatal loss was calculated in months from the loss to the interview. For Peg and Meryl who have had multiple perinatal losses, the number of months since their most recent perinatal loss was calculated. Mothers ranged from 13 to 119 months since the loss. The frequency distribution of months since the loss lent itself to dividing the mothers into 3 nearly equal clusters with gaps of 9 and 11 months between them: 7 mothers experienced their loss 13 to 32 months ago (mean = 23 months; sd = 7.1 months), 9 mothers 41 to 60 months ago (mean = 50 months; sd = 6.9 months), and 8 mothers 71 to 119 months ago (mean = 83 months; sd = 15.9 months).

Of the 7 mothers whose babies died 13 to 32 months ago, the 1-3 year post-loss mothers, 6 (85.7%) report that they are still unresolved, while only 1 (14.3%) reports that she is resolved (her
baby died 22 months ago). In contrast, of the 9 mothers whose babies died 41 to 60 months ago, the 3-5 year post-loss mothers, only 2 (22.2%) mothers report that they still feel unresolved while the majority, 7 (77.8%), report that they feel their grief is resolved. In yet another contrast, of the 8 mothers whose babies died 71 to 119 months ago, the 6-10 year post-loss mothers, 4 (50%) feel unresolved and 4 (50%) feel resolved. For the contrast between mothers whose babies died 1-3 years ago (only 1 out of 7 report resolution) and mothers whose babies died 3-5 years ago (7 out of 9 report resolution), it might be speculated that feelings of grief resolution develop with time. However, in this sample, for the mothers who have had the most time, 6-10 years since their loss, only half feel resolved at this time. This relationship between resolution and time since loss was significant (Fisher's Exact p = .0506). Thus, further exploration of the variables related to time or resolution is necessary to discover what else discriminates between resolved and unresolved mothers in the 3 different "time since loss" groups.

Because time since the loss and feelings about the baby are both related to resolution, the relationship between these 2 variables was explored. When thinking about the baby and the baby's death, of the 7 mothers whose loss occurred 1-3 years ago, 1 (14.3%) feels anger, 1 (14.3%) feels sad, the majority, 4 (57.1%), feel bittersweet, and 1 (14.3%) feels neutral. Similarly, of the 9 mothers whose loss occurred 3-5 years ago, none feel anger, 2 (22.2%) feel sad, the majority, 5 (55.6%), feel bittersweet, and 2 (22.2%) feel neutral.
Thus, in both of these 2 groups, the majority of mothers, 71.4% and 77.8% respectively, feel relatively positive feelings, bittersweet and neutral.

In contrast, for the mothers whose loss occurred 6-10 years ago, the majority, 5 (62.5%), feel relatively negative feelings, angry and sad: 3 (37.5%) feel anger, 2 (25%) feel sad, but only 2 (25%) feel bittersweet, and only 1 (12%) feels neutral. Thus, distribution of feelings among the 1-3 and 3-5 years post-loss mothers is the most similar with a majority of the mothers feeling bittersweet and neutral. Meanwhile in the 6-10 years post-loss mothers, a majority of the mothers feel anger and sadness rather than the less negative feelings of bittersweet or neutral. Although, it appears that as a group, the 6-10 year post-loss mothers feel differently than the mothers with the more recent losses, feelings about the baby and time since the loss are not significantly related (Fisher's Exact p = .6117). Thus, time since the loss and feelings about the baby are essentially related to resolution independently.

However, by looking at the relationship between resolution and feelings concerning the baby and controlling for time since the loss, the relationship between these 3 variables becomes quite meaningful. The relationship between resolution and feelings about the baby is similar among both 1-3 years and 3-5 years post-loss mothers in a couple of ways. First, in both groups, all the mothers who feel sad or angry also feel unresolved, and secondly, all the mothers who feel neutral also feel resolved. Indeed, the only 1-3 year post-loss
mother who reports resolution is Kitty, who is also the only 1-3 year post-loss mother who reports feeling neutral about the baby and the baby's death. However, there is an important difference between mothers whose loss occurred 1-3 and 3-5 years ago: All the 1-3 years post-loss mothers who feel bittersweet also feel unresolved while in the 3-5 year group, all the mothers who feel bittersweet, feel resolved. The 6-10 years post-loss mothers seemed unusual in that the minority, 3 (37.5%), feel bittersweet or neutral. But similar to 3-5 years post-loss mothers, these 3 mothers who feel bittersweet or neutral also feel resolved. Furthermore, all but one of the angry or sad mothers also feels unresolved which is consistent with the 1-3 and 3-5 years post-loss mothers. Anya, the exception, feels sad but resolved. Thus, it appears that with time, feeling bittersweet leads to resolution. And with one exception, In spite of the passage of time, feeling sad or angry coincides with feeling unresolved.

To summarize, regardless of time since the loss, all mothers who feel neutral also feel resolved, and except for Anya, all mothers who feel angry or sad feel unresolved. Of the mothers with the most recent losses, 1-3 years ago, all 4 mothers who feel bittersweet also feel unresolved. In contrast, of the 3-5 years post-loss mothers, all the mothers feeling bittersweet report feeling resolved. These results imply that perhaps it takes the passage of time in addition to bittersweet feelings to feel resolved. Consistent with this premise, 6-10 years post-loss mothers who feel bittersweet also feel resolved. But the passage of time has its limits in facilitating resolution.
Instead of the group of mothers with the most distant losses containing the biggest majority of resolved mothers, only half of the 6-10 years post-loss mothers feel resolved. The lack of resolution displayed by this group of mothers appears to be related to how they feel about the baby's death: 2 of these 8 mothers feel sad; 3 of the 8 feel angry. In fact, this group of mothers contains the largest percentage of angry mothers: 37.5% of the 6-10 years post-loss mothers feel angry as opposed to only 1 (14.3%) of the 1-3 years post-loss mothers and 0 (0%) of the 3-5 years post-loss mothers.

One conclusion that can be drawn from these results is that both the passage of time and feelings about the baby's death play a part in a mother's feelings of resolution. If a mother feels neutral, she does not feel (or acknowledge) painful feelings of grief. Then regardless of the passage of time, the neutral mother can feel resolved. If a mother feels bittersweet, her feelings of grief may be still too painful to feel resolved within 3 years of her loss. With time, feelings of grief may become less painful, allowing the mother to feel resolved. Thus, in addition to bittersweet feelings, the passage of time is also necessary, in order to feel resolved. But, even with the passage of time, it appears that those mothers who still harbor the painful feelings of anger and sadness still feel unresolved.

The only mother who still feels sad yet resolved was Anya, a mother in the 6-10 years post-loss group. Either her resolution in spite of sadness indicates that with time, even feeling sad does not
preclude resolution, or her resolution is independent of her sadness because of the uniqueness of her situation: Anya is the only mother in this sample with a surviving twin. Perhaps having Kim, the surviving twin, is a constant reminder of Rachel, the baby who died; this reminder may play a role in her continuing sadness. Another important factor may be that when Rachel died, not only did Anya lose a baby, but she also lost the chance to raise twins. Perhaps this additional loss keeps her sad. She says,

"It's real hard because I've never stopped to really count but I'm sure it's at least 2 or 3 times a week I'll look at Kim and imagine Rachel. Sometimes we'll be driving in the car to go to the zoo or something and I'll think that I should have 4 kids in the car instead of 3. I grieved for Rachel as a separate person and also for the idea of having twins, that [idea] was important to me."

Interestingly, Peg, the other mother who had twins but lost both babies, has very similar sentiment about losing twins. Peg also feels sad and at 45 months post-loss, feels unresolved. If losing twins is a loss that can keep a mother like Anya sad, then maybe in another couple of years, like Anya, Peg will also still feel sad, but resolved. But in a couple years, Peg may be able to feel bittersweet, not sad, because she does not have a surviving twin. Anya has a surviving twin who constantly reminds her of the baby who died, a reminder that may keep her sad in spite of feeling resolved.

The relationship between resolution and feelings about the baby and passage of time is evident for these mothers. Even Anya's exceptional situation makes sense. However, why are the mothers who lost the baby more than 6 years ago still so angry and sad and
unresolved. There are a number of possibilities. It is possible that more than 6 years ago hospital based interventions did not exist, interventions such as providing contact with the infant and taking photographs, or even encouraging the mothers to make their own arrangements to bury their infants and have memorial services.

Another explanation could be that the 6-10 years post-loss mothers are a unrepresentative sample of mothers whose baby died that long ago. Mothers who have lost a baby that long ago but who are still willing to spend the time and energy to talk about the experience may be unusual in that they are still unresolved, still grieving. Maybe the majority of mothers who feel resolved would not come in to be interviewed, feeling that the loss happened so long ago that it was not important to come in and talk. However, the response of the 4 resolved 6-10 years post-loss mothers who were interviewed indicated that they still felt it was important to be interviewed to help other mothers who experience perinatal loss. Is it possible that after 6-10 years, these sad, angry, unresolved mothers may never feel resolved? Or will it take several more years for them to finally work through their anger and sadness and be able to feel resolved?

This hypothesis that the events and experiences surrounding the loss, eg., contact with the infant or receiving a photograph, can have long term effects on the mother's feelings of resolution is worth some consideration. Thus, the following is a discussion of the events surrounding the loss which mothers reported as profoundly affecting their experience of perinatal loss. There are 2 major questions to
consider: (1) How do these experiences and events affect the mother's memories and emotions associated with her loss? and (2) Are these experiences and events related to the mother's feelings of resolution?
Mothers were asked to describe the events surrounding the loss, including their satisfaction with their experiences. According to the criteria used to select questions for data analysis, 2 experiences associated with the perinatal loss were chosen for examination: (1) contact with the baby and (2) mementos of the baby. These 2 variables were chosen because (a) mothers had varied experiences, (b) as discussed earlier, encouraging contact with the baby and providing a photograph and other mementos are hospital interventions which may facilitate grieving, and (c) the mothers talked at length and with much emotion about contact with the baby and their collection of mementos.

It became apparent from talking to these mothers that contact with the baby and collecting mementos could be meaningfully considered together as 'making memories'. When a baby dies around the time of birth, the mother is not left with many memories of the baby who died. Having contact with the baby and receiving a photograph are 2 very important ways that mothers have of collecting memories of the baby, memories that may help them grieve their loss more easily.

Because the mothers reported that they were more affected by how they feel about their contact and mementos, rather than simply the kind of contact or mementos received, mother satisfaction will be
emphasized with regard to these 2 variables. Thus, in order to examine the role these variables play in grief resolution, the mothers' satisfaction with regard to these 2 variables was correlated with self-report of resolution.

Contact with the Baby

Of the 24 mothers, 15 (62.5%) mothers held the baby, 2 (8.3%) mothers saw and touched the baby, and 7 (29.2%) mothers did not see the baby more than fleetingly at delivery. Interestingly, satisfaction with contact is not related to the type of contact the mother had. Of the 15 mothers who held the baby, barely half, 8 (53.3%) feel satisfied, 3 (20%) feel mixed, and 4 (26.7%) feel dissatisfied. Of the 2 mothers who saw and touched the baby, 1 (50%) feels satisfied while the other (50%) feels dissatisfied. Likewise, of the 7 mothers who did not see the baby more than fleetingly at delivery, 3 (42.9%) feel satisfied, 3 (42.9%) feel dissatisfied, and 1 (14.3%) feels mixed. Thus, across all 3 kinds of contact, about half of the mothers feel satisfied while the other half feel some dissatisfaction; this relationship between type of contact and satisfaction is nonsignificant (Fisher's Exact p = .9435). Because of this nonsignificant relationship, the type of contact does not indicate satisfaction a mother feels about her contact with her baby. Thus, it is especially important to focus on satisfaction with contact, rather than type of contact, as this will indicate the
emotional significance of contact with the baby.

Seven mothers had no contact with the baby or only saw the baby fleetingly at birth. Of these 7 mothers, 3 felt satisfied with this contact. Jane, one of the 3 mothers who feels satisfied with no contact says,

"The doctor asked me if I wanted to look at the baby after I delivered it and I did not want to see the baby— I was afraid that I would see that picture of that baby for the rest of my life and I didn't know if I could handle it."

But these 3 mothers who report being satisfied with no contact nevertheless have a curiosity about the baby. Jane admits later, "... but there are times when I wish I had, just out of curiosity."

Similarly, Elaine gratuitously denies any curiosity:

"I didn't really want to [see the baby]. And I'm not really sorry that I didn't. It doesn't bother me at all, I'm not curious about, 'Gee, I wonder what she'd look like' or 'was she mutilated' or any of that."

Luanne, the third mother satisfied with no contact was afraid she'd "have nightmares or something" but she does have a photograph of the baby so she is able to know what the baby looked like.

Peg, the mother who has mixed feelings about her fleeting contact with her twins also is glad she knows what they looked like but tries to rationalize why it's good she did not see them more than fleetingly at delivery:

"They did offer later if I wanted to see them again and I did in a way but my husband didn't, he was just like 'enough is enough and I don't want to have to deal with that again.' But because it was all blurry when I was in the delivery room, I wanted to. It probably wouldn't have helped now that I think about it... if I had it more fixed in my mind
then I might think about it more than I do."

It could be argued that if she had seen them again, she might think about it less than she does. Seeing them might have helped her to have a less blurry memory of them and lay to rest her curiosity.

All 3 mothers who are dissatisfied with no contact readily admit that they are curious and wish that they could have a memory of what their baby looked like; all 3 of these mothers also did not receive a photograph of the baby. When asked about contact, photograph, and how she feels about her baby, Dara tearfully mentioned her curiosity each time. Holly's baby was delivered by cesarean section and the only time she saw the baby was while she was recovering from the anesthetic. She tearfully describes her feelings about not remembering:

"I knew that I wanted to see her and they wouldn't have shown her to me otherwise because they weren't that smart at this particular hospital. So when I came out [from under anesthetic] I said I want to see the baby and I was really out of it and I was really in a lot of pain and drugged but the doctor brought her into the recovery room and ummm (tears)... I touched her but I couldn't really move or anything because I was in so much pain and I was out of it and one of the things that's real frustrating to me is that I can't remember her because I was so out of it."

Desi was not offered her baby and she is still obsessed with wondering what he looked like:

"I still wonder what he looked like. Every once in a while I think about what's happening in the grave and I don't know why I do that. I guess I just wonder what it would be like to look at him now. I think I'm just obsessed. I needed to see him."
Desl's obsession also expresses itself in a recurring nightmare she's had about the baby, "what he was like in the grave and digging him up and things like that."

Besides satisfying curiosity about their baby, giving them a chance to "know" the baby, contact with the baby also helps make the baby seem more real. Desl's father saw the baby, which "means a lot" to Desl as "it acknowledges that Matthew was real. For Luanne, the only mother with no contact who does have a photograph, she reports that "Having a picture of him makes it like it really happened..." On the other hand, Elaine illustrates how easy it can be to not recognize that it was a baby that died. While she refused to see her baby, her husband wanted to and did. Elaine then describes the differences in their perspectives:

"It's more of an experience than it was a real person, that I really had a baby. I wasn't in touch with the fact that I had a baby. The process wasn't over with. It's like baking a cake in that it wasn't ready to be pulled out of the oven so you never got to eat the cake. My husband viewed it a lot different than I did. He was pretty much in touch with the fact that he had a baby and he lost the baby."

Similarly, Jane talks about her baby boy as "it" and "the miscarriage". Jane and Elaine, neither of whom saw the baby or received a photograph and are satisfied with that, have similar styles of coping with their loss. Neither of them named the baby, both had the hospital dispose of the body and had no funeral. In short, neither of them truly acknowledged that they lost a baby. However, these two mothers differ in that Jane is able to acknowledge her sadness and that her loss has affected how she feels about her
surviving children, while Elaine claims that the loss has not affected her feelings, her subsequent pregnancy, or subsequent child. We will see later that she has had problems which can be traced back to the loss.

Two of the mothers, Lynn and Meryl, were not able to hold their babies but they saw and touched them. Meryl was very satisfied by her experience because it assured her, as it assures many mothers, that the baby looks like a normal baby:

"After he was born they brought him up to the bed, my husband was with me, and we sat and looked at him and touched, I was glad. That was really the best thing that could've happened. I think I thought he was probably a monster, that he was deformed, that there was something wrong with him—[instead] he was a beautiful baby."

Besides being reassured that the baby is normal, mothers in this sample also pointed out that seeing the baby also helps make the baby seem real, allowing the mother "get to know" the baby and giving her memories of her baby. And seeing the baby satisfies curiosity about simply what the baby looked like, a benefit particularly yearned for by the mothers who did not see their baby. Meryl also recognizes these benefits:

"I'm really glad. I think it also helped to ease the sorrow, to have been able to see him. Just because it filled in all those areas that where I could have wondered what went on or what he looked like or what he would be. Just seeing him gave him so to speak a personality, a real concrete substance."

However, just touching her baby was not enough to make Lynn feel satisfied. Her baby, Stephen was born prematurely at 25 weeks and
lived for 5 hours hooked up to life support systems. Because of the tubes and wires connected to his little body, she was unable to hold him and when they decided to withdraw life support, her husband discouraged her from being there. Lynn tearfully describes both the importance of being able to touch her baby and the regret that she couldn't do more:

"There wasn't much to hug because there were all these things coming out of him. So I just kind of hugged him as he lay there on the bed and I told him again how much I loved him....life support was taken off him and we let him go for it. Looking back on it, I wish I had [held him as he died]. But at the time, I think that Jeff was trying to protect me because he knew how much I wanted that baby so when he approached me about it, he said, 'You don't want to hold little Stephen now, do you?' And I went 'No.' The doctors thought I should and Jeff thought I shouldn't so I deferred to his judgment. I was a little mouse. Looking back on it I wish that I had cuddled him close. Hugging him [in his Incubator] isn't quite the same. I wish I could've held him the whole time. He was so beautiful."

Of the 15 mothers who were able to hold their babies, for 8 mothers it was a very satisfying experience but for 7, nearly half of these mothers, holding the baby was dissatisfying for a variety of reasons, all revolving around the fact that these mothers wish they could have held the baby for a longer time.

Sara, Kelly, and Bess all have good things to say about their experience holding their baby, but all 3 wish that they could have had more time with the baby. Sara regrets that she did not hold her baby as he died but is eternally grateful that she had 3 days with him. Kelly talks about how valuable holding the baby is and then later talks about her resentment that she couldn't be with him more as she
was recovering from general anesthetic for an emergency cesarean section. She says:

"Oh, I recommend [holding the baby] for anyone...It makes it real, he's really yours, and he was there.... I just felt I wanted to be with him more and I was unable to.... That's what bothers me most about it, not being able to spend a little bit more time with him. I can accept his death a lot better than that, than not being able to be with him for such short hours as it was."

Like so many of these mothers, Kelly expresses the longing she feels for not having been able to be with her baby as much as she could have.

Bess tearfully and touchingly describes her experience holding her baby and how her dissatisfaction lies in not doing more while she held him:

"I remember when they brought him back in, my husband was standing there at the bed and I was lying in the bed and the nurse walked in the door with the baby all wrapped up as a newborn and I remember thinking the short distance from the door to me, what was she going to do? Was she going to put him in my arms, was she going to lay him on the bed, what was she going to do? And very naturally she walked in, didn't say a word, and handed me the baby and left...(tears) We immediately started to cry very very hard and I took his little hand and held it around my finger the way you do any baby and I just held him like that and kept looking at him...(tears) And then my husband leaned down and kissed him on the forehead and later when we talked about it I said, 'You kissed him', and I said 'I didn't kiss him", and he said 'Yeah, you held his hand and I didn't hold his hand.' And we both looked back at what the other had done and that was what we did but we regretted that we hadn't done the other."

The remaining 4 mothers who feel dissatisfied with holding the baby barely got anything positive out of the experience. Kara's baby was delivered and placed in her arms when the nurse noticed he was
having seizures. She reports,

"When he was born they handed him to me and said 'Oh, this looks like a healthy little baby boy.' And he was beautiful. But the nurse picked up right away that he was having seizures so Nick got to cut his cord and they took him... So that was the only time that I got to hold him while he was alive and it just seemed like it was only a second."

Then later, after Matthew died, Kara and Nick were given some time to spend with him but that did not work out well for Kara:

"I don't know how long Nick and I had spent with the baby but in the meantime there were people that kept coming in and interrupting us and it bugged me, Nick, myself, and the baby, that's all I wanted, to be alone... I just kept feeling interrupted. And then finally my mother-in-law was saying 'Well, you know, you need to let go, the longer you hold onto him, the harder it is to give him up.' But I could've held onto him longer, I wanted to hold onto him longer."

Bryn and Liza describe being in a state of shock, and not being able to meaningfully hold the baby, say goodbye and remember the moment. Bryn says,

"I still feel kind of cheated because I was in such a state of shock that I was doing these things because I knew [I needed to] so I remember looking at the baby- I cannot remember what he looked like and I remember asking them to go ahead and take him away because I was afraid I was going to get crazy and go 'No you can't have my baby!', or where you think it's alive or something. I was just afraid that maybe I was going to be kind of weird. I don't think I would've gotten that way but you just don't know what you're doing... I wish they would've [offered him to us again] because I really wanted to be more under control and know what was going on."

Liza being in shock when she was with her baby has been detrimental to her dealing with the reality of her baby's death:
"... sometimes I feel like he didn't die, that somehow someone else had become attached to him and they realized it was going to be hard [to separate them] and I know that this isn't true. It's a little fantasy that kept me going. So every once in a while I have that feeling that this is so unreal that that's what really happened, is that someone else took him. Sounds kind of unhealthy, I'm sure."

Bryn and Liza as well as mothers like Holly, Desi, and Kelly who were recuperating from general anesthetic, are testimony to the fact that mothers need to spend time with their babies when they are of sound mind, i.e. after the shock or the anesthetic or painkillers wear off, so that they can spend meaningful time with the baby.

Rose tells a story similar to Lynn's and Peg's, even Kara's, that of being persuaded by her husband (or anyone) not to spend more time with the baby. She says,

"I just wanted to spend the time with the baby, this was the first day I'd had with her and he was just so insistent and at that time I just wasn't as confident, I wasn't the kind of person that would say 'I'm staying, you can go home if you want to!' I wasn't that person then, I was a lot younger, dumber, less confident. So now I have all these things I should have done, to spend any second that I could with her... Sometimes I get a real panicked feeling, like 'I've got to spend [time with her]... why didn't I do that?"

Rose, like many of these mothers, is still kicking herself for not spending more time with the baby. In fact, although different mothers feel angry about different things, anger is related to how the mothers feel about their contact with the baby. All 8 mothers who feel dissatisfied with contact with their baby also still feel angry, 3 out of the 4 mothers who feel mixed about the contact still feel angry, while of only half, 6 of 12 mothers who feel satisfied with the
contact still feel angry. This relationship between anger and satisfaction with contact is significant (Fisher's Exact p = .0513).

The fact that these mothers regret that they allowed someone else to persuade them not to spend time with the baby illustrates 2 things: (1) that having a baby die is a very confusing, stressful time and it's hard to make good decisions, and (2) often these mothers don't have the strength or foresight to realize that they need to listen to their own hearts and spend time with the baby regardless of what anyone else thinks or says. So, part of the intervention of giving the mother time to spend with the baby needs to include the awareness of these 2 issues. Perhaps hospital staff should take the time to educate the mother on how she can spend as much time with her baby as she is comfortable with and to ask her if she wants to be alone or who she would like to have with her and when. And tell her that she can request to see the baby again if she wishes, and of course make sure the baby is available for several days.

Finally, one third of the 24 mothers in this sample both held their baby and feel satisfied with their experience. All 8 of these mothers feel that it was a valuable experience, as Meryl described earlier, helping them to realize the baby was real, that the baby was not a monster, to give them a chance to say goodbye. Hannah elaborates:

"[It helped] probably because we sort of knew her for a long time [9 months] and that she was there and she was really a real little baby and a real little person. That helped with that, rather than just, she's gone and there's nothing to it, just like there was not anyone there. There really was. (tears)...I think when I was going through nursing school,
the attitude was more, just don't let the mother see the baby... and that's just the opposite of what you need, it really is. That's just like saying to you, 'Well, it just didn't happen, you didn't have that baby inside you for 9 months and just forget about it.'

For some of the mothers, seeing the baby helped them to grasp the reality that their baby was dead. As Liza was in shock when she was with her baby holds on to the fantasy that her baby is still alive somewhere, Martina describes how seeing her baby helped her to realize he was dead:

"It helped a lot to be able to see him and hold him and know that they didn't take ours and give it to someone else and give us a dead baby. It helped to know that it was ours."

Although dissatisfied, Rose agrees:

"If I hadn't seen her, definitely her, with the band [on her wrist] that said 'Jessica', dead, I don't think I could've settled it in my mind that she was really dead."

The chance to express love to the baby in a physical way is also very important, as evidenced by comments such as Lynn's about wanting to cuddle her baby close, Bess regretting that she had not kissed her son, and Erin tearfully wishing that she could have put her baby in a little dress, "so she could've felt my touch somehow." In fact, Anya reports that "because I had gotten to hold her and everything", she was able to feel more attached to Rachel, the dead twin than Kim, the surviving twin who was in the NICU. Although after 4 days, Anya was finally able to see Kim and feel attached to her too, it has been important for her to be able to think about Rachel and have memories of her. She says those first 4 days were rough, though, "dividing my
time between thinking about Rachel and worrying about Kim." And of course, because the mother can feel attached to her baby during the pregnancy, she can look forward to holding her baby, even though the baby is dead. Jessie talks about her experience with these feelings:

"I wanted to hold her and see her and I was really excited about seeing her because I had imagined for so many months what she would look like. She looked a lot like her father. They had estimated that she'd been dead for 2 days so there were some areas on her face where her skin was torn and that was upsetting to me— I wanted her to be perfect. I remember exactly what she looked like."

Of the 8 mothers who feel dissatisfied with their contact with the baby, 4 (50%) feel unresolved and 4 (50%) feel resolved. Of the 4 mothers with mixed feelings, the majority, 3 (75%) feel unresolved while only 1 (25%) feels resolved. But of the 12 mothers who feel satisfied with their contact with the baby, only a slight majority, 7 (58.3%) feel resolved and 5 (41.7%) feel unresolved. Thus, satisfaction with contact is not significantly related to resolution (Fisher's Exact p = .6597). Although resolution is not related to satisfaction with contact, the mothers' descriptions of their experiences and feelings about contact with the baby definitely indicate that satisfying contact is very important to these mothers. Satisfying contact gives them memories of the baby which they can cherish. Perhaps mothers who are satisfied with contact with the baby are facilitated in their grieving, such that they reach resolution faster or more easily than mothers who are dissatisfied with their contact. But since there is no measure of precisely when or how easily the mothers felt resolved, this idea cannot be tested.
It is worth noting however that mothers with the most recent losses, i.e., 1-3 years ago, 6 out of 7 feel unresolved, and 3 (50%) of these 6 are satisfied with contact and 3 (50%) are not. Thus, mothers with recent losses tend to feel unresolved regardless of satisfaction with contact. Of the 9 mothers whose baby died 3-5 years ago, 7 out of 9 feel resolved; but again, about half of these mothers, 3 (42.9%) feel satisfied and about half, 4 (57.1%) feel dissatisfied with contact. And of the 2 unresolved mothers, 1 (50%) feels satisfied but the other (50%) feels dissatisfied about contact with the baby. So satisfaction with contact does not discriminate resolved from unresolved mothers; a majority of mothers 3-5 years post-loss can feel resolved in spite of dissatisfying contact. In contrast however, among the 8 mothers whose baby died 6-10 years ago, satisfaction with contact can differentiate between most resolved and unresolved mothers: 3 (75%) out of the 4 resolved mothers are satisfied with contact while 3 (75%) out of the 4 unresolved mothers are dissatisfied with contact. However, because of the small sample, this result could be a trend that would not come through with a larger sample of mothers whose babies died 6-10 years ago. On the other hand, it is possible that mothers whose baby died 6-10 years ago did not have the benefits of hospital intervention which promotes a mother having contact with her dead or dying baby. Indeed, 3 (75%) of the 4 mothers 6-10 years post-loss who feel dissatisfied with contact were not able to hold the baby. In contrast of the 8 mothers 1-3 and 3-5 years post-loss who feel dissatisfied with contact, only 2 (25%) were
not able to hold the baby; but 6 (75%) of these dissatisfied mothers were able to hold the baby. So mothers 6-10 years post-loss tend to feel dissatisfied because they were not able to hold the baby, while mothers whose babies died less than 5 years ago tend to feel dissatisfied with the amount or quality of time they were able to hold the baby. Lack of resolution for mothers 6-10 years post-loss appears to be related to feeling dissatisfied with not being able to hold the baby. With a more recent loss, lack of resolution appears to be more a matter of passage of time than satisfaction with contact.

**Momentos of the Baby**

Momentos are important for grieving in that they are a tangible memory of the deceased. Momentos can be particularly important for mothers whose baby dies as the memories are confined to memories of the pregnancy and maybe the first few days of life. And these memories that can't be shared with anyone because only the mother really experiences the pregnancy firsthand. Momentos are an important way of collecting memories to keep where so few memories exist. Besides photographs, other momentos that the mothers have collected include birth and death certificates, footprints, locks of hair, hospital bracelets, autopsy reports, toys or articles of clothing that were given to the baby, sympathy cards received, and ribbons and dried flowers from the funeral. Momentos are an acknowledgment that the baby existed and they are treasured by these mothers. Erin says of
her baby's autopsy report, her only momento, "I carry this autopsy around like a bible." Kelly keeps her momentos in a baby book about which she says, "I love it, it keeps him with me." Cindy says about her momentos of Nicole "I love it... that's another thing that makes it real... she was alive at one time and she was my daughter." Kara saved her baby's hospital cap which covered his head to keep him warm; she says, "I remember I would take this and smell it after he died because I can remember that it smelled like him." Both Kitty and Sara worry about the house burning down, destroying their beloved momentos. Bryn, Kelly, Kara, Kitty, and Cindy even brought their momentos to share during the interview.

But the most Important, treasured, or sought after momento is a photograph of the baby. Usually the photograph was taken by the hospital; some parents also took their own photographs. Approximately half, 13 (54.2%) mothers in this sample have a photograph of the baby and approximately half, 11 (45.8%) do not. Of the 11 mothers that did not receive a photograph, 7 (63.6%) feel dissatisfied with their momentos, wishing that they had a photograph, 2 (18.2%) aren't sure, and 2 (18.2%) are satisfied with not having a photograph. On the other hand, of the 13 mothers who do have a photograph of their baby, 11 (84.6%) feel satisfied about their momentos and only 2 (15.4%) feel mixed because they wish they had more photographs or momentos. Thus, having a photograph is very highly related to the mothers feeling satisfied about their momentos; this relationship is significant (Fisher's Exact p = .0003)
Interestingly, of the 2 mothers with multiple perinatal losses, Peg is satisfied with not having a photograph and Meryl feels "it's OK". Meryl says

"I went through so many pregnancies and it wasn't that I wanted to erase everything but I just, I had to keep going. And having seen the baby there in the hospital was fine for me."

Peg agrees that seeing the baby helped, but that a photograph was unnecessary. She was afraid that having a photograph would "etch every detail in my mind". Both Peg and Meryl are probably satisfied with not having a photograph because (a) they did have the opportunity see this baby whereas they did not see the other babies they lost and perhaps seeing this baby was enough because they had become accustomed to not seeing the baby, much less having a photograph, and (b) as Meryl says, they cope by just moving on and don't want a photograph to make them dwell on the baby that died. However, both Peg and Meryl report difficulty functioning due to trying to avoid grieving. Meryl reports what happened after her second perinatal loss:

"I would try [not to grieve] but I don't think I was very successful at it... after a year I suddenly realized I had been in a depression and I didn't know it. But I couldn't even pay my bills, things would expire, things would be due, things would be threatened to be turned off and I couldn't handle that- I was absolutely lost."

Peg describes how her grief caught up with her upon the birth of her surviving son, Justin:

"After I had Justin, I noticed I started thinking about the other babies alot more because I think I had tried to put
them into my mind as not real living babies but once you have a real living baby and you see that you're actually dealing with a baby, then it really made me start to think about the other babies quite a bit. I went through a period that it was bothering me more than it had before."

Although these 2 mothers with multiple perinatal losses tried to survive by not dwelling on their grief, both admit that there were consequences to their functioning. It can be speculated that having contact with all their babies who died, having photographs, or even other momentos (neither of these mothers had collected any), may have helped them get in touch with their grief and although grieving is painful, their functioning may not have been as impaired when, as much, or for as long as it was.

The 2 other mothers besides Peg and Meryl who aren't totally dissatisfied with not having a photograph are Elaine and Jane. Like Peg, Elaine feels satisfied with not having a photograph; like Meryl, Jane is not sure. Elaine's reported satisfaction is tenuous because of her gratuitous denial of any curiosity. Of not receiving a photograph, she says,

"To me, a baby is a baby... and I don't wonder [what she looked like] because they change so quickly anyway and I'm not curious about it at all."

Elaine's rationalization that babies "change so quickly anyway" is rather weak considering the subject is a baby who died and isn't going to grow up very quickly. She also gratuitously denies any curiosity, similar to her statements about satisfaction with not having contact with the baby.
Jane isn't sure about whether having a photograph would've been desirable, as she admits her curiosity about what the baby looked like. Jane was afraid of even seeing her baby lest she have the image of her baby etched in her memory, "for the rest of my life and I didn't know if I could handle it." Consistent with this fear, she feels OK about not having a photograph, although she wonders what her baby looked like and a part of her wishes she knew. Interestingly, unlike Peg and Meryl who saw the baby in the hospital, Jane and Elaine did not see their babies and therefore without a photograph, have no way of knowing what the baby looked like. This curiosity is the basis for Jane's uncertainty about wanting a photograph, and Elaine's gratuitous denial of curiosity implies that she has some dissatisfaction that she cannot admit. But in general these 4 mothers feel OK that they do not have a photograph. For Jane and Elaine, like Peg and Meryl, this feeling may be a result of having the attitude that it was best to move on and not dwell on their grief. These 4 mothers also had other things in common besides thinking it was OK not to have a photograph: (a) None of these mothers held the baby, and Elaine and Jane did not even see the baby; (b) Only 5 mothers in the study did not go through either of the rituals of burial or funeral for their babies and Jane, Meryl, Elaine, and Peg were 4 of them (Erin was the fifth and she and Jane are the only ones who regret those decisions); (c) Peg, Jane, and Elaine were the only 3 mothers who did not name their babies, and also were 3 of the 4 mothers who lost their babies before 27 weeks, the age of viability outside the womb. All of
these things in common point to a lack of acknowledgment that the baby was real, as Hannah would say, "a little person". This acknowledgment is necessary for the mother to even feel that she has experienced a loss. Indeed, Elaine gratuitously denies feeling any loss:

"Gee it would have been nice to have a little girl and sometimes I wonder now why wouldn't I have another baby so I could have a little girl but I don't have a feeling of loss."

And also like Meryl and Peg, Jane and Elaine have had experiences that could be a result of not grieving the loss. Elaine's denial of her grief impaired her functioning: Upon the birth of her subsequent son, she admits her extreme disappointment that he was not a girl and that she could not start accepting that he was a boy until he was a toddler.

Jane's motivation to move on was partly due to her faith in God, that this was God's will, and partly due to the fact that her loss was treated in the hospital as "an early miscarriage". Before her baby boy died, she had a daughter, after he died, she had another daughter, and then a son. She talks about Josh's birth, and her special difficulty with this child. It could be speculated that her difficulty may partly be a result of her not completely grieving her other son's death:

"I was happy when I had Josh because I really never thought I'd have a boy. I always thought I was going to have girls, I wasn't meant to have a boy and I still wonder if I was meant to have a boy because he is trying me particularly."

Unlike these 4 mothers, the other 7 mothers who do not have a
photograph are very regretful that they do not have a picture of their baby. Perhaps these mothers were able to more fully grieve the death of the baby and thus yearned for and recognized the value of a photograph. Holly did not receive any mementos or really have a chance to be with the baby. After she started attending a neonatal loss support group and reading books on neonatal loss, she understood how much those memories would've helped:

"...then I realized how handicapped we were. That's probably above all, the thing that makes me the angriest or the saddest. It's like, if she had to die, they could've at least handled it right."

Bryn, who was in a confused state of shock the only time she was with her baby, also recognizes how valuable a photograph would've been to her grieving:

"I wish I could've had a picture because I can't remember him. I really regret that because he was a part of me. I think that would've made it a little easier- maybe I could've gotten over things a little faster that way."

Both Dara and Bess have tried to find a picture of the baby that perhaps the genetics or pathology departments at the hospital might have taken. ten years after her loss, Dara still goes through phases where she feels like she wants to try again to get the photographs that they gave permission to be taken in the genetics department. Bess has similar yearnings:

"There was no picture taken and I still regret that to this day. Even 2 years ago (5 years post-loss) I was calling and trying to find a picture, trying to see if pathology had taken one, but I was never able to locate one. That's probably my major regret, that I don't have a picture of him."
Photographs are particularly important for the mothers, like Bryn, who do not have the memories of holding and seeing their baby. Desi too, was groggy with anesthetic when she saw her baby, and has no memory of what her baby looked like. Having the fantasies that dead babies are "deformed", she wishes she could see another mother's picture of her baby, "so I can see what they look like." "But," she says wistfully, "I never have the nerve to ask anybody."

In contrast, of the 13 mothers who have a photograph, all 13 are very glad they have it. Photographs give a face to the baby, a face that these parents did not have time to get to know before the baby was gone. Martina points out the practicality of a photograph:

"I'm glad we've got [a picture] because you never forget the baby but you can forget how they look and later on if you want to look at it you can."

A photograph is also similar to contact and a memorial service in that it is acknowledgment that the baby existed. But it has a large advantage over contact and funeral: it is more than just a memory, it is tangible evidence that the baby existed. Anya touchingly describes how she feels about the few photos she has of Rachel:

"Oh, real glad. They're really blurry and fuzzy and don't look like much. I've never shown them to anyone else but I know they're there and even though they are pretty blurry and hard to distinguish, it's real important, it's something tangible."

Hannah agrees:

"I'm really glad I have that. It helps you know it really happened, she was really a little person."
All of the mothers treasure their photographs of the baby. Sophie and Rose keep the baby's photo on their dresser, Kara keeps one picture on the refrigerator, the rest in a baby book, Kelly also has hers in a baby book she made for her son, Jessie keeps her baby's photo in a folder by her bed, Cindy and Kitty have special boxes where they keep the baby's photo with other momentos. Sara keeps her baby's photo in the family photo album but talks about how she agonized where to keep her baby's photo so it would be safe:

"The photograph—It's the most wonderful thing that ever happened to me. For years I was torn with what to do with that picture, I mean, I was ready to get a safety deposit box so that nothing would happen to that picture. It was a real special thing."

Jessie acknowledges that most people probably don't understand how important the baby's photograph can be:

"I'm really glad we have pictures, I look at them alot. Some people think that they're kind of gruesome but they're real important to me."

Cindy found out the hard way that people might think the photographs are "gruesome":

"My sister-in-law, I showed her these pictures and she was like, 'That's really gross!' It really hurt my feelings bad. So then I was really aware, before I showed people it was like, 'If you don't want to see them, tell me, because they might upset you and I couldn't handle the remarks....' So if they said no I would just leave it alone."

But at first, even the mother can think the idea of a photograph is gruesome. A hospital that understands this will take a photograph anyway and let the mother know that she can get it from them when she
wants it. Kara explains how this procedure worked for her, and how such mementos help:

"They said, 'Well, do you want us to take some pictures of him?', and at the time I was like, 'You've got to be kidding me, that's disgusting!' And a week or so later someone from the hospital called and said I've got these photos of him after he died. I'd really like to send them to you. I said 'Send them! I want them!' So they're in a book and it's like a treasure to Nick and myself. I think that's something that really helps parents to go through the grieving process. I saved everything I could. He was really important to us."

Kara also says proudly, "You could really see he was a pretty baby."

Anya and Liza are the 2 mothers who have mixed feelings about their mementos. Anya mentions that besides photographs, she would also like to have "footprints or something, some other mementos, maybe a little bit more recognition that she had existed." Liza also mentioned that she wishes she could have a picture of her baby, before he died, without the wires and tubes that were stuck in his body. Every mother who has a photograph, however blurry or unbecoming it may be, is very thankful to have it, but these two mothers make an important point: Having several mementos, including a good picture of the baby can be very meaningful.

These mothers feel strongly about mementos in general, not just the photograph. Besides being the only tangible evidence that the baby really existed, and representing some of the few memories the mother has of the baby, mementos also help the mother remember the baby. A lot of mothers mentioned fears of forgetting the baby. Rose
talks about all of these reasons for why the momentos of her baby are so important to her:

"I cling to them. I think I would feel horrible if they weren't there. When I go through the cards... it showed me that people really cared about me and her and without them I think it would be a big part missing. Since I don't have her I try to grab everything that was about her, it's like she's still there."

Rose indicates that she is trying to hold on to Jessica—"it's like she's still there"—by "clinging" to the momentos. She reports that she's had people tell her that it's been 4 years and she should be over her grief, but she points out,

"I'm going to have to live with this for the rest of my life and I don't think I'd ever come to a point where I'll feel good about it or satisfied... I haven't closed the book on it and maybe I should, I don't know, but I don't think I should, she still was a part of my life, she was a daughter just like Lori and Anna is now. I don't think anybody would expect me to do that if Lori or Anna were to die now, I don't think they would force me to get over it... they're not a newborn, like newborns are something else."

Rose makes a point that a lot of these mothers agree with, that they feel like people don't think they should grieve so much or try to remember their newborn baby that died. But that's exactly at least part of the reason these mothers so desperately want to hold onto their momentos and their memories—because if they don't remember the baby, no one else will. Kitty remarks:

"I think it's hard because I think I'm the only one that's thinking about her, me and maybe my husband. And I wonder if anyone else is thinking about her."

It is a reasonable assumption that since no one knew the baby, no
one will remember the baby but the parents. Kitty also thinks that without her box of momentos, "that I might forget her" because she never really got to know her baby either. Desi makes sure she thinks of Matthew every night before falling asleep and Rose feels like she wants to hold onto intense feelings of loss because:

"That's all I have of her... those feelings reassure me that I still love her and I'm not forgetting her."

Cindy would agree with Rose that remembering the baby is very important but disagrees that you have to hold onto your grief. Cindy has learned that you can stop grieving but keep on remembering and loving the baby:

"It's not over, ever, completely over. You're always going to love her but you have to end the mourning on it. You have to end going back to it and making yourself feel bad on purpose. You have to... If you don't then you lose yourself."

Another way that many of the mothers remember the baby is by telling their subsequent children about the baby that died so that these children can join her in remembering. Rose talks about Lori who is now 3 years old:

"Lori talks alot about Jessica, about her dying and things, because I want Jessica to be a part of our lives."

Kara has already started to indoctrinate Alex who is only 6 months old, but recognizes that it's mostly for her benefit:

"I have a picture [of Matthew] on my refrigerator... and so when I look at him I say, 'Yeah, there's Matthew' and I take Alex and I say 'That was your brother.' I mean, you know, he's too young to-, but that's just how I am, and I say things like, 'He would've liked you, you would've liked
hitn.' You know, it's my own working things out, I'm sure."

Cindy also talks about integrating Nicole into her and her daughter, Emily's life. Here she talks about taking Emily, now 2 1/2 years old, to Nicole's grave:

"I like it too because it gives Emily a place to go and a place where I can explain to her, 'This is where Nicole is buried.' For her it's more natural than if when she grew up and I said, 'Well, I had another baby.', and it would be a stranger. Now I think she'll feel like there's a little bond, she'll know that was her sister and she died before she was born. That's important to me. I don't want to forget about Nicole. I don't want to pretend that it never happened and I don't want Emily to grow up never knowing about it because that's pretending it didn't happen to me."

Cindy recognizes on some level that sharing memories of Nicole with Emily acknowledges Nicole's existence and helps her to remember the baby she lost. Jess explains that taking to Katy about Meagan, the baby who died, is part of recognizing that Meagan will always be her first born:

"I talk to Katy about her, that she had an older sister, and I wish she was here too... I hold a place for her. She's still our first child and Katy's older sister and I don't feel that other people do that so much and that upsets me sometimes when they say [referring to Katy], 'Oh, is this your first child?', and 'This is your first Mother's Day.' And I feel kind of bad that she's being deprived of those things that were rightfully hers."

Similarly Kitty is determined to hold a place in the family for Melanie, the baby who died:

"I think of her more as a sister [to my other children] now than I do the baby that I didn't have. We think of her as a part of our family and Paul [her first born], he talks about her. When Julie is old enough to understand, she's going to understand that she did have a sister."
Not all of the mothers are so eager to share memories of the dead baby with the subsequent child. To some mothers, the memory of their baby is so precious that to share it with a young child might trivialize it. Bess explains this point of view:

"I guess I'm afraid that I want them to understand and I think they'll be sad and I think they'll want to go see the grave but I don't want Meg going to kindergarten and saying, bragging, 'I had a brother' and showing off about it and chatting about it like it meant nothing. So I thought if she was a little older she might understand it. I just don't want it to become trite."

In summary, having a photograph is highly related to feeling satisfied with mementos of the baby. These mothers also indicate that feeling satisfied with having a photograph and other mementos is important because acknowledging and remembering the baby is important. Thus, not surprisingly, of the 7 mothers who feel dissatisfied with their mementos, 5 (71.4%) feel unresolved and only 2 (28.6%) feel resolved; of the 4 mothers who feel mixed about their mementos, all 4 (100%) feel resolved. However, this trend does not pan out with mothers who feel satisfied with their mementos. Of the 13 mothers satisfied with mementos, about half, 6 (46.2%) mothers feel resolved and 7 (53.8%) mothers feel unresolved; thus being satisfied with mementos is not significantly related to resolution (Fisher's Exact p = .1183).

Interestingly, although satisfaction with mementos is not related to resolution, satisfaction with mementos is related to time since the loss. Of the 7 mothers 1-3 years post-loss, 6 (85.7%) feel satisfied and only 1 (14.3) feels dissatisfied with mementos. Similarly, of the
9 mothers 3-5 years post-loss 6 (66.7%) feel satisfied, 2 (22.2%) feel mixed, and only 1 (11.1%) feel dissatisfied with momentos. In contrast however, of the 8 mothers 6-10 years post-loss, only 1 (12.5%) feels satisfied and 2 (25%) feel mixed while 5 (62.5%) of these mothers feel dissatisfied with momentos. Thus, the more recent the loss, the more likely a mother will feel satisfied with her momentos. This relationship between time since loss and satisfaction with momentos is significant (Fisher's Exact p = .0231). Perhaps in recent years, hospitals have become more conscientious about offering momentos, particularly a photograph of the baby, to the mother, so that if the mother wants to collect these momentos, she can. Some of the mothers' experiences highlights the foresight sometimes necessary: Kara, whose baby died 18 months ago, was able to later obtain a photograph the hospital had saved for her, in spite of her initially rejecting the offered photograph. On the other hand, Bess and Dara, whose babies died more than 6 years ago, both talk about unsuccessfully trying to track down a photograph from the hospital in the hopes that one happened to be taken by pathology or genetics.

Thus, both resolution and satisfaction with momentos are significantly related to time since the loss. However, given that resolution and satisfaction with momentos are not significantly related to each other, these 2 variables must be independently related to the passage of time. This independence becomes particularly apparent when examining their relationship while controlling for time since the loss. Similar to satisfaction with contact, mothers with
recent losses tend to feel unresolved regardless of satisfaction with mementos: 6 out of 7 mothers whose baby died 1-3 years ago feel unresolved, although 5 (83.3%) of these 6 unresolved mothers are satisfied with mementos. Then mothers 3-5 years post-loss tend to feel resolved regardless of satisfaction with mementos: 0 of the 9 mothers whose baby died 3-5 years ago, 7 out of 9 feel resolved; about half of these mothers, 4 (57.1%) feel satisfied while 2 (28.6%) mothers feel mixed and 1 (14.3%) feels dissatisfied with mementos. Interestingly, the 2 unresolved 3-5 years post-loss mothers are both (100%) satisfied with their mementos; thus these mothers also feel unresolved in spite of satisfaction with mementos. Then, among mothers 6-10 years post-loss, 3 (75%) out of the 4 resolved mothers and 4 (100%) out of 4 unresolved mothers feel dissatisfied with mementos. Thus for mothers 6-10 years post-loss, resolution can occur in spite of dissatisfaction with mementos, but about half of the dissatisfied mothers still feel unresolved. Clearly, satisfaction with mementos does not discriminate between resolved and unresolved mothers for any passage of time since the loss.

Although satisfying contact and mementos are not statistically related to resolution, the mothers' verbatim descriptions of their feelings pertaining to these events indicate the emotional significance of satisfaction with contact and mementos. Retrospectively, these mothers do feel that the interventions of providing contact with and mementos of the baby are ways that hospitals can facilitate a mother's grief work. The mothers describe
the importance of feeling satisfied with contact and momentos in terms of 3 issues: contact and momentos are (1) the only opportunity a mother has to see, hold, know her baby, (2) a way the mother can validate the baby's existence as a real person, separate from her, not just as a pregnancy (3) the only memories the mother has of her baby, and thus a way for the mother to remember the baby she never really had a chance to know. Although memories are an important component of grieving, unfortunately, this study cannot test whether grieving is facilitated beyond the mothers' reports of their experience.

Although the mothers report that contact and momentos of the baby have a profound effect on their feelings, these experiences are not related to resolution. Resolution appears to be a function of passage of time. However, the passage of time is related to resolution in an unusual way. As could be expected, a majority of 1-3 years post-loss mothers feel unresolved and the majority of 3-5 years post-loss mothers feel resolved, implying that resolution develops with time. But instead of the mothers who have had the most time elapse (6-10 years) since the baby's death being the most resolved, only half of these mothers feel resolved.

As discussed earlier, how the mothers feel now about the baby and the baby's death is also related to resolution and also helps to account for the relationship between resolution and the passage of time. Thus, the discussion now turns to how the mothers feel now about the baby and the baby's death.
Although the mothers report that contact and mementos of the baby have a profound effect on their feelings, these experiences are not related to resolution. Perhaps, although these experiences may have facilitated the mothers' grief work during the first couple of years following the loss, interviewing mothers 1 to 10 years after their loss introduces another variable with which resolution appears to be related: Resolution is significantly related to the passage of time. However, the passage of time is related to resolution in an unusual way. As could be expected, a majority of 1-3 years post-loss mothers feel unresolved and the majority of 3-5 years post-loss mothers feel resolved, implying that resolution simply develops with time. But instead of the mothers who have had the most time elapse (6-10 years) since the baby's death being the most resolved, only half of these mothers feel resolved.

As described by the mothers and discussed earlier, feeling unresolved is related to the mothers still feeling intense emotions and a lack of acceptance of these emotions or their baby's death. Unresolved mothers may feel a little too tender yet to feel resolved—those painful grieving feelings of sadness, yearning, and remembrance are probably still too sharp. Some of the painful feelings some mothers have involve dissatisfaction with contact or mementos, but
dissatisfaction with contact or mementos is not consistently related to feeling unresolved. It could be that some mothers are more sensitive to this dissatisfaction, contributing to unresolved feelings.

By exploring in more detail how the mothers feel now about the baby and the baby's death may be a way to uncover these individual differences. Feelings about the baby is the only resolution indicator that is significantly related to feelings of resolution. This relationship between resolution and feelings about the baby suggests that a mother's perception of her grief resolution is tied to her feelings about the baby. Feelings about the baby also helps to account for the relationship between resolution and the passage of time, i.e. mothers who feel neutral or feel bittersweet and are more than 3 years post-loss are the mothers who feel resolved; except for Anya, regardless of the passage of time, mothers who feel sad or angry also feel unresolved. What makes some mothers still feel sadness and anger and other mothers feel bittersweet or neutral? And how do these feelings tie into feeling resolved or unresolved?

The discussion now turns to how the mothers feel now about the baby and the baby's death. First, each category of feeling, i.e., anger, sadness, bittersweet, and neutral, will be explored to clarify and describe how the mothers feel. Secondly, in each category, an attempt will be made to explore what circumstances the mothers have in common in order to speculate why the mothers as a group feel the way they do; in particular, contact with the baby and having a photograph
of the baby will be examined. Thirdly, in each category, an attempt will be made to explore the relationship between resolution and feelings about the baby, i.e. how do a mother's feelings about the baby reflect her feelings of resolution? Table 5 is an outline of these variables, listing each mother in order of how long ago her baby died, feelings of resolution, feelings about the baby, and her experience and satisfaction with contact and mementos of the baby.

Anger

Four mothers reported angry feelings in response to how they feel nowadays about the baby. Interestingly, all of these mothers describe sadness as well as anger, among other emotions associated with the loss. For instance, Holly describes feeling sad as well as anger and frustration:

"A lot of sadness. Sadness in terms of loss of being together and potential. Still frustration at not knowing the cause, having no control, anger still about the hospital and what happened afterwards but much more perspective about the situation. It is frustrating to me to think that although I know the pain or the caring never goes away, in a sense I think it should be easier for me now, or I wonder, 'Am I hanging on to it, am I hanging on to this and being more negative or sad than is healthy or than I should be?"

Holly feels a lot of anger at how the hospital handled her loss, such as not offering to let her see and hold the baby, not taking photographs of the baby. Dara had a similar hospital experience; she also did not get to see her baby or receive pictures. She describes
TABLE 5

TIME SINCE THE LOSS, RESOLUTION, FEELINGS ABOUT BABY’S DEATH, AND MATERNAL SATISFACTION WITH CONTACT AND MOMENTOS

<table>
<thead>
<tr>
<th>MOS SINCE MOTHER LOSS</th>
<th>RESOLUTION</th>
<th>FEEL ABOUT BABY’S DEATH</th>
<th>CONTACT*</th>
<th>MOMENTOS**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelly</td>
<td>13</td>
<td>unresolved</td>
<td>bittersweet</td>
<td>hold x</td>
</tr>
<tr>
<td>Kara</td>
<td>18</td>
<td>unresolved</td>
<td>bittersweet</td>
<td>hold x</td>
</tr>
<tr>
<td>Sophie</td>
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<td>hold</td>
</tr>
<tr>
<td>Kitty</td>
<td>22</td>
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<td>no</td>
</tr>
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<tr>
<td>Hannah</td>
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<tr>
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<td>Bryn</td>
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<td>hold</td>
</tr>
<tr>
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<td>Elaine</td>
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<td>Desi</td>
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<td>resolved</td>
<td>bittersweet</td>
<td>no</td>
</tr>
<tr>
<td>Dara</td>
<td>119</td>
<td>unresolved</td>
<td>anger</td>
<td>no</td>
</tr>
</tbody>
</table>

* Contact, with the baby: "see" includes seeing or touching the baby; "no" includes seeing the baby fleetingly at delivery. Dissatisfaction or mixed feelings about contact are denoted by "x".

** Momentos: "yes" means the mother has a photograph of her baby, "no" means she does not have a photograph. Again, dissatisfaction or mixed feelings about momentos are denoted by "x".
anger, sadness, and curiosity:

"I feel cheated at the way things were done, sad obviously at times, curious as to what she really did look like, wishing I'd done things differently. (tears)...curious about what she looked like, what she would be like now."

Lynn expresses sadness and indirectly, anger:

"I feel sad not only at my loss but also his loss that he didn't get to see this beautiful world. I didn't get to take him fishing and he didn't get to take swimming lesson, he didn't get to throw rocks in the pond and make snowballs that hit me in the face."

That her son would "make snowballs that hit me in the face" strongly implies angry feelings, perhaps anger at her baby for dying. Erin is able to admit that she feels angry at her baby for dying, as well as anger at modern medicine that she died, sadness for the loss, and gladness that the baby died painlessly:

"I feel sad that she can't be around. I feel fortunate that she didn't have a traumatic couple of months of life, like maybe have a heart defect and have to go through surgery. I feel angry that she didn't live, like with modern medicine, why didn't she live? But I don't have an anger to go around telling other people not to have babies because it hurt. And it didn't stop me from having another baby. I really wanted 3 children and my first one, if she'd lived, I'd have 3 children because I felt like by the time Wendy came along I was too old to continue. So sometimes I'm a little resentful to Barbie for doing this to me. It wasn't very fair of her."

All the mothers in this category feel sadness in addition to anger. Although these feelings could have many sources, including childhood experiences with separation and loss, these feelings may also be related to events surrounding the loss. Two of the mothers, Holly and Dara still feel upset about not being able to hold their
baby and not having a photograph. Lynn was able to see her baby but
wishes she could have held him and spent more time with him. Erin on
the other hand, was able to hold her baby and found it satisfying.
But like Holly and Dara, Lynn and Erin also do not have photographs
and wish that they did. These mothers also feel a lot of
dissatisfaction with disposal of their baby's body or funeral
services, memorial rituals which can be important for grief work.
Lynn feels satisfied with her arrangements to bury her son but regrets
that she had no memorial service; the other 3 mothers feel
dissatisfied with both arrangements made for disposal and memorial
services. Additionally, the cause of death for Holly and Erin's
babies remains unknown, which makes many mothers feel a lack of
closure or control as they will never know logically, medically "why"
the baby died. And Dara feels her baby's death was nonpreventable,
another source of feeling a loss of control, i.e., there was nothing
that could or should have been done to prevent her baby from dying.

Thus, these mothers as a group have a lot of dissatisfaction in
the form of anger, sadness, and frustration with their collection of
memories, memorial rituals, and control issues. And although 3 of
these mothers lost their babies more than 6 years ago, it may largely
be these feelings and events which still fill them with so much regret
and keep them feeling unresolved. Because of these lingering
intensely painful feelings, it could be argued that particularly Dara,
Erin, and Lynn, whose babies died more than 6 years ago, are examples
of "chronic mourning". As discussed in Chapter 1, these mothers are
experiencing prolonged feelings of grief and have failed to accept and integrate the loss into their lives. Dara acknowledges the pain she still feels, both when she tearfully talks about feeling cheated and sad about the baby and when she describes feeling unresolved, that "I still have some work to do in terms of my own reactions." When Erin talks about feeling unresolved, she describes herself as a "soppy, sad, cry'y person" implying that she is not one to get over painful feelings. When describing her unresolved feelings, Lynn admits that she has "always been one to hide emotions" as opposed to working them out and so it's not surprising that she expresses her angry feelings about her baby indirectly, such as when she talks about how he didn't get to "make snowballs that hit me in the face." Holly clearly illustrates the feeling these mothers have of hanging on to painful feelings when she acknowledges that her sad, negative feelings are more painful than perhaps they should be, "...am I hanging on to this and being more negative or sad than is healthy or than I should be?", and thus she feels unresolved.

Thus, all these mothers describe their feelings about the baby and feeling unresolved in terms of still feeling too much pain. All of these mothers acknowledge that they still feel they have some work to do in terms of still feeling so much emotional turmoil that they know they are not resolved. But Holly is an exception in this group of mothers. Her baby died just over 2 years ago, and it's the norm for the 1-3 years post-loss mothers to feel unresolved, so she cannot be considered as chronic in her grieving as Dara, Erin, and Lynn.
Also, when Holly talks about feeling unresolved, she talks about working toward resolution in terms of "acceptance of the sadness... not fighting it, or denying it, or overdoing it... getting towards integration." Thus, although she feels anger, she seems to be progressing toward resolution whereas the other 3 mothers seem to be stuck. Lynn implies that she is stuck when she says, "I know there's still more to be resolved but I don't know how it's going to be resolved." Similarly Erin wonders if there is no such thing as resolution. And Dara sounds stuck when 10 years after her loss she is still thinking she has "some work to do". Maybe it is the anger that keeps them stuck or maybe being stuck keeps them angry. Holly, at 2 years post-loss may outgrow her anger and as she herself suggests, she will soon begin to feel resolved. But of Lynn and Erin whose baby's died 7 years ago and Dara whose baby died 10 years ago, it might be speculated that these 3 mothers are chronic mourners and may never be able to let go or work through their anger and feel resolved.

The way the Dara and Erin talk about how they have moved on with their lives also indicates that they are stuck in their lack of resolution. Both Dara and Erin talk about how life goes on and so have they. Dara says, "Obviously we've had more kids and pulled our lives together and things go on." Erin remarks, "I'm going to deal with it because I've got other children at home and life goes on and I can't bring her back... So I just kind of moved on." But their statements seem to imply that they have moved on because "life" and "things go on" and not because they wanted to or were ready. They
have moved on because of the pressure of life moving forward and dragging them along, while maybe they would rather hang back and take the time to grieve their loss more intensely than the pressures of day-to-day life allows them.

While there is evidence of chronic mourning in these 4 angry mothers, interestingly, 2 of these mothers, Lynn and Holly, also describe going through lengthy episodes of absent grieving. Lynn immersed herself in volunteer work in order to avoid grieving. Typical of the "absent griever", she reports,

"I did alot of denial. I kept trying to say all this really didn't happen and I'm going to wake up tomorrow morning and everything will be alright."

Nearly all of the 24 mothers report feelings of denial, but when they are prolonged as in Lynn's case, lasting almost a full year, grieving can be considered pathological. Lynn finally did begin to grieve her loss when, about 11 months after her loss, she was in the third trimester of her subsequent pregnancy and total bedrest was necessary to hold off premature labor. It was then that she "went into grieving... I had nothing to immerse myself into."

Holly put off her grief for 2 years. She describes this period in terms of appearing organized and functional to the outside world while inside she was really in a confused, disorganized "fog", a classic symptom of absent grieving. She explains:

"I look back now to the whole 2 years and think I've been in a fog for 2 entire years... that I have functioned beautifully to the outside and pulled an incredible amount of work load and accomplished an incredible amount of things and personally, I've just been in a fog. It's amazing to me
I've pulled it off but I think by being so strong (sic), I've caused myself more agony."

Both of these mothers illustrate the compulsive, overworking symptoms of absent grieving. It seems that by keeping so busy, they could avoid dealing with their grief. Holly and Lynn were the only mothers to describe this compulsive workaholism in themselves so it is interesting that now both of these mothers appear to be experiencing chronic mourning, the still pathological opposite of absent grieving. It could be speculated that prolonged absent grieving might indeed lead to prolonged chronic mourning. Holly wonders about absent grieving leading to chronic mourning in herself when she admits that perhaps by avoiding grieving, "I've caused myself more agony."

Sadness

Sad feelings are described by Bess:

"How do I feel now, 7 years later, about the loss? That there is a missing part in our life, that the family is incomplete. (tears) I still miss him and I don't know that that ever goes away. It's less now—it used to be every minute of every day and then it was just a few days a week and then a few weeks in the month. Sometimes, I'll be like this only once in a year. Sometimes it's worse and sometimes it's not. I just wish it had never happened, never, ever, ever."

Like Bess, Peg, whose twins died nearly 4 years ago, also describes the feeling of sadness that persists but is not overwhelming:

"I do still think about them. I think it's something that you think about it and it makes you sad but it's not nearly as sharp or as definite as it was at the time or even a year
ago or 2 years ago— it fades a little bit to the background. You know, you think about them and you're sad and you wish that it hadn't happened.

In contrast to the mothers who feel angry, these mothers mention that their sadness is not so painful or overwhelming. But these mothers could also be classified as chronic mourners: this theme of wishing it had never happened expressed by Bess and Peg would seem to suggest that instead of adjusting to the fact that their baby's death is an irrevocable event, they still wish the baby hadn't died. Perhaps herein lies part of the source of their unresolved feelings— that they have not accepted the loss, made the best of it, and moved on. They are stuck on wishing it had never happened and cannot see anything positive. Hannah expresses such feelings when she says,

"I just think it's always going to be sad. Having a baby die is just never going to change into a happy experience. And I can't put it into, 'Well, it means something or other and it was meant to be'- that just doesn't fit for me. So when I think about it, it's always going to be sad."

Even Anya, the only mother who feels sad but resolved also mentions this regret:

"It's something I feel real sad about and I have regrets about because it happened... I feel wishful that we had her with us and wondering what she'd be like. Mostly just sadness and wishful that things hadn't gone the way they did."

Although Anya expresses sad, regretful feelings similar to the other 4 sad mothers, she differs on her feelings of resolution in that she feels "that I could accept it." The other 4 mothers are not accepting the loss which plays a role in feeling unresolved, and
indicates chronic mourning.

For instance, Hannah talks about not accepting the baby's death when she talks about how she feels unresolved:

"... I'm never going to be happy about losing her. So I'm never going to just totally put it away and say 'That's over and done with and I'm never going to think about it again' or 'I'm just going to go on and be strong and never cry about it.' I don't feel that way at all. Resolution sounds like you're supposed to say, you don't think about it or you don't be sad, or I don't know what it means exactly.... When people say that [resolved] it's almost like you're saying you forgot."

But, similar to Anya, and as Peg and Bess mention above, Hannah does recognize that the feelings are not as painful as they used to be, and that time helps:

"It's not as intense and I have Michael to focus on and that helps a lot. But I think time is probably one of the biggest things that resolves things and it doesn't do it in any particular way, it's just distance. Somehow it just changes and you start getting involved in other things because you have to and it's farther away."

Martina agrees that the sad and lonely feelings are not as painful as they used to be:

"It's a lot easier to think about him now than then. I can keep on doing what I'm doing. When I think about him it's not something that is so bold like it was before, that when you start thinking about him you just gotta stop everything because you're in a daze for a week. It's not like that. It's gotten a lot better."

But Martina also sounds stuck when she talks about how she feels unresolved:

"There's no final phase of grief, I know that. It's just not as hard as it used to be."
Thus, all of these mothers recognize that they are feeling better, but the intensity of their grief and not accepting the loss contribute to feeling unresolved, and indicate chronic mourning. Martina, Hannah, and Peg all lost their babies within the last 4 years and this chronic mourning may be a part of the normal grieving process for them. Indeed, other than Peg wishing she could've spent more time with her babies, these mothers are satisfied with the events that surrounded the loss, i.e., collecting memories and memorial rituals. Although these mothers sound somewhat stuck, they are not as overwhelmed with prolonged feelings of grief as the "angry" mothers. Thus, these "sad" mothers may just need more time to accumulate the bittersweet feelings of acceptance, peace, or happiness associated with the baby which signal feelings of resolution. Bess's baby died 6 years ago, so she has had more time than Martina, Hannah, and Peg to feel resolved. However, unlike those 3 mothers, Bess has feelings of regret and sadness about her contact with her baby, about not having a photograph, and about wishing she had arranged a larger funeral for her baby. These events and feelings may contribute to her ongoing sadness and feeling unresolved, and she is probably the most representative candidate in this group for chronic mourning. Anya whose baby also died 6 years ago on the other hand only regrets that she doesn't have more mementos. Unlike Bess, she was able to spend satisfying time with her baby, received a photograph, and is satisfied that they did not have a funeral. She, also unlike these other mothers feels resolved, in spite of her sadness. As discussed
earlier, her sadness is probably due to the fact that she is raising the surviving twin of the baby that died and both being sad to not raise twins and having Kim as a constant reminder of the baby who died are unusual circumstances which, she reports, keep her sad.

In summary, mothers who describe feelings of anger or sadness when they think of the baby all report feeling unresolved and particularly the angry and sad mothers 6-10 years post-loss, illustrate chronic mourning. Although these mothers cannot be accurately assessed in terms of functioning in different aspects of their lives, it appears that none of these mothers are incapacitated by their chronic mourning. When asked, all of these mother reports that grief over their baby does not intrude on normal functioning. Instead, it appears that their baby's death simply continues to be something they feel upset about, a source of unhappiness that may seep into other parts of their lives. Another hallmark of chronic grief is that these mothers are aware of the connection between intense emotions and the baby's death. All of them can talk about feeling unresolved because of their grieving feelings and in terms of the baby's death and how that continues to make them feel intensely angry and sad.

Bittersweet

Bittersweet feelings were first identified by Peppers and Knapp (1980) and are confirmed by Kowalski (1984) as a combination of sadness and happiness that many bereaved mothers feel about the baby
and the baby's death. Bittersweet feelings were reported by 11, almost half of the mothers in this study. Bittersweet feelings are aptly described by Rose:

"Sometimes [I feel] real happy, real proud, and other times just real sad and real missing you feelings, it's all mixed."

As Jessie points out, the happy feelings are associated with the baby while the sad feelings are associated with the baby's death:

"I feel like I'll always be changed and I'll always remember her and be sad that she's not living with us but happy that we had her for a while and had the experience."

Although 3 of these mothers mention that they still wish that it had never happened, the majority express feelings of acceptance. Even the 3 mothers who still wish it hadn't happened are able to see the positive and move on, unlike the angry mothers or the mothers who still feel only sadness and wish it had never happened. Meryl illustrates how bittersweet feelings help her to move on and feel resolved, in spite of still wishing it hadn't happened:

"While I don't want to live through it again, and I wish it could've been otherwise, there are a lot of good things that came out of it; in a lot of ways I think I came out of it a better person. That's not the way I want to come out a better person but, everything's OK now, it's alright."

However, not all of the mothers who feel bittersweet also feel resolved. Sophie, though feeling bittersweet and feeling that her grief has "mellowed", can still have relapses and feels that she has not accepted the loss and thus feels unresolved:

"I don't think I'll ever completely accept it but it's kind
of a gradation— you never really get over it but you hopefully learn to cope with it better."

Similarly, Luanne still feels like she's grieving and that things get better but she'll always live with some pain:

"It will always be there, I'm sure, even in 50 years I'll still remember. I'm not grieving like you do right afterwards. But you still have sadness and pain. It still bothers me but not everyday."

As discussed earlier, some of the bittersweet mothers who feel resolved remember feeling like they would never accept the loss and always have grieving relapses. But, they report, eventually you do feel better, you do accept it. For bittersweet mothers, the passage of time appears to play a large role in feeling resolved. In fact, 3 of the 4 unresolved, bittersweet mothers listed "time" among the things that helped them to feel better, implying that they seem to recognize the role time appears to play in feeling resolved. As Jane, who is resolved, says,

"Time is a very good healer. I think for everything that happens to you if you can just take a breath and think '6 months from now I'm going to see this from a different perspective', I think it helps you get through any situation."

In fact, these resolved and unresolved bittersweet mothers differ on little else besides passage of time since the loss. For the 1-3, 3-5, and 6-10 years post-loss mothers, about half, 50%, 42.9%, and 50% respectively, feel dissatisfied with contact, and although half of these bittersweet mothers feel dissatisfied with contact, all but one were still able to hold the baby. And only one 3-5 years post-loss
mother and one 6-10 years post-loss mother feels dissatisfied with momentos. All of the 1-3 years post-loss mothers feel satisfied with the arrangements for burial or funeral, while 4 out of 5 of the 3-5 years post-loss mothers and 1 out of 2 of the 6-10 years post-loss mothers feel satisfied with one or both. Thus, these mothers in general had satisfying experiences surrounding the loss with regard to collecting memories and memorial rituals. It could be speculated that in a couple more years, all of these mothers who feel bittersweet, with time, will also feel resolved.

The bittersweet mothers are the only group who do not appear to be suffering from pathological mourning. In the literature on grief, the cutoff point is considered to be 1 year, after which continued grieving is labeled "unresolved" and pathological grief is indicated. However, from this sample of mothers, only after 3 or 4 years is resolution of grief the norm. Indeed, the bittersweet mothers who feel unresolved give the impression that at 1-3 years post-loss, they are progressing toward resolution and with the passage of time, they will feel resolved and that their continued grieving is the norm, not pathological.

For the angry, sad, and bittersweet mothers, besides the statistical relationship, there is another relevant indication of the relationship between feelings about the baby and feelings of resolution. Within each mother there was remarkable similarity and consistency between descriptions of feelings about the baby and descriptions of feelings of resolution, both resolved and unresolved
feelings. This is a direct indication that the mothers’ feelings of resolution come from their perception of how they are feeling about the baby and the baby’s death. In the PLI itself, these 2 questions were separated by 8 questions pertaining to the other “resolution indicators”; “feelings about the baby” was the first “resolution indicator” question and the question about self-report of resolution followed the other 8. That the mothers then would answer these two separately worded, separately asked questions so similarly is validation of the relationship between resolution and feelings about the baby.

Rose probably provided the most remarkable example of the connection between these 2 feelings (see Appendix A). When asked how she felt when thinking about her baby and the baby’s death, her reply answered both her feelings about Jessica’s death as well as her feelings about resolution. The interviewer did not even ask her about resolution as she had answered the question on her own. In Appendix A her reply is divided up into feelings about the baby and resolution for clarity and consistency with the format. In other mothers, the repetition and overlap is also apparent. For example, in reply to both questions, Meryl talks about wishing it hadn’t happened, but that it’s OK; Kara talks about having both happy and sad feelings; Martina talks about feeling better with time; Hannah talks about feeling like she’s always going to be sad; Erin talks about her anger that her baby died. Thus across resolved and unresolved mothers, bittersweet, sad, angry, it is clear that feelings about the baby and
feelings of resolution are highly related, often similar.

Neutral

The mothers who feel neutral have been excluded so far because they are unusual for a number of reasons. The "neutral" classification was created post-hoc for the 4 mothers who described it. For the most part, these mothers feel removed from the experience. Kitty describes the neutral, distant feelings she has about her loss. She says,

"I don't really think about it as much as I used to because now I have a baby to keep me busy. When I got the card to come here, I thought, well it's been almost 2 years - I feel like I've forgotten..."

Elaine describes how, in a 2 week period, she worked through her grief so that it's just a memory now with no feelings attached to it:

"I released allot of anger and I cried allot and I isolated myself so I had a lot of time to myself so I feel like I did work it through. I don't feel anything about it now. I don't ever relive it, it's not a negative thing to me... Intensity. I remember it like a drama with lots of detail, even nitty gritty detail."

However, the impression that all 4 of these mothers give is that they are denying or hiding from more painful feelings. Although all 4 mothers report feeling resolved, it is speculated that they are examples of "absent grieving" in varying degrees. In absent grieving, the mother is seemingly unaffected by the loss, shrugging it off as inconsequential. And in contrast with chronic mourners, absent grievers do not acknowledge their loss as being the source of painful
emotions such as sadness, anger, or longing. Kitty is probably the least example of absent grieving among these 4 mothers. Kitty is the only one of these 4 mothers to feel satisfied with both contact and momentos of her baby, and she is able to use her momentos to remember her baby. Although Kitty was afraid she had "forgotten", she rediscovered her painful feelings when she went through her momentos and "had a good cry" before she came in for the interview:

"I opened my box [of momentos] and it all came back to me... I think that if I wouldn't have my box of things, it might have been difficult [to remember] but I've been going through it and so I got a lot of my feelings out before I got here."

So, for Kitty, she is able to tuck her grief about her loss into the box with the rest of the momentos of her baby and when she brings out the box, she brings out painful grieving feelings. With this technique, she has been able feel resolved, to move on with her life and become involved with her new baby.

Bryn is another mother who replied neutrally to the question about how she feels nowadays about the baby, but is not the classic absent griever. She describes in detail all the feelings of grief she experienced during the first 3 years after her baby died. She is also able to express sadness and anger during parts of the interview, and sounds quite similar to the sad and angry mothers who appear to be chronic mourners. For instance, Bryn shows how her loss still impacts her view of life as she expresses sadness at the change in her philosophy of life:

"I led a very lucky life. I always had the philosophy that,
hey, everything works out for the best. I cannot have that philosophy anymore because I will never be able to say it was best that he died. I can never say that."

Then Bryn immediately goes on to talk about her pregnancy with Christopher, the baby who died, and expresses anger at the twists of fate:

"It made me mad. I had been on the pill. I went off the pill for a year and a half in anticipation [of getting pregnant] because I knew that was something to think about. I did not drink any caffeine, I did not drink any alcohol, I did not smoke, I did not do anything. I led my life so perfectly as far as going by the rules and then here's this woman sitting down on Colfax [the seedy side of town], drinking wine while she's pregnant and her boyfriend comes along, catches her with another man, shoots her, the baby is shot right through her stomach, they deliver the baby, and the baby's fine! Now why does that woman have a baby and I don't have a baby. I had a perfect pregnancy, there was nothing weird about the pregnancy. What [kind of justice] is that? That doesn't make sense."

But when asked how she feels nowadays, Bryn replied with a very neutral answer, describing the typical feelings of distance described by these mothers:

"There are times that I'll never forget him but there are also times when I am totally free of any memories."

Thus, like Kitty, Bryn describes her feelings about the baby in neutral terms. And both mothers also describe feeling resolved neutrally. Kitty again describes her remote feelings when she describes resolution:

"It's getting to the point where it's just a memory now, like I'm thinking about somebody else. It doesn't even feel like it was me."
Similarly Bryn talks about feeling resolved without really mentioning feelings:

"It's a very sad thing but you don't feel like such a victim after you get to a certain point. Like it's OK."

Bryn recognizes that her baby dying is a "sad thing" rather than saying she "feels sad" about it. Both Kitty and Bryn have feelings they talk about but they do not express them when asked directly about their feelings about the baby, a time when it would be very appropriate to acknowledge those feelings about the baby's death. It could be argued that these mothers are not truly resolved, that they still have grief they do not acknowledge. By not acknowledging feelings of grief, they gain a perhaps false feeling of resolution. Although proper assessment could not be made during a 2 hour interview, neither of these mothers appear to be suffering from classic symptoms of absent grieving such as self-destructive behavior, compulsive behaviors, or chronic physical symptoms. However, it could be speculated that with further investigation, signs of absent grieving might show up in some area of their lives. On the other hand, Liza and Elaine, the other 2 mothers classified as "neutral", show clearer signs of absent grieving.

For Liza the other mother who seems a candidate for absent grieving, evidence for their denial and hiding from painful feelings can be found in her expressions of sadness and anger as she talked about various issues surrounding their loss. Like Bryn, she describes grieving feelings she has experienced, and like Bryn, can give the
Impression of being a chronic mourner with her descriptions of the intense grieving she experienced for most of the 3 years following the loss. It is evident that Liza still experiences those feelings, in spite of consciously claiming to feel remote from those emotions. For instance, Liza intensely expresses both sadness and anger as she vividly described her experience with her dying son in the NICU:

"I remember he was getting real dry from the lights and [I was] trying to rub lotion on him and feeling like I didn't even know how to walk around the isolette because I was afraid I'd almost trip on something, and having one of the nurses come over and say, 'Now, he's gonna get too cold', and just feeling like he'd really been taken away from me already or something. I was so desperate to hold him [tears]... I was almost ready, when I realized they were going to take the tubes out, I was ready to take them out myself almost. I was just trying to pick him up and this man comes up, a nurse or doctor's aide or something, he said, 'You can't do this, you can't take that out. We have to have the pathologist do this.' And I'm standing there just wanting to hold him while he's alive or something and just remember feeling like, here's this person that's keeping me from holding my son even after they've removed some of the tubes because he has to have somebody else come do this and they're not there. Also, you could tell that the man just had no feeling at all, whoever this was, it was like, 'Lady, you can't touch!' It was like [David] was already a body for this person or something."

As Liza finished describing the insensitivity of the NICU staff toward her needs for contact with her son, she shook with emotion and exclaimed her surprise at the intensity of her feelings of sadness and anger. For Liza, this distance, the neutral feelings, probably protect her from these intensely sad and angry feelings that still haunt her. In fact, 2 minutes before she told of her experience in the NICU, she gratuitously denied that she still feels intense emotions about her loss. She says,
"I look back and I don't think I was insane but my reactions were so strong that it was the closest thing to it. I'm a pretty emotional person but I don't think I've ever felt that Intense an anger. But if I hadn't expressed anything, I feel like I'd still be feeling all of that."

According to her statement, she does not have intense emotions anymore but her behavior during the interview indicated otherwise. Indeed, she reports that every year, for the entire month of June, she experiences an anniversary reaction, a reaction that surprises her with it's intensity. And severe anniversary reactions are but one symptom of absent grieving. Thus, her neutral feelings may be a sign of absent grieving. These neutral feelings may also act as a coping mechanism. In fact, when asked how she feels nowadays about her baby, Liza describes the refuge she finds in her neutral feelings and feelings of distance:

"I like to be remote from it because it was so intense that it gives me a good feeling to be able to feel like that was almost, that was me but it was another person."

It is unclear how absent grieving may currently interfere with different aspects of Liza's life or functioning. She did report that during the first 6 months or so, she avoided grieving and had a variety of physical ailments as a result:

"I started to realize that if I didn't go ahead and grieve, if I didn't try to address my feelings, I started noticing that lot of people [in parent support group] would come in a say I stifled things, for about 6 months and I was just totally physically ill."

Liza also reports having marital problems following the loss. This history indicates she is at least prone to absent grieving.
Although now she reports good health and a stronger marriage, with more investigation, it is speculated that there might be other areas of her life that are compromised and typical with the absent griever, she would not trace her difficulties back to the loss.

Interestingly, besides occasionally giving the impression of chronic mourning, both Bryn and Liza are very dissatisfied with their contact with and momentos of the baby. Perhaps this dissatisfaction, like with angry and sad mothers, prevents them from really working through their feelings and moving on. Also,

Elaine provides the clearest example of absent grieving and difficulties that result. Although Elaine denies any feelings about her loss, her gratuitous denial above that "I don't ever relive it, it's not a negative thing.." is the first clue that perhaps she does relive it, perhaps it is a negative thing. She even denies that she had a baby, much less experienced a loss. She says,

"It's more of an experience than it was a real person, that I really had a baby. I wasn't in touch with the fact that I had a baby... gee, it would've been nice to have a little girl and sometimes I wonder now why wouldn't I have another baby so I could have a little girl but I don't have a feeling of loss."

Naturally, she reports being satisfied with not seeing her baby and with not having a photograph, although when she gratuitously denies any curiosity:

"It doesn't bother me at all. I'm not curious as to 'Gee, I wonder what she looked like', or 'Was she mutilated?', or any of that."

However, even though Elaine denies feelings of loss and
disappointment, these feelings are apparent when she describes how she wanted a girl so badly that after her baby girl died, she was convinced throughout her entire subsequent pregnancy that she would have another girl. She decorated the nursery in pink and filled the baby's closet with dresses. As she talks about her subsequent pregnancy, she says,

"The only thing I was mad at... I had done everything, I had known when I was ovulating so I was going to have a girl, and so I knew it was a girl. Even through the whole pregnancy, I was telling people it was a girl and there was no doubt in my mind that it was a girl. So when Chris came, Tom said, 'It.. It.. It.. Its' and I said 'It's a what?' and he said 'Elaine, he's a boy!' You know, I had talked him into we were having a girl too. And I remember feeling disappointed and I felt like a jerk because I thought, 'You're disappointed in the sex of your child?' I remember being a little disappointed that he was a boy. And it never once brought me back to 'Well, if I hadn't lost the other one I would've had a girl.' I didn’t go through that."

Elaine denies that she was disappointed that Chris was a boy because she wanted a daughter, but this gratuitous denial makes it obvious that that's exactly why she was disappointed. Her difficulty in resolving the fact that Chris is not a girl becomes more apparent when she talks about adjusting to having a boy instead of a girl:

"He was a horrible baby, he was real [fussy]. He was a hard baby. It took me a while but I adjusted to him... I always had warm feelings for him but it took me a time to say, 'I'm really glad I have a boy.' Maybe it's that resolution- it took me that time to resolve that he was a boy... Probably within a month's time, or maybe it wasn't that quick, when Chris was walking, maybe more like a year or 2, I was thinking what a blessing it was to have 2 boys. [Here her affect drops] [It took a while] because then [as a toddler] he could wear boys things- you know, when he was a baby it was still not clear that he really was a boy... [when he was older] it was more recognizable that he was a boy instead of, umm, something, just a baby."
Here it can be strongly speculated that the "ummm, something" really means that "It was more recognizable that he was a boy instead of a girl." She also rationalizes, rather weakly, about the advantages of having boys instead of girls:

"I'm real oriented to boys now and I have friends that have girls and stuff and I'm always looking at the girls and thinking, oh, what a pain, their hair and they're moody, just like girls versus boys are."

What makes this rationalization rather weak is that when asked whether it's been easy or difficult to raise Chris, Elaine describes him as moody, tempermental, and demanding, exactly what she says she is avoiding by not having a girl. Thus, for Elaine, it appears that she is stifling alot of anger and disappointment over her loss. Her plan to try to replace the daughter she lost with a subsequent daughter was foiled by the fact that she had a son. So she engages in alot of denial of her feelings and is thus able to feel "resolved" in her grief. And her absent grieving does appear to be interfering in her relationship to her subsequent child.

As they report that they do not feel emotional about their loss any more, as would be expected, all 4 of these mothers also report that they feel resolved. Indeed, with their neutral feelings shielding them from more painful feelings of sadness, anger, and disappointment, it's no wonder that they feel resolved. But given the above discussion, it could be argued that these mothers are not totally resolved. To many mothers, resolution means being able to feel emotion about the loss without being overwhelmed. In contrast,
these 4 mothers deny that they feel emotion, although it is observed that they do still feel strong emotions associated with the loss. Perhaps they deny emotions that exist in order to avoid being overwhelmed; then, are they truly resolved? It can be speculated that they are not resolved in one sense, in that they have not found peace with their emotions, but that they are resolved in another sense, in that they do not consciously feel overwhelmed with emotions about their loss. Bryn used to feel overwhelmed. She talks about holding onto her grief for about 3 years as a way of not accepting the baby's death:

"I did not want to get over it because it was like accepting it. I did not want to accept that this bad thing had happened and I was going to have to live with this for the rest of my life and that was a terrible thing."

But now Bryn feels like she's "not such a victim" any more and there are times that Bryn is "totally free of any memories". As mentioned earlier, Liza recognizes the refuge that neutral feelings give her. Thus, it could be speculated that these 4 "neutral" mothers engage in a lot of denial of their feelings and are thus able to find refuge from strong emotions. Then they are able to feel, but perhaps not really be, resolved in their grief.

Interestingly, these 4 mothers are not the only mothers that recognize the value of neutral feelings. For instance, it appears that feeling neutral helps mothers cope with the sadness. Bess, in addition to feeling sad, also has neutral feelings sometimes:

"Sometimes I just think about him, just as a statement almost, and then I don't have any emotions with it."
The development of neutral feelings over time is described by Sara:

"Before when I thought about him I thought about him in terms of feelings and now when I think about him I picture him, I see what he looks like, whereas before it was just a feeling.

Lynn whose baby died 7 years ago has neutral feelings to cope with the grief that she knows is still unresolved. She describes her neutrality:

"I have always been one to hide emotions— I'm able to talk about it almost as if I had detached myself from the situation."

But these mothers are not out of touch with the feelings they still have about their loss. Lynn is able to express sad and angry feelings when talking about the baby's death and recognizes that she still has some unresolved feelings that "need to be resolved". Bess recognizes that she still feels unresolved because she hasn't "reached a state of acceptance". And Sara feels resolved but also can acknowledge the feelings she still has about her baby's death.

In summary, feeling resolved is for the most part identified by the mothers as feeling bittersweet about the baby and an acceptance or integration of the loss into their lives. Mothers who feel bittersweet seem to feel more acceptance of their sadness while the neutral mothers seem to deny any painful feelings, allowing a perhaps false sense of resolution. While feeling neutral allows a mother to feel resolved regardless of the passage of time, with bittersweet feelings, resolution develops over time. And feeling angry or feeling
sad without any peaceful or happy feelings, ensures that a mother feels unresolved because her feelings about her loss are still too painful to be able to feel any peace or acceptance, i.e., resolution.

There is also evidence of absent and chronic mourning among the angry, sad, and neutral mothers. Some of these mothers have gone through episodes of both of these types of pathological grieving. Just as Lynn and Holly describe episodes of absent grieving and now appear to be experiencing chronic mourning, it is interesting that Liza and Bryn give the impression of experiencing lengthy chronic mourning in the past and now appear to be experiencing absent grieving. This tendency to experience both prolonged absent and chronic mourning would seem to suggest that a mother who is prone to pathological grieving may be prone to both types, absent and chronic. However, it is difficult to judge from a 2 hour interview to what extent every mother experienced chronic or absent grieving and whether these 4 mothers are the exception rather than the rule for mothers who have difficulty grieving. Indeed, as discussed in the "Momentos of the baby" section, Peg and Meryl report earlier experiences of absent grieving and it is speculated that Jane might also show signs of absent grieving. In fact, like Meryl and Jane, all of the now resolved, bittersweet mothers describe years of feeling terrible: Sara reports it took her 2 years to get to the point where she could work through her guilt and Desi had 5 years of battling infertility during which she experienced chronic mourning; In retrospect, Jessie feels that she was clinically depressed for a year; Rose and Cindy
both describe "hanging onto" their grief for more than 2 years. Thus, it appears that even the mothers who now feel resolved have not fared very well with grieving their loss.

It would be interesting to follow mothers during at least the 5 years after a loss and to get periodic and detailed descriptions of grieving. Perhaps it is just the mothers who work through their grief relatively poorly who are likely to succumb to prolonged episodes of absent or chronic mourning. More likely, as these mothers imply, the progress toward resolution would be discovered to be long and difficult, with every mother experiencing prolonged episodes of absent or chronic grieving which would interfere in various aspects of her life. If it is the norm for all mothers with perinatal loss to be prone to prolonged episodes of absent or chronic mourning and to be compromised in their functioning even after 1 year, then should this still be considered pathological grieving? And when is the cutoff point after which a mother who feels unresolved is considered to be "pathologically grieving". The 4 mothers 6-10 years post-loss who feel unresolved do not appear to be particularly nonfunctional as "pathological grieving" would imply. And the other 8 unresolved mothers represent 73% of mothers whose baby died within 1 to 4 years ago. Perhaps feeling unresolved is also normal with perinatal loss, particularly during the first 4 years following a loss and with those mothers whose baby died before 1979, who most likely did not have the opportunity to hold the baby.

Next the discussion turns to the question, does resolution have
any effect on the mother's relationship to a child born subsequent to a perinatal loss? Many of these mothers' doctors had advice to give about waiting a certain amount of time before conceiving, often based on beliefs about the effects of resolution or the passage of time on the mother-subsequent child relationship. The following is a discussion of what advice mothers received, how they felt about it then and how they feel about it now, and how long they actually waited, and why. Then the discussion will continue on to whether resolution or the passage of time is actually related to these mothers' perceptions of their relationship to a subsequent child. Because this study relies on self-report of resolution, regardless of the speculation that neutral mothers may not be resolved, maternal self-report of resolution will be utilized. If indeed grief resolution or the passage of time is related to effects on the mother-subsequent child relationship, with this information, doctors can advise mothers and mothers can make informed decisions about how long to wait to conceive another child.
CHAPTER VI

DOCTOR ADVICE

Of the 24 mothers, 5 (20.8%) mothers did not receive specific advice from their doctor about how long to postpone conceiving another pregnancy, 5 (20.8%) were advised to wait less than 6 months, 7 (29.2%) were advised to wait 6 months, and 7 (29.2%) were advised to wait longer than 6 months, up to 12 months. Of the 5 mothers who received no specific advice, 2 mothers, Sophie and Martina, report that their doctor educated them on the advantages and disadvantages of waiting and left them to make the decision on their own. Interestingly, these 2 mothers waited only 1 - 3 months to try to conceive again while the 3 mothers whose doctors did not discuss subsequent pregnancy waited 8 to 19 months to try to conceive. Perhaps the reason these 3 mothers' doctors did not broach the subject is that all 3 of these mothers knew they wanted to wait and either the doctors knew that or the mothers did not ask the doctor about how soon they could try again, and so received no such advice.

Of the 19 mothers whose doctors did advise waiting a specified number of months to conceive, all 5 (100%) mothers advised to wait less than 6 months did so, but in contrast, only 2 (28.6%) mothers advised to wait 6 months managed to wait that long; likewise only 2 (28.6%) mothers advised to wait longer than 6 months actually waited that long. Indeed, of the 10 mothers who did not follow their
doctor's advice to wait 6 months or more, all 10 decided to wait less than 6 months, similar to the decisions made by the mothers who were actually advised to wait less than 6 months. As it turns out, however, even the mothers who "followed" their doctors advice were not making decisions based only on the advice they received; these mothers stress the fact that they waited that long because they agreed with the advice, not because they were simply obedient to their doctors. This attitude becomes clear in the following discussion of how the mothers felt then and feel now about the advice they received from their doctor. Table 6 lists each mother according to the advice she received from her doctor, how long she decided to wait, and her opinions about her doctor's advice.

No specific advice

Of the 5 mothers who received no specific advice on how long to wait before trying to conceive another pregnancy, just 2 mothers, Sophie and Martina, were educated by their doctors about the advantages and disadvantages of waiting. Martina's doctor advised her in this way:

"He said to wait until I felt ready. He said, 'They can tell you 6 months or a year, whatever', but he says, 'You've got to tell yourself when you're ready because some people can't handle it right away, and some people have to get pregnant right away because they can't handle not having that baby.'"

But even including the 3 mothers whose doctors did not broach the subject, all 5 of these mothers felt positive then and feel positive
DOCTORS' ADVICE TO MOTHERS:
ADVICE RECEIVED, NUMBER OF MONTHS MOTHERS DECIDED TO WAIT BEFORE TRYING TO CONCEIVE A SUBSEQUENT PREGNANCY, ACTUAL NUMBER OF MONTHS BETWEEN LOSS AND SUBSEQUENT BIRTH, AND MOTHERS' OPINIONS ABOUT ADVICE

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>ADVICE</th>
<th>WAIT</th>
<th>LOSS</th>
<th>SQ</th>
<th>BIRTH</th>
<th>MOTHER OPINION ABOUT DOCTOR'S ADVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophie</td>
<td>educated</td>
<td>3</td>
<td>13</td>
<td></td>
<td></td>
<td>Appreciated, he trusted us to figure it out.</td>
</tr>
<tr>
<td>Martina</td>
<td>educated</td>
<td>1</td>
<td>21</td>
<td></td>
<td></td>
<td>Great, made us feel in control.</td>
</tr>
<tr>
<td>Dara</td>
<td>none</td>
<td>8</td>
<td>24</td>
<td></td>
<td></td>
<td>Fine, my own decision to wait a while.</td>
</tr>
<tr>
<td>Anya</td>
<td>none</td>
<td>17</td>
<td>26</td>
<td></td>
<td></td>
<td>Glad it was up to me.</td>
</tr>
<tr>
<td>Elaine</td>
<td>none</td>
<td>19</td>
<td>28</td>
<td></td>
<td></td>
<td>Fine, I knew I should wait to heal.</td>
</tr>
<tr>
<td>Holly</td>
<td>0</td>
<td>3</td>
<td>26</td>
<td></td>
<td></td>
<td>Then glad, now resent push to move on fast.</td>
</tr>
<tr>
<td>Kara</td>
<td>1</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>Then glad, now think if I had waited, maybe I could separate the babies better.</td>
</tr>
<tr>
<td>Bass</td>
<td>2</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td>Then glad, now OK- pregnancy helps but glad Meg was born 18 mos later- I could be happy.</td>
</tr>
<tr>
<td>Lynn</td>
<td>2</td>
<td>3</td>
<td>13</td>
<td></td>
<td></td>
<td>Fine, pregnancy was my cure.</td>
</tr>
<tr>
<td>Sara</td>
<td>3-6</td>
<td>1</td>
<td>11</td>
<td></td>
<td></td>
<td>Then couldn't wait, now can appreciate the need to heal, emotionally and physically.</td>
</tr>
<tr>
<td>Cindy</td>
<td>6</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td>Then terrible, now OK: ache for baby overtakes fear of subsequent pregnancy.</td>
</tr>
<tr>
<td>Kelly</td>
<td>6</td>
<td>1</td>
<td>11</td>
<td></td>
<td></td>
<td>Then OK, now think it should be individual decision- pregnancy helped me.</td>
</tr>
<tr>
<td>Jane</td>
<td>6</td>
<td>3</td>
<td>12</td>
<td></td>
<td></td>
<td>Disliked, did research and decided for self.</td>
</tr>
<tr>
<td>Hannah</td>
<td>6</td>
<td>4</td>
<td>23</td>
<td></td>
<td></td>
<td>Terrible- too long to wait, doc should educate, let mom make personal decision.</td>
</tr>
<tr>
<td>Rose</td>
<td>6</td>
<td>5*</td>
<td>14</td>
<td></td>
<td></td>
<td>Disregarded, no reason to wait, desperately needed to get pregnant.</td>
</tr>
<tr>
<td>Erin</td>
<td>6</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td>Good, body needs time to recover.</td>
</tr>
<tr>
<td>Liza</td>
<td>6</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td>Then good to wait, but should be personal decision- you know what's best for you.</td>
</tr>
<tr>
<td>Luanne</td>
<td>6-12</td>
<td>2</td>
<td>12</td>
<td></td>
<td></td>
<td>Terrible, its important to have another baby.</td>
</tr>
<tr>
<td>Kitty</td>
<td>6-12</td>
<td>4</td>
<td>15</td>
<td></td>
<td></td>
<td>Good but should be personal decision.</td>
</tr>
<tr>
<td>Jessie</td>
<td>12</td>
<td>3</td>
<td>29</td>
<td></td>
<td></td>
<td>Devastated, too long to wait; more helpful for doc to give options, educate, let us decide.</td>
</tr>
<tr>
<td>Desi</td>
<td>12</td>
<td>2</td>
<td>00</td>
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<td></td>
<td>Crazy, should be personal decision.</td>
</tr>
<tr>
<td>Bryn</td>
<td>12</td>
<td>4</td>
<td>13</td>
<td></td>
<td></td>
<td>Terrible, pregnancy helped me feel better.</td>
</tr>
<tr>
<td>Peg</td>
<td>12</td>
<td>11</td>
<td>20</td>
<td></td>
<td></td>
<td>Then terrible, now good- with time realized I needed a breather to get mentally set again.</td>
</tr>
<tr>
<td>Meryl</td>
<td>12</td>
<td>58</td>
<td></td>
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<td></td>
<td>OK, recognized that body wasn't ready to carry a pregnancy successfully.</td>
</tr>
</tbody>
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* Rose waited 5 months only because she was on medication.
now about not receiving specific advice; Martina explains why:

"I was glad because I feel that every person's different. Some people need that baby right then and they want to go right back into a pregnancy - I did at first... And if they give you 6 months or a year, whatever, you figure like that's a timeline - if you don't get pregnant after 6 months or after a year, whatever, something else is wrong. If they leave it up to you, it gives you, makes you feel like you can do something right, if they can leave it up to you."

Here, Martina makes several points about why this type of advice is so helpful. (1) It recognizes that every mother is an individual, with her own needs and feelings, and without placing judgment on those needs and feelings. (2) This advice has no pressure - no pressure to wait until a specified number of months pass, and no pressure to start trying by a certain time. (3) It gives the mother a feeling of control over her own life and her own decisions, which is especially important since losing a baby can give such an out-of-control feeling. (4) By leaving the decision up to the mother, the doctor is demonstrating confidence in the mother's ability to make a good decision for herself, boosting her self-esteem. Additionally, especially if her doctor has laid out the options, their advantages, disadvantages, and possible positive or negative consequences, (5) whatever the mother decides, she can feel that it is a sound, informed decision.

Sophie, the second mother whose doctor discussed conceiving another pregnancy but left the decision to her, agrees:

"It helped me put things in perspective, that if waiting a long time was going to make me crazier, it wasn't that significant medically. I think he trusted us to figure that out. I appreciated that he didn't impose his own standard
on us. I had a sense that I would never be completely ready and if I waited until I was completely ready, I'd be dead and I wouldn't be having any babies!"

Like Martina, Sophie felt the need to try again soon, and she could feel good about her decision because it was informed and not judged by her doctor.

The 3 mothers who received no advice, Dara, Elaine, and Anya, although their doctors did not discuss conceiving another pregnancy, all 3 mothers felt good about being left to make their own decisions, then and now. Perhaps one reason their doctors did not discuss conceiving another pregnancy is that all 3 of these mothers, for their own reasons, knew they should and wanted to wait. Dara waited 8 months because she and her husband were planning to move in 6 months; for her, "there was no sense in getting pregnant until we were settled someplace." Elaine's baby died because of a placental abruption, and she knew that her body needed time to heal for the next pregnancy; she waited 19 months. Finally, Anya had a surviving twin to raise and had wanted to wait 2 years. As it was, her subsequent pregnancy was "an accident", conceived after 17 months. In this group of mothers there is quite a contrast between Dara, Elaine, and Anya who willingly waited more than 8 months and Martina and Sophie who waited less than 4 months. But what they all have in common is feeling good about being left to make their own decisions.

Advised to wait less than 6 months

Another 5 mothers were advised by their doctors to wait less than
6 months to try conceiving another pregnancy. At the time, 4 of these mothers felt the advice was good advice because they all, like Martina and Sophie, felt an urgent need to become pregnant again. But in retrospect, 3 of these mothers feel that such advice is not good because they now see the value in waiting to conceive again. Holly's doctor told her not to wait at all, which now she considers poor advice, partly because of the pressure to move on, and partly because it did not acknowledge that she would need any time to grieve the death of her baby. She explains,

"'Get pregnant right away.' That was their advice. 'Let's just kind of write this one off and move on.' I didn't [resent the advice] at the time but I do now... that's not what you tell women to do. So yes, I resent that because I think it adds to the demeaning of the life that was [the baby that died]."

Bess now feels mixed about the advice she received. Her doctor told her to wait 2 periods and she was "glad he didn't suggest that I wait." Even now, she feels that her first subsequent pregnancy conceived 2 months after David died, was a positive thing for her to do. But that pregnancy ended after 9 weeks and then Meg wasn't born until 18 months after David died. But Bess also feels glad about that: by 18 months, Bess was feeling much better so that Meg "fit right in and I could be happy about her"

Kara, whose doctor advised that she only had to wait 1 month, was glad then because "Nick and I had our heads set to be parents." But now, since Alex was born 1 year after Matthew's death, she wonders, "If I had waited 2 years, maybe I could separate the babies better."
Thus, like Bess, Kara recognizes now that waiting might be better for the mother-subsequent child relationship.

Lynn, the fourth mother still feels the advice was good advice because she says, "pregnancy was my cure". The only mother who felt the advice was bad then was Sara, who was told to wait 3 to 6 months. But she was so desperate to get pregnant, she felt to wait even 3 months was too long. Having had Gary within a year after Jamie's death, though, she now feels that waiting 3 to 6 months would've been better. Like Bess and Kara, Sara now recognizes that having a baby too soon can be difficult. For her, both the subsequent pregnancy and Gary's first year were hard. She talks about her feelings during the final weeks of her pregnancy with Gary:

"Increasing terror. I'm sure this would all be different if I'd waited 2 years and then had another baby, but all that is such a blend. It was such the same time period, it's hard... you go into one pregnancy excited and dying (sic) to see your baby and you go into the next one being sure it's going to be dead."

Later Sara talks about how difficult the first few months were after Gary's birth:

"Who knows if I had postpartum blues- it was less than a year after Jamie died, I don't know what, exhaustion, postpartum, grief, everything, that first year was a nightmare; even after Gary was born, not knowing what was the cause for my tears that day. I was just a mess."

Thus, of the 5 mothers who were advised to wait less than 6 months, 4 mothers now recognize the value of waiting, i.e., waiting would've been better for grieving and/or better for their relationship to the subsequent child.
Advised to wait 6 months

Seven mothers were advised to wait 6 months before trying to conceive another pregnancy. At the time, only 2 of these mothers felt it was good advice: Erin and Liza both felt that physiological recovery was important for a successful subsequent pregnancy. Erin still feels the advice was good but Liza has since realized that it's also important to take into consideration emotional recovery and only the mother herself can be the judge of that. So, Liza points out that how long to wait should be a personal decision. She decided for herself that waiting 6 months was good for her and she recognizes the benefit of feeling in control:

"That was something I decided myself and that made me feel good because that was one little place I could have control... It really seems like it should be an individual decision."

Like Erin and Liza, Kelly at the time thought that waiting 6 months was OK advice. Since it had taken a while to conceive her first baby, she and Steve started trying again after a month thinking it might take 6, as the doctor suggested. Much to their surprise and joy, she conceived in the second month. For her, getting pregnant so soon was helpful because being pregnant counteracted her deep feelings of failure. For her, waiting would've been too much wondering, "Can I? Will I ever again?" Because getting pregnant so soon was helpful for her, Kelly now feels that how long to wait should be a personal decision.

Of these 7 mothers advised to wait 6 months, 3 mothers felt the
advice was bad, then and now. Rose made her own decision to get pregnant as soon as she could and, like Kelly, being pregnant helped her feel better:

"I just had that empty feeling I wanted to fill and it was a compulsion, an obsession, I had to get pregnant... I didn't really take their advice. It's silly. I don't think there's any reason not to get pregnant. I think alot of people need it desperately. I don't know what I would've done if I'd stayed in that state longer!"

Thus, Kelly and Rose would agree with what Sophie said earlier: "...waiting was going to make me crazier... ". Hannah and Jane were the other 2 mothers besides Rose who felt the advice was bad then and now. Hannah says about the 6 month wait, "I mean, [the doctor] might as well have told me 10 years, it just seemed forever!" Hannah decided for herself to wait 4 months, recognizing that "The chances of having a healthy baby are better if you give your body a certain period of time to recuperate." She also knew that having another baby too soon could hamper her emotional recovery and get her "Into a replacement kind of thing". But it was all she could do to wait 4 months. By 6 months she was pregnant but had a miscarriage after 12 weeks and then waited another 4 before trying again, so almost 2 years had passed by the time Michael was born. She says of the 2 year lapse, "I think maybe your body knows to some extent when it's ready." She too believes waiting should be a personal decision.

Jane, the third mother also felt the yearning to conceive another pregnancy sooner than 6 months. She also felt emotionally ready: "I had accepted I think the baby's death and I wanted to get on with my
life... I just wanted to get pregnant real bad." Similar to Rose, she says, "The hardest thing I felt was a sense of emptiness that I don't think could've been filled unless I had another baby." She also made her own decision, going to the library to research for herself how long to allow for physical recovery. Since her reading indicated waiting 3 months, that was how long she waited. Thus, independently from her doctor, Jane educated herself and made her own informed decision.

Interestingly, Jane, Hannah, and Rose, the 3 mothers who felt the advice to wait 6 months was bad both then and now, also report being obsessed about getting pregnant again. Not all mothers report being obsessed; some mothers, like Liza and Erin, found it easier to wait longer than others.

The seventh mother who was advised to wait 6 months was Cindy. At the time she felt the advice was bad but now she thinks it's "OK". Her dramatic response to that advice then was "Forget you, I want a baby NOW!" At the time it was all she could do to wait 1 month, whereupon she immediately conceived her subsequent pregnancy. But like Sara, Cindy attributes her intensely anxious subsequent pregnancy to the experience of having a baby die being too recent, too fresh in her memory. But she has mixed feelings about waiting longer than she did: Although she thinks waiting might have made the pregnancy easier, she also felt the need to have another baby as soon as possible. She says,

"I think the fear wouldn't have been as bad being pregnant with Emily if I would've waited longer. Because it was
like, that just happened and now I'm going through it again and oh boy! I mean I was really scared... It would've been alot more calmer pregnancy if I would've waited at least a year. But then the aching for a baby overtook the fear... It was like, I wanted a baby, so forget the fear, we're having a baby!"

Interestingly, whether the subsequent pregnancy was conceived within 1 month or 4 years after the baby dies, 23 of the 24 mothers felt the subsequent pregnancy was more anxious than any pregnancy before losing a baby. So waiting may not banish anxiety altogether, but as Cindy and Sara believe, it might diminish it.

These mothers advised to wait 6 months confirm further that the decision to wait should be an informed personal decision, as these mothers have different needs and feelings for which only they can find the proper balance. Also, only Erin and Liza actually waited 6 months before trying again, and for Liza, the decision was still hers. Thus, these mothers are making their own decisions, indicating that the doctor may play a more useful, effective role by educating rather than advising.

Advised to wait longer than 6 months

Finally, 7 mothers were told to wait more than 6 months. In contrast to all the other groups of mothers, none of these mothers felt good about this advice at the time. The only mother who felt it was "OK" advice at the time was Meryl, one of the 2 mothers who had multiple perinatal losses. After losing 3 babies in 3 years, she knew her body was not ready to carry another pregnancy successfully and she
waited a year before starting to try again. Peg, the other mother who had multiple perinatal losses was upset at first to hear that she should wait a year: "A year! Do you know how long a year is?!" It was hard to think about waiting because "...my mind was centered so much on having a baby...". She did eventually decide it would be good to wait a year and emotionally, it did help. But she is careful to mention that her decision was based on her special circumstances and would not necessarily be good for everyone:

"Once I waited a little bit I think I realized it was good [advice]. Maybe it was more the string of losses that had happened more than any one in particular... It really helped after the twins to wait, for me. It was hard to do, it was really hard for me to do because I still wanted to have a baby but it did help me mentally to get myself more prepared for it. I think with just one [loss] it might not be quite as necessary to wait that length of time."

She does still think that telling a mother to wait a year is awfully difficult for the mother to hear; she suggests that "'6 months to a year' doesn't sound nearly as long."

Although Meryl and Peg did decide that waiting a year would be a good idea for them, they were persuaded by their "string of losses" rather than the doctor. Naturally, the remaining 5 mothers, each having only the doctor to persuade them, only waited between 2 and 4 months. Desi is the only one of these 5 mothers who, with hindsight concedes that waiting a year may be good advice for some so that you can "...grieve for this baby and get all your feelings out so you're not pregnant and still dealing with 2 things at once." Cindy and Sara would agree. But at the time she received this advice, her doctor did
not give her any reasons, just told her to wait a year and she thought he was "crazy". She only waited 2 months because she figured, "I can't wait a year because that would be 2 years before I would hold a baby."

The other 4 mothers who were told to wait more than 6 months felt then and now that It is bad advice. At the time Kitty decided to wait 4 months because, similar to Jane, "I felt I was able to handle it right then." Bryn also waited 4 months, thinking that if this baby also died, then she wouldn't have gotten to a point where she was feeling good, only to be devastated again. By getting pregnant soon, while still "at the bottom", she felt that she could handle another tragedy better. Luanne only waited 2 months, partly because she wanted to get over the feelings of failure, and partly because, like other mothers, she felt the compulsion to have another baby. She says, "Something inside of me, I just had to have another baby. I was afraid I wouldn't ever have any kids again." She adds that such advice doesn't recognize a mother's feeling that "it's important after you lose a baby, to have another one."

Jessie waited 3 months, thinking 12 to be "an eternity" and she says, "I had all this parenting energy and nowhere to direct it." She then thoughtfully states her opinion on doctors' advice in general:

"A year is accurate in terms of recovery time but I don't know that it necessarily precluded another pregnancy. I think it would've been more helpful had he given us parameters for recovery and maybe that could've been one example and then left it more up to us in terms of when we felt we were ready."
Again, Jessie is pointing out what a lot of these mothers feel: the need to be educated by the doctor and then make their own informed decision. And ultimately, every one of these mothers did make their own decision, but unfortunately some were less informed than others.
CHAPTER VII

MOTHERS' PERCEPTIONS OF THE EFFECTS OF PERINATAL LOSS
ON THE RELATIONSHIP WITH THE SUBSEQUENT CHILD

Because of the speculation that another pregnancy does preclude grieving many doctors feel it is better for the mother to wait so she can grieve her loss before conceiving another pregnancy. There are several problems with this blanket statement however. Not all mothers feel that another pregnancy interferes with grieving. For instance, Cindy remarks, "I worked through the mourning while I was pregnant with Emily, believe me." And many mothers, like Sophie, Kelly, Lynn, to name but a few, felt that getting pregnant soon helped them feel better, although for others, being pregnant soon had some drawbacks: Cindy mentions the anxiety, Sara mentions the emotional turmoil, and Liza does feel that her grief was suspended during her pregnancy and within a couple of days after her subsequent child's birth, she says, "I was really starting to grieve again." Thus, it seems, each mother must weigh for herself what she needs and what she feels.

Then there is the speculation that waiting may ensure that the mother feels resolved by the time the subsequent child is born, reducing the chances of effects on the mother-subsequent child relationship. However, waiting does not necessarily ensure that feelings of grief will not recur. For instance, Peg waited 11 months before trying to conceive and her son Justin was born 20 months after
her twins died. Peg remembers feeling like she had put her grief behind her until Justin's birth brought it back:

"... once you have a real living baby and you see that you're actually dealing with a baby, then it really made me start to think about the other babies quite a bit. I went through a period that it was bothering me more than it had before... my grief was something I felt I had pretty much gotten over and then when I had Justin it kind of brought it back to me a little bit and started me thinking that it still bothers me."

Thus, waiting a year and even feeling like the grief has been worked through is no guarantee that the grief won't return upon the birth of the subsequent child. And among mothers who did not feel resolved by the subsequent child's birth, the range in months between the loss and subsequent birth was 11 to 65. Thus, waiting a long time is no guarantee that the mother will feel resolved by the birth of the subsequent child.

Also, half of the mothers in this study, ranging from 1 to 10 years post-loss, still feel unresolved in their grief. If a mother should wait until she feels resolved to conceive another pregnancy, many mothers would have a long wait. As Sophie pointed out earlier about waiting to conceive another pregnancy, "I had a sense that I would never be completely ready and if I waited until I was completely ready, I'd be dead and I wouldn't be having any babies!" And even of the 12 mothers who now feel resolved, 6 of them did not feel resolved until anywhere from 1 to 5 years after the loss. And 5 of these 6 mothers did not feel resolved until after the subsequent child was born, 4 of whom feel that having a subsequent child helped them feel
better and move on with life. So for how long is it reasonable for these mothers to wait before having another baby? And how does one take into account the fact that nearly half, a total of 10 mothers in this study credit their pregnancy or the birth of the subsequent child with helping them to feel better? And do mothers who felt resolved by the birth of the subsequent child differ from mothers who still felt unresolved in terms of their perception of the effects of the loss on their relationship with that child? Only 6 mothers in this study report feeling resolved by the birth of the subsequent child: Jane, Elaine, Jess, Kitty, Anya, and Meryl. Perhaps even feeling resolved by the birth of the subsequent child is no guarantee that the loss will not affect the mother's relationship to the subsequent child.

Parenting of the subsequent child was assessed under the following "parenting" variables: (1) Perception of effects of loss on parenting or mother-child relationship, (2) Overprotectiveness, (3) Replacement, (4) Setting limits, and (5) Emotional Investment. Parenting variables #2 through #5 are those issues which were spontaneously mentioned by 15 (62%) or more of the 24 mothers. To find out whether time or resolution has any effects on the parenting of a child born after perinatal loss, the 2 "parenting" variables which were chosen for further analyses were correlated with the following 4 "time" and "resolution" variables: 1) time since the loss, (2) time between loss and subsequent birth, (3) current feelings of resolution, and (4) feelings of resolution at the time of the subsequent birth. First, the relationship between perception of
effects of the loss and these specific parenting variables will be explored to see in what way these mothers feel their relationship to the subsequent child has been affected.

**Overview**

Mothers were asked if they felt that either their parenting or their relationship to the subsequent child has been affected by their experience of having a baby die. Of the 24 mothers, 20 (83.3%) feel that their relationship to the child has been affected and 17 (70.8%) feel that their parenting has been affected by the loss. Interestingly, all 17 mothers who feel their parenting has been affected also feel that their relationship to the subsequent child has been affected. Of the remaining 3 mothers who feel their relationship has been affected, 1 does not believe her parenting has been affected and 2 are not sure. The 4 mothers who don't believe their relationship to the subsequent child has been affected by the loss, 3 also don't believe their parenting has been affected and 1 is not sure. This relationship between perception of effects of the loss on parenting and effects on the relationship to the subsequent child is highly significant (Fisher's Exact p = .0016).

Thus, either (1) for the mothers, the 2 separate questions about effects of the loss on parenting and relationship to the subsequent child do not discriminate very well between these 2 concepts, or (2) a discrimination does not truly exist. In any case, just one of these
variables, effects of the loss on the relationship to the subsequent child, was chosen for further analyses. There are 3 reasons for this choice. (1) The 17 mothers who responded affirmatively to "effects of the loss on parenting" are included in the group of 20 mothers who responded affirmatively to "effects of the loss on the relationship to the subsequent child". (2) Answers to the question about the relationship to the subsequent child were all definite, that is, all 24 mothers answered either "yes" or "no" to this question, while to the question about parenting, 3 mothers answered that they were not sure about effects of the loss. (3) Perception of effects of the loss on the relationship was significantly related to "overprotectiveness" and "emotional investment", 2 of the 4 specific "parenting" variables mentioned above. In contrast, perception of effects of the loss on parenting was not significantly related to any of the "parenting" variables. The following is a discussion of the relationship between the perception of effects of the loss on the relationship with the subsequent child and each of the 4 specific parenting variables mentioned by the mothers, including samples of the mothers' descriptions of these variables.

Overprotectiveness

Of the 20 mothers who perceive effects of the loss on their relationship to the subsequent child, 11 (55%) admitted that they feel they are overprotective and 7 (35%) mentioned overprotectiveness but denied that they were overprotective (i.e., gratuitous denial); the
remaining 2 (10%) mothers did not mention overprotectiveness. In contrast, of the 4 mothers who do not perceive effects of the loss, none (0%) admitted feeling overprotective, 2 (50%) mothers mentioned but denied being overprotective, and 2 (50%) did not mention overprotectiveness. Thus, mothers who perceive effects of the loss on their relationship to the subsequent child are significantly more likely to feel or be aware of overprotective feelings as a result of the loss than mothers who do not perceive effects of the loss (Fisher's Exact p = .0398).

Peg, whose son Justin is 3 years old, describes the overprotective, vulnerable feelings these mothers feel for the subsequent child:

"I always worried about him choking on something and I always thought I was going to feed him Cream of Wheat until he was 5 so I would never have to worry about him choking. I have had a first aid class so I know what to do but that doesn't mean I could do it if I had to. I think of all these off the wall things that could happen to him."

Kelly provides a clear example of how gratuitous denial of an issue indicates that the mother is wrestling with the issue. Kelly gratuitously denies her overprotective feelings, believing that she worked through those feelings during her subsequent pregnancy. Here, she repeatedly denies overprotective feelings, most probably because she is continuing to work through those feelings:

"I always feared, right after I got pregnant, that I'd be overprotective of him because of the loss and stuff. That's the feeling when I first got pregnant- 'Oh I'm gonna just smother him.' But I don't do that. I dealt with that during the pregnancy that I cannot be like that. And I think that I've had to work on that. But I'm not
[overprotective], I'm really not, I'm proud of myself for not, I really thought I would be."

Emotional Investment

Of the 20 mothers who perceive effects of the loss on their relationship to the subsequent child, 19 (95%) said it made them feel more invested in the child born subsequent to the loss, more invested than they would have felt if they had not had a baby who died. Of the 4 mothers who do not perceive effects of the loss, only Erin mentioned that her subsequent children are special but she doesn't believe that she feels this way because her first baby died, while the other 3 (75%) did not mention overprotectiveness. Thus, mothers who perceive effects of the loss on their relationship to the subsequent child are significantly more likely to say they feel more emotionally invested as a result of the loss than mothers who do not perceive effects of the loss (Fisher's Exact p = .0076).

Like 19 of the 24 mothers, Sophie believes that her emotional investment with her subsequent child, Evan, has been at least partly affected by the loss:

"I wonder sometimes whether I'm too invested in him because of losing Stephanie and the real strong probability that we won't have any other kids."

Replacement

Of the 20 mothers who perceive effects of the loss on their relationship to the subsequent child, 11 (55%) feel that the subsequent child somehow replaces the child that died, or is not totally separate from the child that died; 6 (30%) mothers
gratuitously denied having replacement feelings; the remaining 3 (15%) mothers do not mention these feelings. In contrast, of the 4 mothers who do not perceive effects of the loss, none (0%) admit having replacement feelings. 3 (75%) mothers gratuitously deny having these feelings and only 1 (25%) does not mention it at all. Although suggestive, this relationship between perception of effects of the loss and replacement feelings is nonsignificant (Fisher's Exact p = .1335).

Jane admits having feelings of replacing the baby that died even though she knows that she "shouldn't" think that way:

"I'm curious about how I would've handled it if I had not gotten pregnant again fairly soon because there are people who have lost one and never replaced- I shouldn't say replaced but I guess in my mind that's what I did."

Jane's mention of "replaced" sounds fairly benign, as she implies that since one baby died, she simply conceived another. In contrast, Kara illustrates the trouble some mothers have separating the subsequent child from the baby who died. Kara mentions that she wishes her subsequent child had been born 2 years instead of only 1 year after her baby died because "maybe I could separate the babies better." However, later she gratuitously denies replacement feelings:

"It's not like I look at Alex and say you're Matthew because it's not that at all. They do have a strong brotherly resemblance... I don't try to use Alex in Matthew's place at all- they are 2 separate people and I'm fully aware of that."

Holly more readily admits this "replacement" dilemma and how she tried to prepare for it by having an amniocentesis so she could know
the sex of the subsequent child. Then before the baby was born, by knowing it was a girl, she could acknowledge and work through her grief that the girl was not Heidi, the baby who died. She says:

"During the pregnancy I pictured Faith as a duplicate of what I thought Heidi was like, just a healthy baby. I had an amnio so I knew it was a girl and I did that specifically for 2 reasons. One, I wanted to be able to say there are problems I know this baby won't have, and [two] I wanted to know the sex because I had always wanted a girl and I knew that if it was a boy I was going to have that sense of loss to deal with and that if it was a girl I was going to have to work on sort of the separating her from Heidi. I remember when I got the results, being excited it was a girl but being really frustrated or sad and crying for a long time. The doctor said, 'Well, you have a healthy baby girl.' and I was like, 'But why couldn't it have been Heidi?"

Setting Limits

Of the 20 mothers who perceive effects of the loss on their relationship to the subsequent child, 7 (35%) mentioned that they had trouble setting limits in disciplining the subsequent child, i.e., were afraid they were spoiling the child; 7 (35%) gratuitously denied having trouble with discipline, while 6 (30%) did not mention discipline issues at all. Thus, these 20 mothers were fairly evenly spread across these 3 categories. The remaining 4 mothers who do not perceive an effect of the loss on their relationship with the subsequent child, none (0%) admitted trouble setting limits, 1 (25%) mother gratuitously denied having trouble setting limits, and 3 (75%) did not mention this issue. However, mothers who perceive effects of the loss were equally likely to admit problems as they were to not even mention the issue; "setting limits" is not significantly related
to perception of effects of the loss on the relationship with the subsequent child (Fisher's Exact $p = .3360$).

Rose talks about her first subsequent child, Lorl who is now 3 years old, and the trouble she has had with discipline:

"With Lorl I think maybe that I've created a lot of bad habits: the fact she won't go to bed by herself and she won't take a nap because I never let her. I never got those good disciplines started. Life was totally undisciplined. Whatever hit me— if I felt like holding her all day, I'd hold her all day. I was never real disciplined with her so she's not a real disciplined child. Some of the real basic things she doesn't do. I think I'm doing a good job now. I think some of the things I've done with Lorl aren't ongoing things or [are] things I didn't do right at first now I would do differently. It's not like I'm continuing bad habits. I'm having to put up now with the things I created. I'm trying to be a lot more disciplined with her and setting limits, boundaries with her."

Kelly, whose baby Cory, was only 5 weeks old at the time of the interview, probably echoes how Rose felt when Lori was that young and likewise will probably regret her errors by the time Cory is 3 years old:

"I love having a child. I'm going to spoil him rotten. I'm going to enjoy that."

Hannah gratuitously denies problems with discipline; she feels more relaxed about setting limits but feels that she is still reasonable with her discipline of her subsequent child, Michael:

"I don't know if I'm more patient or more tolerant of some things than I would've been if I hadn't lost a baby, not to the extent of not feeling comfortable stopping certain things. It just makes you stop and think, is this really important, you know, he might not even be here. I'm concerned about doing the right thing, the right parenting things. I want to do things that are basically good with him."
Although "replacement" and "setting limits" are nonsignificantly related to perception of effects of the loss on the relationship with the subsequent child, all 4 of these variables are probably worth further investigation. However, for this dissertation, only "overprotectiveness" and "replacement" will be explored further, with regard to (1) the relationships between these 2 "parenting" variables and the "time" and "resolution" variables, as well as (2) the mothers' descriptions and the dynamics involved in their feelings of overprotectiveness and replacement. The following is a discussion of the criteria, which were first outlined in the section on "Data Analyses", that were used in choosing "overprotectiveness" and "replacement" for further analyses.

As discussed above, mothers who perceive effects of the loss on their relationship with the subsequent child are significantly likely to also mention overprotectiveness. "Emotional investment" is also significantly likely to be mentioned by these mothers but 19 of 24 mothers feel more emotional investment with the subsequent child as a result of their loss, so there is not much variability among mothers on this issue. "Replacement", though not significantly related to perception of effects of the loss, is still at least mentioned by 17 of the 20 mothers who feel the loss has affected their relationship with the subsequent child. In addition, "replacement" and "overprotectiveness" are 2 conceptually discriminable and statistically unrelated variables. Conceptually, overprotectiveness refers to feelings of vulnerability to tragedy, while replacement
refers to difficulty separating the subsequent baby from the baby who died. Only 6 mothers acknowledge both, 4 mothers mention but deny both, and only 2 mothers don't mention either one. Then of the remaining 12 mothers, 8 mothers acknowledge one while mentioning but denying the other, 2 mothers admit one and don't mention the other, and 2 mothers mention but deny one and don't mention the other; this relationship is nonsignificant (Fisher's Exact p = .5246).

Thus, these 2 variables were chosen because (a) unlike "emotional investment", there is variability among mothers' perceptions such that no more than 11 mothers are coded in any given category, i.e., acknowledges, gratuitously denies, does not mention and (b) these 2 variables are conceptually and statistically independent. In addition, (c) "overprotectiveness" and "replacement" respectively correspond to the "vulnerable child" and "replacement child" syndromes which are cited in the literature as possible effects of perinatal loss on parenting subsequent children, whereas "setting limits" and "emotional investment" have not been addressed in the literature. Finally, unlike "setting limits", (d) for each of these 2 variables 20 (83%) of the 24 mothers spontaneously mentioned the issue, and (e) for these mothers, having overprotective and replacement feelings can both be clearly traced back to the experience with perinatal loss. These 2 variables will be analyzed for their relationships with the 4 "time" and "resolution" variables to see whether the passage of time or feelings of resolution are indeed related to these issues of parenting the subsequent child. If these variables are related, then perhaps
doctors can educate mothers about these relationships so that mothers can make informed decisions about delaying subsequent pregnancy, based on possible consequences to their relationship with the subsequent child. Table 7 provides an overview of these variables: Each mother is listed with the passage of time since her loss and between her loss and the subsequent birth, whether she now feels resolved or unresolved, and whether she admits, denies, or does not mention overprotective or replacement feelings with her subsequent child.

Overprotectiveness, Resolution, and Time

Overprotectiveness and Current Feelings of Resolution

It can be speculated that mothers who currently feel resolved would be less likely to be overprotective than mothers who feel unresolved. Of the 12 mothers who feel unresolved, 4 (33.3%) mothers admit being overprotective, 5 (41.7%) mothers mention but deny overprotectiveness, and 3 (25%) mothers do not mention overprotectiveness. But of the 12 mothers who do feel resolved, a majority, 7 (58.3%) mothers admit being overprotective, 4 (33.3%) mothers mention but deny being overprotective, while only 1 (8.3%) resolved mother does not mention overprotectiveness. Thus, contrary to speculation, the trend suggested here is that unresolved mothers are less likely to mention or admit being overprotective than resolved mothers. However, this relationship is nonsignificant which means that
TABLE 7

TIME, RESOLUTION, AND MATERNAL FEELINGS OF OVERPROTECTIVENESS OR REPLACEMENT WITH THE SUBSEQUENT CHILD

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>YEARS</th>
<th>MOS. LOSS-</th>
<th>SQ BIRTH**</th>
<th>RESOLUTION</th>
<th>OVERPROTECTIVE</th>
<th>REPLACEMENT</th>
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</thead>
<tbody>
<tr>
<td>Kelly</td>
<td>1-3</td>
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</tr>
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<tr>
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</tr>
<tr>
<td>Peg</td>
<td>3-5</td>
<td>&gt;15</td>
<td></td>
<td>unresolved</td>
<td>denies</td>
<td>no mention</td>
</tr>
<tr>
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<td>&gt;15</td>
<td></td>
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<td>admits</td>
</tr>
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<td>denies</td>
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<tr>
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<td></td>
<td>resolved</td>
<td>admits</td>
<td>admits</td>
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<tr>
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<td></td>
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<td>admits</td>
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<td>resolved</td>
<td>admits</td>
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<td>&gt;15</td>
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<td>admits</td>
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<tr>
<td>Desi</td>
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<td>admits</td>
</tr>
<tr>
<td>Elaine</td>
<td>6-10</td>
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<td></td>
<td>resolved*</td>
<td>denies</td>
<td>denies</td>
</tr>
<tr>
<td>Meryl</td>
<td>6-10</td>
<td>&gt;15</td>
<td></td>
<td>resolved*</td>
<td>no mention</td>
<td>admits</td>
</tr>
</tbody>
</table>

* Mother has felt resolved since before the birth of the subsequent child.
** >15 = more than 15 months elapsed between loss and birth of subsequent child; range = 17 to 65 months. <15 = 15 months or less elapsed between the loss and birth of subsequent child; range = 11 to 15 months.
resolved and unresolved mothers are equally likely to be overprotective (Fisher's Exact $p = .5695$).

**Overprotectiveness and Resolution at the Birth of the Subsequent Child**

It is speculated in the literature that mothers who feel resolved before the birth of their subsequent child will be less likely to be overprotective than mothers who feel unresolved. Of the 18 mothers who felt unresolved at the birth of their subsequent child, 7 (38.9%) mothers admit being overprotective, 8 (44.4%) mothers mention but deny overprotectiveness, and 3 (16.7%) mothers do not mention overprotectiveness. But of the 6 mothers who felt resolved by the birth of the subsequent child, a majority, 4 (66.7%) mothers admit being overprotective, 1 (16.7%) mother mentions but denies being overprotective, while only 1 (16.7%) resolved mother does not mention overprotectiveness. Thus, contrary to speculation, the trend suggested here is that resolved mothers are equally likely to mention or admit being overprotective as unresolved mothers, as this relationship is nonsignificant (Fisher's Exact $p = .5832$).

**Overprotectiveness and Time Since the Loss**

It can be speculated that the effects of the loss would diminish with the passage of time such that mothers with a more distant loss might be less affected in their relationship with their subsequent child than mothers with a more recent loss. Indeed, overprotectiveness seems more likely in mothers with more recent
losses than mothers with more distant losses: Of the 7 mothers 1-3 years post-loss, the majority, 5 (71.4%) mothers admit being overprotective, while 1 (14.3%) mother mentions but denies being overprotective, and only 1 (14.3%) mother does not mention overprotectiveness. Of the 9 mothers 3-5 years post-loss, about half, 5 (55.6%) mothers admit being overprotective and the other half, 4 (44.4%) mothers mention but deny being overprotective. Keeping with the trend of mothers with a more distant loss being less likely to be overprotective, of the 8 mothers 6-10 years post-loss, only 1 (12.5%) mother admits being overprotective, while half, 4 (50%) mothers mention but deny being overprotective, and 3 (37.5%) mothers did not mention overprotectiveness. Indeed, of the 4 mothers who did not mention overprotectiveness, 3 (75%) are mothers whose baby died 6-10 years ago. Thus, it appears that overprotectiveness diminishes with the passage of time since the loss. This relationship between overprotectiveness and time since the loss is marginally significant (Fisher's Exact p = .0795).

Overprotectiveness and Time Between Loss and Birth of the Subsequent Child

Of the 24 mothers, 12 gave birth to a subsequent child within 15 months following the loss and 12 had a subsequent child more than 15 months following the loss. It is speculated in the literature that the passage of time between a loss and birth of the subsequent child may decrease the likelihood of the mother being overprotective with
her subsequent child. However, in this sample, mothers whose subsequent child was born more than 15 months after the loss are only slightly less likely to mention or admit overprotectiveness than mothers whose subsequent child was born within 15 months after the loss. Of the 12 mothers whose subsequent child was born within 15 months after the loss, a majority, 7 (58.3%) mothers admit being overprotective, 4 (33.3%) mothers mention but deny being overprotective, and only 1 (8.3%) mother does not mention overprotectiveness. In slight contrast, of the 12 mothers whose subsequent child was born more than 15 months after the loss, less than half, 4 (33.3%) mothers admit being overprotective, 5 (41.7%) mothers mention but deny being overprotective, and 3 (25%) do not mention overprotectiveness. Of the 4 mothers who do not mention overprotectiveness, 3 (75%) are mothers whose subsequent child was born more than 15 months after the loss. Although there is a trend for mothers whose subsequent child was born more than 15 months after the loss being less likely to mention or admit overprotectiveness than mothers whose subsequent child was born within 15 months after the loss, this relationship is nonsignificant (Fisher's Exact p = .5695).

In summary, regardless of feelings of resolution both currently and at the birth of the subsequent child, and regardless of the amount of time between the perinatal loss and the birth of the subsequent child, mothers feel overprotective. The only variable which is related to overprotectiveness is time since the loss. Thus, it appears that overprotectiveness diminishes as the perinatal loss
becomes more distant in time. Now discussion turns to the relationship between overprotectiveness and the subsequent child variables of age, sex, birth order, and neonatal health status. Since all 4 of these variables can be speculated to mediate overprotective behavior or feelings in the mother, overprotectiveness will be correlated with all 4.

Overprotectiveness and Subsequent Child Variables

Overprotectiveness and Age of Subsequent Child

It can be speculated that the younger the subsequent child, the more overprotective a mother will feel. Of the 6 mothers whose subsequent child is an infant less than a year old, the majority, 4 (66.7%) mothers admit being overprotective, 1 (16.7%) mentions but denies being overprotective, and 1 (16.7%) mother does not mention overprotectiveness. Of the 6 mothers whose subsequent child is a toddler, between 12 and 36 months old, only 2 (33.3%) mothers admit being overprotective, 3 (50%) mothers mention but deny being overprotective, and 1 (16.7%) mother does not mention overprotectiveness. However, the trend toward being less overprotective with the older child does not pan out with the mothers of preschoolers, 3 or 4 year olds. Of these 8 mothers, a majority, 5 (62.5%) mothers admit being overprotective, while the rest, 3 (37.5%) mothers mention but deny being overprotective. But then the trend toward being less overprotective with the older child continues with
mothers of a school age child, age 5 to 7 years: none of these 4 mothers admit being overprotective, while half, 2 (50%) mothers mention but deny being overprotective and half, 2 (50%) mothers do not mention overprotectiveness. Though suggestive, this relationship is nonsignificant (Fisher's Exact p = .2131).

And yet, (1) mothers of a school age subsequent child appear to be less likely than mothers of a younger child to admit or mention overprotectiveness, (2) many mothers mentioned how they used to be more overprotective when the child was younger; in addition (3) those mothers with more than one subsequent child mention feeling less overprotective with the second subsequent child, all of which suggest that having a baby survive for a period of time helps these mothers realize they can have a child that lives. However, 'age of subsequent child' is confounded with 'time since the loss', that is, in general, the older the subsequent child, the more distant the loss (Fisher's Exact p = .0000). And, as discussed above, time since the loss is significantly related to overprotectiveness such that feelings of vulnerability fade as the perinatal loss becomes more distant in time. But, some mothers report that it probably helps, as Rose says, to get "in the routine of having healthy kids" Thus, decrease in overprotectiveness is largely accounted for by the passage of time though for some mothers it is also possibly facilitated as the subsequent child gets older.
Overprotectiveness and Birth Order of the Subsequent Child

It can be speculated that a mother whose subsequent child is her first and only child may be more overprotective than a mother whose subsequent child is later born of surviving healthy children or the first of 2 or more healthy subsequent child. However, these mothers appear to feel overprotective regardless of the birth order of the subsequent child. Of the 13 mothers with first and only subsequent child, 5 (38.5%) admit being overprotective, 7 (53.8%) mention but deny being overprotective, and only 1 (7.7%) mother does not mention overprotectiveness. Similarly, of the 5 mothers with more than 1 subsequent child, 2 (40%) admit being overprotective, 1 (20%) mother mentions but denies being overprotective, and 2 (40%) do not mention overprotectiveness. Then, unexpectedly, of the 6 mothers whose subsequent child is later born, i.e., those mothers who have healthy children born before the loss, the majority, 4 (66.7%) mothers admit being overprotective, 1 (16.7%) mother mentions but denies being overprotective, and 1 (16.7%) mother does not mention overprotectiveness. Thus, having healthy children born before the loss does not protect these mothers from feeling vulnerable with healthy children born subsequent to a loss. In fact, Jane, Anya, Kitty, and Martina report that after the loss, they felt overprotective with the healthy child who was born previously. Jane describes how vulnerable she felt with Lisa who was 14 months old when Jane lost her baby boy:

"I would lay in bed worrying about Lisa. I was afraid that something was going to happen to her and then my other baby
would be gone. I was extremely careful with her, probably overprotective."

Similarly, since the loss, Anya has felt more overprotective of her older daughter, Kitty mentions fears of her older son getting killed by a car when he rides his bicycle, and Martina reports feeling overprotective with her older daughter even though she was 10 years old when Gregory died. This relationship between overprotectiveness and birth order is nonsignificant (Fisher's Exact p = .2883).

Overprotectiveness and Sex of the Subsequent Child

It can be speculated that a mother whose subsequent child is the same sex as the baby who died may be more overprotective than a mother whose subsequent child is the other sex from the baby who died. Of the 13 mothers whose subsequent child is the other sex from the baby who died, 5 (38.5%) mothers admit being overprotective, 5 (38.5%) mothers mention but deny being overprotective, and 3 (23.1%) mothers do not mention overprotectiveness. Of the 11 mothers whose subsequent child is the same sex as the baby who died, 6 (54.5%) mothers admit being overprotective, 4 (36.4%) mothers mention but deny being overprotective, but only 1 (9.1) mother does not mention overprotectiveness. Thus, mothers whose subsequent child is the same sex as the baby who died are slightly more likely to admit or mention overprotectiveness. And of the 4 mothers who do not mention overprotectiveness, 3 (75%) mothers have subsequent child of the other sex from the baby who died. Although suggestive, this relationship is
nonsignificant (Fisher's Exact $p = .7601$).

**Overprotectiveness and Neonatal Health Status**

It might be speculated that mothers whose subsequent child had life-threatening illness during the neonatal period would feel more vulnerable and overprotective than mothers whose subsequent child was healthy. Of the 6 mothers whose subsequent child had major, life-threatening illness in the first month of life, indeed, the majority, 4 (66.7%) mothers admit being overprotective, 1 (16.7%) mother mentions but denies being overprotective, and only 1 (16.7%) mother does not mention overprotectiveness. Of the 5 mothers whose subsequent child had minor problems at birth, 2 (40%) mothers admit being overprotective, 2 (40%) mothers mention but deny being overprotective, and 1 (20%) mother does not mention overprotectiveness. However, the 13 mothers whose subsequent child was healthy seem to be equally likely to at least mention overprotectiveness: 5 (38.5%) mothers admit being overprotective, 6 (46.2%) mothers mention but deny being overprotective, and only 2 (15.4%) mothers do not mention overprotectiveness. Thus, regardless of the subsequent child's health status during the neonatal period, these mothers feel vulnerable and overprotectiveness is an issue (Fisher's Exact $p = .8044$).
Summary and Discussion of Overprotectiveness

Overprotectiveness is not related to maternal feelings of resolution so for a mother to put off having a subsequent child until she feels resolved will not be likely to affect her overprotectiveness. Overprotectiveness is not related to the lapse in time between the loss and subsequent birth, so there is no specific waiting period that will diminish overprotectiveness. Overprotectiveness is not related to the age, sex, birth order, or neonatal health of the subsequent child, so mothers of any subsequent child can expect to have overprotective feelings. Overprotectiveness is however, related to the time since the loss. But even as the passage of time diminishes overprotectiveness, there are 2 reasons that one cannot justifiably advise women to wait a long time to conceive to avoid overprotectiveness. For one thing, overprotectiveness does not diminish with larger lapses in the time between the loss and subsequent birth, and so it is not simply the passage of time that diminishes overprotectiveness. Secondly the mothers themselves have observed that overprotective feelings diminish as the mother gets accustomed to having a child who is healthy and doesn't die. Thus, as the mothers report, overprotectiveness probably diminishes from a combination of the passage of time and becoming accustomed to having a child who doesn't die.

But even with the passage of time and becoming accustomed to having a child survive, these mothers still report feeling vulnerable
to losing the subsequent child. For the most part, these overprotective feelings arise from feeling vulnerable to tragedy as a result of first-hand experience with the death of a child. In fact, this phenomenon would more appropriately be called the 'vulnerable mother syndrome' rather than 'vulnerable child syndrome' because in this case it is not the child who is vulnerable to dying; it is the mother who feels vulnerable, vulnerable to losing her child to death.

Of course, every mother realizes that a child can die, but until it happens, a mother does not really consider her child's death a likely event. But after actually experiencing the death of a child, death is considered possible for any other children she has or will have. In fact, for most of these mothers, death of the subsequent child is not considered to be just a possibility but is considered to be very likely to happen. Anya, a mother who feels resolved both currently and at the birth of her subsequent child, and whose subsequent child was born 26 months after her loss, describes these feelings of vulnerability that result from having a baby who dies:

"All parents worry about their children but I think there's a certain amount of denial that exists that allows you to not really believe in your heart that something's going to happen to them. And then when something does happen to one of your children, you know it can happen, you know it's for real.

Anya demonstrates how mothers, in spite of feeling resolved now, in spite of feeling resolved by the birth of the subsequent child, and in spite of many months elapsing between the loss and the birth of the subsequent child, feel vulnerable to having a child die. Anya's
description eloquently captures the essence of the vulnerability these mothers feel. Similarly, for Holly, this feeling of vulnerability is "... just knowing that something can happen to any person or any child at any time. That's scary to me." Bryn expresses her vulnerability when she says, "... life is very tenuous, you cannot count on it... you're afraid to trust that everything's gonna be OK." Kara agrees, "... you never know how long you're going to have them." And Rose says, "Anything can happen. I don't feel protected in any way." So the basic theme is that these mothers feel a real lack of control over their children's well-being. Because of their experience with having a baby die, they feel that this kind of tragedy can strike at anytime, without warning, and in fact they do not trust that they may be spared more tragedy. It appears that these feelings of vulnerability can fade with time. But as this vulnerability was expressed by mothers who were anywhere from 13 to 89 months post-loss, if these feelings of vulnerability do fade, it can obviously take many years.

There are 4 major themes of overprotectiveness and vulnerability described by these mothers: (1) fears of illness or accident, (2) wanting to be a responsible, conscientious, always available, perfect parent, (3) fears that the baby will stop breathing, and (4) being absolutely convinced that the baby will die or be taken away. Sara describes the gamut, how her fears escalate when Gary has been sick, wanting to always be with him, fears of him not breathing when he is asleep, as well as being convinced that this baby was going to die:

"When he was jaundiced at birth I was sure that he had liver problems; the first cold, I was sure it was pneumonia."
Everything that kid did I was sure was going to end his life. I didn't leave that baby with a sitter for over year. I did not let that child nap without my interrupting the nap for a year. I was terrified he was going to die and I was gonna be sure that I was going to be there when he did. I didn't even want to leave him with my husband because I just knew that if something happened to him and I wasn't there, that would be it for me. If that happened with 2 kids. I remember thinking I will just definitely kill myself then, definitely."

Naturally, Sara attributes her fears directly to the death of her baby, Jamie:

"I know I hovered and I know I would not do that with a baby if I had not lost a first one."

Fears of Illness or Accident

Anya describes how difficult her children's illnesses have been, particularly when her subsequent child, Jared had meningitis shortly after birth:

"... It was real scary because I thought, 'This baby is going to be taken away from me too.' I don't think I would've been quite so terrified if we hadn't lost Rachel. But it makes me know that that can happen instead of having that kind of built in denial.... Kim had pneumonia when she was 16 months old and I immediately escalated that into something really life threatening."

This fear of illness or accident is common, mentioned by 7 mothers. Jane, Luanne, and Holly mention that they are adamant that the baby be in a car seat, not a bad idea for any mother to have, but they do it because they are sure that if they don't, the baby will be killed in a car accident. Kitty is "real nervous" about her older son, Paul getting "hit and killed or something" when he rides his bicycle. Jane talks about making sure all her children have regular
medical checkups and Kara admits she is "neurotic" about Alex receiving immediate medical attention, "I do notice that I'm kind of demanding in that I do want him taken care of now." Luanne also feels particularly worried when her subsequent children get sick, Bryn talks about the time Leslie had a high fever and she even took her to the emergency room at the hospital because she was so scared that it was a life-threatening situation. Unfortunately for Desi, not wanting to be overprotective, she put off taking Sam to the doctor for a "rash" that turned out to be a serious staph infection. She says,

"I didn't want to rush him to the doctor. I didn't want to be one of those mothers because I had been to the doctor so much and I thought, 'We're not going to start this.'"

Wanting to be a Perfect Parent

Like Sara, Rose and Peg also had trouble leaving the subsequent child with someone else; Rose still cannot leave Lori, 3, and Anna, 1, with a sitter and is planning to "home school", that is, educate her children at home so she doesn't have to send them to school. She says,

"I just really want to home school them because I just feel that I want to be with them every second and give them anything I can. I just want them to squeeze out anything they can out of me and I don't want anybody else to have reigns over my kids. I never felt that way before. I just thought, 'they'll grow up, they'll go to school, no big deal', you know?"

Part of Rose's desire to keep her children home from school is so she can "shelter" her children from the "cruel world we are living in." Along this same theme, because of the loss, 7 other mothers feel
an increased responsibility to be a conscientious parent, the best parent they can be. Cindy says,

"I'm a better mother to Emily than I would've been to Nicole. I wouldn't have been so concerned about little things. I wouldn't have been so overprotective and aware of how important life is... I'm going to be the best mom I can be."

But to many of these mothers, this increased responsibility means sacrificing their own needs for an existence outside of motherhood. It is a real challenge for these mothers to find a healthy balance between their needs and the child's needs. For instance, some of the mothers feel obligated to stay home with the subsequent child. Rose plans to stay home to educate her daughters herself, and Sara has not returned to work although she had originally planned to, so she can stay home with her son. Peg wrestled with this issue but finally decided it would be best to go back to work; she explained her dilemma, "It's like, I wanted this baby so bad, how can I leave him?"

Desi also feels this conflict between her needs and her child's needs:

"Being able to sit down and have a cup of tea with a toddler, they want you up and around and to me, I get selfish and then I feel guilty because I wanted this child so bad and now I'm upset because I can't have 30 minutes to myself. We put him to bed at 8:00 but that's still not enough time."

Sara agrees that it is difficult to feel like it is OK to be angry or resentful of the subsequent child. She describes how she felt when Gary was a few months old and still required night feedings:

"I can remember one night, I was holding him at like 3 o'clock in the morning because he wouldn't go to sleep and sitting there thinking, WHY don't you go to sleep and
feeling so guilty for even getting the least bit angry at this kid here..."

Bryn also feels this conflict when, as any normal parent, she feels the burdens of parenthood. However, Bryn recognizes that her resentment is normal and healthy, and she feels OK about it:

"They kept telling me in that [support] group- don't feel guilty if there are times when you go, 'Why did I do this?'. You've got to know that there will be times when you say, 'Why am I a parent?'. You know, you're up at 3 in the morning, your kid's really sick, you're afraid for them and all this. I think it was good that they told me It's OK to have those normal feelings of 'What did I do this for?' because you think you've got to always be sold on motherhood because you lost a baby and you don't have the right to complain about the baby [who survived]."

Thus, some mothers feel pressure to meet the child's needs to the exclusion of meeting their own, and to even feel guilty for their own needs, outside of motherhood. Many mothers mention that this pressure probably comes from feeling like they can't take their child's life for granted, and because they wanted this child so much. As Kara says, "I think you realize that you better take real good care of [your] kids and love them because you never know how long you're gonna have them." As a result, these mothers feel a tremendous responsibility for parenting this child who survived. Bryn mentions the high expectations she places on herself, "I feel more responsible to do the right thing; I think it's harder when you've lost a baby." Sara, Hannah, Liza, and Kara all wish they could be perfect mothers; Kara says simply, "I want everything to be perfect but it can't be, so I'm working through that." Like Kara, Liza felt a compulsion to be a
perfect parent to Michelle, but eventually has realized she'll just do the best she can:

"I had some idea that there was some kind of perfect parent and I was going to do that, that I would never scold her and I just let my imagination go wild with me. I felt like I could just be super mom because of what had happened. It's been kind of a shock to find out that I'm pretty ordinary.... I somehow thought I could read all the books and be a perfect mother and it's been difficult to realize that no one has all the answers and that I really have to go from day to day."

A couple of mothers, Liza and Erin, mentioned being adamant about breast feeding, which may be another way to try to be the super mother. For Erin, she felt that she was being a conscientious parent when she would not allow her subsequent child, Ian to have anything but her breast milk for his first year, even pumping and rushing home for lunch after she returned to work at 6 months. Liza feels like she has been giving her daughter Michelle enough parenting for 2 children, since she had 2 but 1 died. She says, "I feel like I'll overwhelm her. I have got so much energy I'd like to put into child rearing, I ought to have a few more." But she says that she feels "Michelle will be my last child." She mentions that she breast fed Michelle for 18 months: "It was like I made up for my son." Instead of breast feeding 2 children for 9 months each, she breast fed 1 for 18 months. Elsewhere during the interview, she even admits, "It's hard to gauge but I'm sure in some ways she's been 2 children to me." Thus, it sounds like Liza is "overparenting", perhaps a term appropriate for these mothers who feel so conscientious and responsible.
Fears the Baby will Stop Breathing

The most widespread fear these mothers have is the fear that the baby will simply stop breathing. Of the 20 mothers who mention overprotectiveness, 15 describe this fear. Holly and Desi mention their fear of SIDS (sudden Infant death syndrome), and Peg talks about her fear that Justin would choke and that she thought she'd like to feed him Cream of Wheat until he was 5 to avoid that tragedy. Liza reports simply, "The first year after my daughter was born I was totally frightened all the time that something would happen to her." Eleven other mothers, including 2 mothers who report being resolved by the time the subsequent child was born, and mothers whose baby was born anywhere from 11 to 65 months after the loss, describe sleeping with their hand on the baby's chest, waking the baby up if they could not detect breathing, or still checking the child at night to make sure they are still alive. Lynn's description is typical of many of these mothers:

"I had fears. I put the bassinet next to my side of the bed and I would wake up in the middle of the night and just touch his face to make sure he was still warm and I did that for 2 or 3 months."

Bryn also describes her fear of her baby's sleep, so typical of these mothers:

"I'd go in, every night I would put my hand on her back to make sure I'd feel [her breathing] and if I didn't feel that I'd try and do something that would make sure she'd [breathe]. She started sleeping through the night real early and that scared me. One time she slept through the night and I got to sleep in and I was like, I've got to get some rest so I want to sleep in but there's another part of me going, 'What happens if I get up and find out...?' So
there would be mornings when I was afraid. Is she just sleeping late or is something wrong? So I couldn't enjoy sleeping in."

Jessie, Luanne, and Rose still check their children at night, and similar to Bryn, Rose says "Even now, when both the girls are sleeping late, I have anxious thoughts like, are they dead?" Even Elaine, who does not perceive effects of the loss on her relationship with her subsequent child, gratuitously denies these fears of her baby dying in his sleep, brushing them off as normal motherly anxiety:

"Like when you go in [their bedroom], they're sleeping and if you don't see their chest going up and down you wake them up; until the first month or so when they sleep so soundly, but that's a mother's protective instinct."

Some of these mothers cannot even let their children take a nap without being filled with anxiety. Martina, Rose, and Sara report not being able to let their baby nap without watching or constantly checking the baby. Martina talks about her overprotective feelings with her 11 month old baby, Robin:

"With Robin, we laid her down and every 5 minutes I was over there, 'If you're not breathing kid or I can't see you move, you're waking up!' And it was always like that. It's not as bad now but I'm constantly watching her to see if she's still breathing."

It is interesting that so many mothers focus on breathing as the sign of life they rely on for reassurance and that they fear it's absence the most. They don't worry about the heart stopping, or cerebral hemorrhage, or fatal malfunction of other organs. They worry about the lungs, airways, breathing. Perhaps it is related to the
cause of death of the previous baby. Of the 25 babies who died, 17 (68%) of the deaths were either cord accidents, sepsis, prematurity, or unknown. Other than not breathing, the baby is perfectly formed, or as Bryn, whose baby died from sepsis, remarked "... he was healthy, he was fine, except for he was dead." For all 4 of these causes of death, it seems plausible that for the mothers, the most salient feature of their baby's death is that the baby simply fails to properly oxygenate, either through the umbilical cord, or immature or diseased lungs. Also, breathing is a very salient sign of life, one that doesn't take special instruments or training to detect. And to these mothers, a peacefully sleeping baby, eyes closed, motionless, looks very similar to a dead baby, which can arouse a mother's fears. Whatever the reasons, these mothers focus on fears that the baby will stop breathing, particularly if asleep.

**Being Convinced the Baby will Die or Be Taken Away**

Being convinced that the baby will die is not simply an increase in the mother's awareness that babies can die. It is the firm belief that any baby of hers will certainly die. Sara alludes to this belief when she says, "I was terrified that he was going to die and I was gonna be sure that I was going to be there when he did." Bryn and Rose refer to this belief when they talk about their fears that when the baby would sleep late, it was because the baby was dead. For several mothers, Luanne, Martina, Bryn, Sara, Rose, Hannah, Lynn, Erin, and Cindy, their anxiety compelled them to constantly check on
the sleeping baby, even waking the child up if they could not detect breathing, and sleeping with the baby. Cindy describes how she slept with her hand on Emily's stomach because she was convinced that tragedy was inevitable:

"Right after she was born I was afraid that something would happen; if she didn't die, she'd be retarded. You just start thinking about all these terrible things... I was afraid she'd die from crib death. It just seemed like I couldn't keep her really, that she might die. So that's why I slept with my hand on her stomach... to make sure she didn't stop breathing."

This belief that if they are with the baby, the baby won't die is not uncommon. Rose elaborates on her hypervigilant attention to her subsequent child, Lori, due to her belief that Lori would die if Rose couldn't see her:

"When Lori was born I was real compulsive. I didn't want her to sleep in her own room and I never let her get out of my sight and it had a lot to do with Jessica. I thought she was going to die any time I couldn't see her... With Lori, I just never knew. I thought if she didn't have some kind of problem internally that she would die of SIDS. If she didn't die of SIDS she'd die of something else, get hit by a car, whatever... A lot of times I would take naps with Lori so I wouldn't have to leave her. I mean, I would lay there and sometimes just watch her for 2 hours rather than getting up and doing anything because I didn't want to leave her by herself."

That Rose recognizes this behavior is compulsive is probably accurate. Several mothers report that they have to check the child before they go to bed, or else they will feel anxious and cannot sleep. As a compulsive behavior is one that reduces anxiety, for many mothers, constantly checking the baby becomes compulsive because it reduces a constantly present anxiety. Rose illustrates the compulsive
nature of this hypervigilance when she describes how she tried to relax and not be so hovering over Lori: "Even when I didn't want to be as obsessive, I mean, even when I tried to break away a little bit, I couldn't." Her use of the term "break away" clearly illustrates how trapped some of these mothers feel by their compulsive, hypervigilant mothering.

Rose, Cindy, Bryn, Martina, and Sara are the 5 mothers who, more than the other mothers, describe themselves as hypervigilant. These mothers feel like they are the child's guardian angel, that the child won't die if they are vigilant enough, always watching, checking for breathing during sleep. Perhaps this is an unconscious way they express guilt over the previous baby's death. Indeed, all 5 talk about being wracked with guilt over their baby's death, even though they can acknowledge that it was not really their fault. As Rose says, and all these mothers would agree, "Even if you have nothing to feel guilty about, your psyche will produce a reason." Martina echoes this sentiment with feelings of both guilt and failure:

"You're not a woman anymore if you can't have a baby that lives. It's your fault. And it's not your fault. You go through guilt and then you realize finally that it wasn't you that did it and you try to blame it on everybody... But I can remember blaming it on myself more than anything."

Indeed, both feelings of guilt about and failure over the previous baby's death may tie into this hypervigilant behavior with the new baby. In fact, Bryn, Rose, and Sara still feel guilt and Martina is the only 1 of these 5 mothers who does not still feel failure over the baby's death. Thus, being convinced the subsequent
baby will die and being hypervigilant to make sure this child doesn't die may be due to both (a) feeling increased vulnerability to tragedy since the baby's death and (b) working through feelings of failure and guilt about the baby's death.

A perhaps more severe form of this belief that the baby will die is the feeling that 3 mothers had that the baby is not really theirs to keep. Martina describes her feelings about Robin, who is now 11 months old:

"I went through times of feeling like I was taking care of somebody that wasn't mine, the feeling that she wasn't really ours. There was times up until probably 2 or 3 months ago that I still had this feeling that someone was going to come and take her away and I wouldn't see her again."

With Martina, it would seem that her attachment to this baby would be severely compromised since during the first 8 or 9 months of this child's life she felt that the baby did not belong to her. Similarly, Luanne describes her lag in attaching to her baby, Molly:

"You don't think it's yours. I didn't even want to feed her. I didn't want her in my room very long. My husband held her better than I did so I let him hold her. I didn't realize that maybe the feelings I had about her was because of [the loss], but maybe it was. It was hard to believe it was mine."

Kitty compares her experience with Paul, who was born before the loss, to her experience with Julie, born after the loss. Interestingly, like Luanne, Kitty was realizing for the first time that this lag she felt with Julie was probably a result of her experience with perinatal loss:
"When I had Paul I instantly fell in love with him and I don't know, I didn't really associate it with Melanie, I didn't even think that was what it was. But maybe so, because you feel like someone is going to snatch her away just like with Melanie."

With the passage of time, these mothers report that feeling convinced that the child will die is a feeling that fades, but they do still recognize the possibility that the child could die. As Cindy says, "She could just die, tomorrow, I mean she could wake up dead, you never know."

In summary, 83% of the mothers in this sample mention overprotectiveness as an issue they deal with in their relationship to the subsequent child. These mothers feel overprotective of the subsequent child because of increased feelings of vulnerability with regard to the tragedy of having a child die. Overprotective, vulnerable feelings are expressed in fears of illness and accident, fears that the baby will stop breathing, especially during sleep, being convinced the baby will die or be taken away, and wanting to be a perfect, always available mother. Intense fears and being convinced the baby will die can last a year or more, and even thereafter in general these mothers do not take their child's life for granted. And mothers have these feelings of overprotectiveness and vulnerability, regardless of their feelings of resolution currently or by the time of the subsequent child's birth, and regardless of the amount of time between the loss and the subsequent child's birth. The passage of time does diminish these feelings, a fact that many of these mothers recognize. In addition, these mothers feel that as they become
accustomed to having a child who is healthy and doesn't die, their intensely overprotective feelings fade, although the recognition of the possibility that the child could die does not fade.

Cindy, whose daughter Emily is 2 1/2 years old has just started to come to grips with her overprotective behavior. As she describes a situation that happened a few days before the interview, she clearly illustrates (1) the anxiety these mothers feel over seemingly harmless situations, (2) the self control that these mothers need to restrain this compulsive overprotective behavior, (3) the triumph they can feel when they finally let go, and (4) the recognition that time and getting accustomed to having a child survive:

"[The loss] has made me overprotective of Emily and they warned me about that and I am. The other day we went to a park with one of my girlfriends and she has a girl that's 3 days older than Emily. And her little girl went over to the slides and just started playing. And I said 'I can't let Emily go down the slide by herself; I can't sit back and let her do it alone! I have to be there and stand there!' But I can't go in the sand with my cast on (mom broke her ankle one week before the interview), so I was like, let her go or she won't be able to play. And I let her go and it was really hard. She got up those slides and did like every other kid and it was a good feeling to me. I said 'Wow, I let her go and she did it!' I didn't even realize I could do that... and it made me realize I was overprotective. It was hard sitting there watching, believe me, but the next time it won't be so hard... I think it'll get easier as I get older, as I grow more and realize that I have to give her that space. As she gets older too, I'll trust her balance more."

Replacement Feelings, Resolution, and Time

Replacement and Current Feelings of Resolution

It can be speculated that mothers who currently feel resolved
would be less likely to have replacement feelings than mothers who feel unresolved. Of the 12 mothers who feel unresolved, 4 (33.3%) mothers admit having replacement feelings, 5 (41.7%) mothers mention but deny having replacement feelings, and 3 (25%) mothers do not mention replacement feelings. But of the 12 mothers who feel resolved, a majority, 7 (58.3%) mothers admit having replacement feelings, 4 (33.3%) mothers mention but deny having replacement feelings, while only 1 (8.3%) resolved mother does not mention replacement feelings. Thus, contrary to speculation, the trend suggested here is that unresolved mothers are less likely to mention or admit having replacement feelings than resolved mothers. However, this relationship is nonsignificant; resolved and unresolved mothers are equally like to have replacement feelings (Fisher's Exact p = .5695).

Replacement and Resolution at the Birth of the Subsequent Child

It is speculated that mothers who feel resolved before the birth of their subsequent child will be less likely to have replacement feelings than mothers who feel unresolved. Of the 18 mothers who felt unresolved at the birth of their subsequent child, 7 (38.9%) mothers admit having replacement feelings, 8 (44.4%) mothers mention but deny replacement feelings, and a minority, 3 (16.7%) mothers do not mention replacement feelings. But of the 6 mothers who felt resolved by the birth of the subsequent child, a majority, 4 (66.7%) mothers admit having replacement feelings, 1 (16.7%) mother mentions but denies
having replacement feelings, while only 1 (16.7%) resolved mother does not mention replacement feelings. Thus, contrary to speculation, the trend suggested here is that resolved mothers are equally likely to mention or admit having replacement feelings as unresolved mothers; this relationship is nonsignificant (Fisher's Exact p = .5832).

Replacement and Time Since the Loss

As was observed with overprotectiveness, it could be speculated that feelings of replacement might diminish with the passage of time such that mothers with a more distant loss might be less likely to admit or mention replacement feelings than mothers with a more recent loss. However, in all 3 "time since loss" groups, the majority of mothers at least mentioned replacement feelings; and the 4 mothers who did not mention replacement feelings were distributed among all 3 groups. Of the 7 mothers 1-3 years post-loss, 3 (42.9%) mothers admit having replacement feelings, while 3 (42.9%) mothers mentions but denies having replacement feelings, and only 1 (14.3%) mother does not mention replacement feelings. Of the 9 mothers 3-5 years post-loss, about half, 5 (55.6%) mothers admit having replacement feelings, while 2 (22.2%) mothers mention but deny having replacement feelings and 2 (22.2%) mothers do not mention replacement feelings. Similarly, of the 8 mothers 6-10 years post-loss, 3 (37.5%) mothers admit having replacement feelings, 4 (50%) mothers mention but deny replacement feelings, and only 1 (12.5%) mother does not mention having replacement feelings. Thus, unlike overprotectiveness, replacement
feelings do not appear to diminish with the passage of time. This relationship between replacement feelings and time since the loss is nonsignificant (Fisher's Exact p = .8464).

Replacement and Time Between Loss and Birth of the Subsequent Child

It is speculated in the literature that the passage of time between a loss and birth of the subsequent child may decrease the likelihood of the mother having replacement feelings. However, in this sample, mothers whose subsequent child was born more than 15 months after the loss are even slightly more likely to mention or admit replacement feelings than mothers whose subsequent child was born within 15 months after the loss. Of the 12 mothers whose subsequent child was born more than 15 months after the loss, a majority, 7 (58.3%) mothers admit having replacement feelings, 3 (25%) mothers mention but deny having replacement feelings, and only 2 (16.7%) mothers do not mention replacement feelings. In contrast, of the 12 mothers whose subsequent child was born within 15 months after the loss, less than half, 4 (33.3%) mothers admit having replacement feelings, 6 (50%) mothers mention but deny having replacement feelings, and 2 (16.7%) mothers do not mention replacement feelings. Of the 4 mothers who do not mention replacement feelings, 2 (50%) are mothers whose subsequent child was born more than 15 months after the loss and 2 (50%) are mothers whose subsequent child was born within 15 months after the loss. Although there is a trend for mothers whose subsequent child was born more than 15 months after the loss being
more likely to mention or admit replacement feelings than mothers whose subsequent child was born within 15 months after the loss, this relationship is nonsignificant (Fisher's Exact p = .5695).

In summary, and similar to overprotectiveness, replacement feelings are not mediated by resolution or time between the loss and subsequent child's birth. However, while overprotectiveness diminishes with the passage of time, replacement feelings appear to be constant across mothers 1-10 years post-loss.

**Replacement Feelings and Subsequent Child Variables**

The only subsequent child variable with which replacement feelings would be sensibly related is sex of the subsequent child. It can be speculated that replacement feelings might be heightened by having a subsequent child who is the same sex as the baby who died, as it may be more difficult to separate the 2 babies when they are both girls or both boys. Replacement feelings might also be heightened if the subsequent child is the other sex from the baby who died, and there are no siblings of the sex of the dead baby. For instance, if the baby who died was a girl and the mother really wanted a daughter and all she had was sons, she might feel disappointed if she could not "replace" the girl with another daughter. Finally, replacement feelings may be least activated if the subsequent child is the other sex from the baby who died but there are siblings of the same sex as the dead baby. For instance, if the dead baby was a girl and the
subsequent baby was a boy, then the mother may not be so disappointed in not having another girl if she also has a surviving daughter.

Of the 11 mothers whose subsequent child is the same sex as the baby who died, about half, 6 (54.5%) mothers admit having replacement feelings, 4 (36.4%) mothers mention but deny having replacement feelings, and only 1 (9.1%) mother does not mention replacement feelings. Similarly of the 7 mothers whose subsequent child is the other sex from the dead baby and who do not have children of the same sex as the baby who died, about half, 4 (42.9%) mothers admit having replacement feelings, 2 (28.6%) mothers mention but deny having replacement feelings, and 2 do not mention replacement feelings. Not much different are the 6 mothers whose subsequent child is the other sex from the dead baby but who do have at least one child the same sex as the baby who died: 2 (33.3) mothers admit having replacement feelings, 3 (50%) mothers mention but deny having replacement feelings, and 1 (16.7%) mother does not mention replacement feelings. Thus, replacement feelings are nonsignificantly related to the sex of the subsequent child (Fisher's Exact p = .8771). Indeed, the fact that only 1 or 2 mothers in each category do not mention replacement feelings is indicative of the prevalence of replacement feelings regardless of the sex of the subsequent child.

**Summary and Discussion of Replacement Feelings**

Regardless of feelings of resolution, the passage of time, or sex
of the subsequent child, the majority of mothers have replacement feelings. These data indicate that it is useless for a mother to put off conceiving a subsequent child in order to fend of replacement feelings. Rather, just as it appears to be the norm to have overprotective, vulnerable feelings, it appears to be the norm to have replacement feelings.

Posnanski (1972) describes replacement feelings in terms of an older child dying and the mother then deciding to conceive another baby. When the new baby is born, the mother may have difficulty focusing on the new baby as an individual separate from the child who died, even imposing expectations for the new baby to be like the dead child. But normally, if an older child dies, the mother is left with memories of that child as an individual, with a unique appearance, personality, and habits. Then after the new baby acquires a personality, the mother can have a memory of the dead child's appearance, personality, and habits that is distinctly different from the new baby's appearance, personality, and habits. Thus, replacement feelings are considered abnormal.

However, there may be some differences when the dead child is a baby who died at birth, such that it is normal to have replacement feelings. When a child dies at birth, the mother never has the opportunity to get to know the child as an individual. Then replacement feelings can go one of 2 ways: (1) if the mother has idealized the dead infant as the baby who would have been perfect, even tempered, clever, and attractive, she may be disappointed when
the subsequent baby does not live up to those unrealistic expectations; or (2) when the subsequent baby is born, the mother cannot impose the dead baby's personality on the new baby because the dead baby never acquired a personality. Thus, replacement feelings for the mothers may become more a matter imposing the new baby's personality on their ideas of what the dead baby might have been. These mothers typically talk about having trouble "separating" the 2 babies.

**Idealization of the Dead Baby**

Only 3 mothers clearly alluded to the idealization of the dead baby. Bryn referred to idealization directly while, for Sara and Elaine, idealization of the dead baby and imposing idealized expectations on the subsequent child were implied from their statements.

Sara, as quoted earlier, explains how difficult it is to feel OK about being angry or resentful of the subsequent child. While anger and resentment are emotions normally felt by parents, the source of Sara's resentment is her disappointment in how difficult it has been for her to get along with her subsequent child. For example, she describes how they rejected breast feeding:

"I hated it, he hated it, he loved the bottle. It was not a mutually satisfying experience. The first time I tried to give that child my breast, he turned his face, he turned the other way, and yelled. It's kind of been the way he's been. He started saying 'no' the first time I met him."

Earlier in the interview she described how resentful she was of
him keeping her up at night when he still required night feedings:

"I can remember one night, I was holding him at like 3 o'clock in the morning because he wouldn't go to sleep and sitting there thinking, WHY don't you go to sleep and feeling so guilty for even getting the least bit angry at this kid here and then starting to cry about Jamie and then thinking why would I cry over Jamie because If it weren't for Jamie's dying, Gary wouldn't be here."

Remarkably, her statement "If it weren't for Jamie's dying, Gary wouldn't be here" can be interpreted 2 different ways. She consciously meant that she was so thankful to have Gary, a healthy baby, who would not have been conceived if Jamie had lived, that to cry over Jamie's death feels equivalent to crying over Gary's existence, and why would she want to cry over Gary's existence. But crying over Gary's existence may be precisely how she felt, because after all, he was keeping her up at 3 in the morning. It could be speculated that Sara is an example of a mother who has not separated the idealized deceased infant, Jamie, from the reality of what Jamie would have been, had he lived. She may feel that Jamie, the ideal, would not have turned away from her breast or have kept her up at 3 in the morning, whereas Gary is fussy which made her feel rejected and he keeps her up at night. So Gary pales in comparison to her ideal of what Jamie would have been. Of course the reality is that Jamie probably would have had his fussy moments and kept her up at 3 in the morning, but unfortunately for Gary, Sara has not let go of her idealized image of the baby who died.

Elaine is the other mother whose idealized notion of the dead baby also interferes in her relationship with her subsequent child.
Elaine had a baby girl who died and during her subsequent pregnancy, she wanted another girl so badly that she was convinced she was carrying a girl. But her plan to replace the daughter she lost was foiled when she bore a son, Chris. In fact she admits that "when he was a baby, it was still not clear that he really was a boy..." And she implies that she could "pretend" that Chris was a girl until he was older and then "it was more recognizable that he was a boy". "Chris" is even the name she had planned to give to her baby girl that turned out to be a baby boy. Her continuing disappointment after 4 years that her subsequent child is a boy is apparent, and discussed in detail on pages 196 and 197. Interestingly, like Sara, Elaine also describes her subsequent child as being difficult for her to get along with, that he was a "horrible baby", and is still tempermental.

Although Elaine and Sara appear to have difficulties with their subsequent child due to their retention of an Idealized Image of the dead baby, it could also be speculated that the source of this dysfunction is unresolved grief. Sara describes the difficulty she experienced with still grieving her loss and having a new baby to take care of, and each day, "not knowing what was the cause for my tears that day." Elaine also feels that part of Chris's tempermental nature is because she was unavailable to her son during his first few months of his life because she broke her foot and "that's maybe why he didn't get his needs met early on." Thus it could be speculated that in Sara and Elaine's cases, unresolved grief exhibited itself in not being able to let go of the Idealized Image of the baby who died and they
have placed unreasonable expectations on the subsequent child to be what they thought the baby who died would have been.

Bryn, on the other hand, recognizes that her fantasies of life as a mother to the baby who died were simply idealized notions which quickly vanished when her daughter Leslie was born. She says,

"Some of the fantasies you have are not true. You picture yourself in the spring out there and the baby toddling around and you're digging the garden and that doesn't happen because you've gotta watch that kid every second. So a lot of those things, it was good for me to realize... It helped me to be exhausted in the middle of the night and saying 'If she cries one more time how am I going to get up?' That helps to see the reality of it, the good and the bad. It would've been so awful if I had not been allowed to have a baby- It's so healthy to have reality there."

So for Bryn, instead of Leslie paling by comparison to the idealized image of the baby who died, the reality of what's involved in parenting helped Bryn let go of her idealized image of the baby who died. This is a contrast to Sara and Elaine who have maintained an idealized image of the baby who died and as a result have probably been more resentful to Gary and Chris than Bryn has felt toward Leslie.

Trouble Separating the 2 Babies

While idealization of the dead infant can result in the mother imposing this image of the dead baby on to her subsequent child, trouble separating the 2 babies results in the mother imposing her image of her subsequent child on to her image of the dead baby. Trouble separating the babies seems less dysfunctional for the mother-
child relationship because the mother is not placing unrealistic expectations on her subsequent child to live up to the idealized image of the dead baby. Rather, she may be trying to fill in the mystery of what the dead baby would have been like if s/he had lived, by seeing what the subsequent baby is like and imagining from there what the baby who died might have been like.

In fact, many of the mothers catch themselves looking at the subsequent child and wondering if the baby who died would have looked the same, or if their personalities would have been similar. Liza had a little boy who died and then a little girl who lived. She expresses this need to compare when she says,

"Sometimes I wish I had another little boy so that I'd see a little bit more of what he would be like. It's a feeling that you'd like to have 5 or 6 children so that all the personalities combined, you'd be able to see what the [baby who died] would be like."

Similarly Jessie who lost a girl and then had another girl says,

"With Katy I think of her a lot when I see Katy wearing things that were given to Meagan or doing things that I had imagined Meagan would do."

Jane lost a baby boy, then had a little girl followed by another little boy. Not when her daughter was born but when this boy was born she was full of "wondering what his brother would've been like. I wonder, would he have looked as much like his dad as Josh does."

Similarly, Cindy says, "When you look at Emily and see how she acts, you wonder if Nicole would've been like her and if she would've looked like her and all that." And Kitty says, "I think about what she could
look like, I wonder what her smile would've been like. But when Julie was born she looked an awful lot like Melanie so I kind of feel like I can watch her grow up and I'm not saying Julie is Melanie but I think she would've looked a lot like her. So apparently these mothers feel like they can watch their subsequent children and get an idea of what the dead baby would've been like. It's almost like these mothers are getting to know the dead baby through the subsequent child by imagining the similarities that could have existed.

In fact, particularly if the mother's experiences with both pregnancies are similar, it may be easy for the mother to feel that it is the same baby again; after all there is no concrete evidence to the contrary. Luanne clearly presents this dilemma:

"Some people get mixed up and think it's the same pregnancy. I never got mixed up like that but I know I thought about him. It was hard to believe it was another person, another child, I don't know if you understand but it was really hard for me to imagine there could be 2 of them. I knew it was another, but..."

Logically, rationally, Luanne knew she was pregnant with a different baby but it was still difficult to really know that for sure. Of course, every mother rationally realizes that her 2 children are separate individuals. But during pregnancy and shortly after birth, both the baby who died and the subsequent baby are such vague entities and yet have such a powerful impact on the mother's emotions. The mother's experience with both babies being so similar, it is not surprising that a mother might have trouble separating the 2 babies, particularly during the pregnancy and until she gets to know the
subsequent baby as an individual. In fact, 6 mothers spontaneously mentioned that both babies looked similar at birth. Hannah says of Laura who died, and Michael, the subsequent child, "They looked alot alike. I remember thinking about the physiological resemblances."

And like Luanne, 5 additional mothers admitted that, during the subsequent pregnancy, they imagined they were pregnant with the baby who died, or that the baby they were carrying would look and be like the baby who died. Kelly says,

"I had alot stronger feelings for this pregnancy. I thought this was Scott's way of coming back to us in a different way. I knew it was a boy from the day I knew I was pregnant. I told everyone it was a boy from day one and it was."

Kelly did have a little boy and so was not disappointed as Elaine was when she too assumed that her subsequent child would be the same sex as the baby who died. Hannah also acknowledges this desire to replace the daughter who died by having another baby girl when she says,

"I think we wanted a girl. Maybe that was part of the replacement thing in a way but I think we both tended to wanting to have a girl. And then I thought, well, you know, I just want a healthy baby."

Fortunately for Michael, her subsequent son, and in contrast to Elaine, Hannah is able to accept the fact that she had a boy instead of a girl.

Similarly, Liza felt that she could replace her baby boy by having another little boy. She says, "Even when I was pregnant with my daughter, I kept thinking maybe I'll have a little boy and he'll
look just like Daniel... in my mind I was pregnant with him." However, she is glad she had a little girl because it made her really accept the fact that Daniel was not coming back.

In contrast, after Jessica died, Rose desperately wanted to have another girl, and she did. So unlike Liza, Rose was not forced to accept the fact that Jessica was not coming back, and she had a lot of trouble separating the 2 babies. When Lori was born, Rose remembers,

"I remember thinking that they looked an awful lot alike. I didn't have any feelings of replacement, I almost felt like it WAS Jessica, kind of. I mean, I didn't think I was replacing Jessica, I thought it WAS Jessica. Lon had some of the same feelings, like, we finally brought our baby home. It took us 2 years but we brought her home. Like it was almost the same baby."

Later Rose insists that Lori was not "a replacement baby" because having Lori did not replace her grief over Jessica's death. But clearly Rose had trouble separating these 2 babies. This trouble separating the 2 babies gave her some anxious moments:

"I was so neurotic I had her sleeping in our bed with us, right next to me. I had the nightlight on so I could see her breathing. And a lot of times during the night I'd look over and she'd look so much like Jessica I'd wake her up so she could respond."

It does seem that mothers who have a subsequent baby the same sex as the baby who died are more prone to this trouble separating. As mentioned earlier, Holly had an amniocentesis and she wanted to know the sex of the baby. As it turned out, it was a girl, like the baby who had died, and knowing this Holly was able "to work on sort of the separating her from Heidi" during the pregnancy. Even so, Holly
admits, "During the pregnancy, I pictured Faith as a duplicate of what I thought Heidi was like..." Jessie, who lost a baby girl, remembers hoping her subsequent baby would be a boy "so it would be easier to separate the 2." As it was, she had another girl:

"Right away I scrutinized and examined her and I could see similarities in her appearance with Meagan but I could see some real differences right away... I mean, she looked enough different from Meagan, I liked it that she resembled her in some ways but she also looked very different in some ways too."

Jessie reports that these differences between her 2 daughters made it easier for her to separate the 2. Unfortunately for Kara, she sees "a strong brotherly resemblance" between her 2 sons. Although she admits having, as she says, "trouble separating the 2 babies", she gratuitously denies placing Matthew, the dead baby, in Alex: "It's not like I look at Alex and say you're Matthew because it's not that at all." Chances are, on some level of awareness, that's exactly what she feels. Even though Bryn's 2 babies were different sexes, she also, several times, gratuitously denies having trouble separating her 2 babies, Christopher who died, and Leslie, her subsequent daughter:

"I know they were 2 separate beings and I didn't feel like I was trying to make her over into anything he would've been. It was very strong in my mind that there were 2 separate babies there... There's no question in my mind that they are separate."

If there was really "no question" in her mind that her 2 babies are separate, then she probably would not keep bringing up the issue. What is really interesting about Bryn's statement though, is the idea of "trying to make her over into anything he would've been". This
statement sums up the possibility that these mothers have trouble separating the babies because, having never gotten to know the dead baby they are left wondering if the dead baby would have been like the subsequent baby. After all, both babies came from the same place, the same gene pool.

Unlike overprotective feelings, replacement feelings do not seem to be associated with anxiety, nor do they seem to promote compulsive behaviors. Mothers who do not let go of the idealized image of the dead baby inevitably feel resentment toward and disappointment in the subsequent child who cannot possibly live up to the idealized image. There are 2 mothers in this sample who can be classified as such. On the other hand, it appears to be the norm that mothers look at the subsequent child as a way to imagine what the dead baby might have been like. These mothers are simply reacting to the fact that the baby who died was a transient entity about whom the mother will always wonder, while the subsequent baby is permanent and growing and responding, a baby the mother has the opportunity to know. This leads to the speculation that replacement feelings do not diminish with the passage of time, because their questions about what the baby would have been like are never answered. With overprotective feelings, the distance from the tragedy and perhaps becoming accustomed to having a baby survive are ways that the mother can let go of some feelings of vulnerability. With time, the mother gets to know her subsequent child as an individual, and she may not have trouble separating the 2 babies as time goes on. But the feeling of wondering what the dead
baby would've been like and wonderingly imposing the subsequent child's appearance, personality, and habits onto her image of the baby who died, is the only way the mother will ever have of filling in her curiosity about the baby she never got to know.
CHAPTER VIII

SUMMARY AND CONCLUSIONS

Grief Resolution

Resolution was identified by the mothers who feel resolved as a feeling of acceptance and integration of the loss into their lives. While these mothers still have sadness, their sadness is a mellow feeling, not intense, and they also describe having fond, peaceful, even happy memories of their baby. Thus, the resolved mothers have both happy and sad, or bittersweet feelings about the baby who died. These resolved mothers also recognize that they can accept their loss while still occasionally having grieving feelings and still remembering the baby who died. In contrast, many of the unresolved mothers feel that accepting the loss would suggest that they were happy that the baby died and that not feeling intense grief would lead to forgetting about the baby who died. These unresolved mothers believe that holding onto their grief is a way to remember this baby who died.

Peppers and Knapp (1980) also observed this basis for unresolved grief, referring to this reluctance to let go as "shadow grief". While Peppers and Knapp (1980) felt that this shadow grief was a burden these mothers continue to bear, Kowalski (1984), proposes that shadow grief is not a burden but a cherished bittersweet memory of the
baby who died. In the present study, the unresolved mothers appear to conform to Peppers and Knapp’s (1980) observation: For these mothers, grief does appear to be a burden and in general, unresolved mothers do not have a feeling of acceptance and none feel an integration of the loss into their lives. For the unresolved mothers, their feelings of sadness, anger, loss, and grief are still too intense to give them the peaceful, accepting feeling that the resolved mothers describe. Having memories that still evoke painful emotions and this failure to accept and integrate the loss are hallmarks of being unresolved which are cited by Rubin (1984) and Bowlby (1980).

But the resolved mothers in the present study appear to conform to Kowalski’s (1984) observation: These mothers describe bittersweet feelings associated with the baby and although they still feel grief, they feel that their grief is incidental, an accepted, integrated part of their lives, and indeed part of the memories they keep. Because the loss, their memories, and their grief is accepted and integrated into their lives, these mothers do not appear to be burdened by this "shadow grief". Thus, the present study confirms that continuing to have feelings of grief associated with the baby’s death is the norm; whether the grief appears to be a burden or not depends on the mother’s ability to have or recognize bittersweet feelings about her baby and her acceptance or integration of the loss into her life.

These data on feeling bittersweet, accepting, and resolved versus sad, angry, unaccepting, and unresolved are consistent with the literature on grief and perinatal loss. But while the literature
contains speculations on the pathological nature of unresolved grief, the unresolved mothers in the present sample do not demonstrate pathology associated with feeling unresolved. Compared to the resolved mothers, the unresolved mothers appear to be more burdened or pained by their grief but they do not appear to be more dysfunctional as a result. Thus, the data in the present study are discrepant with the literature in several ways.

First, the cut-off point cited by Stringham et al. (1982), Parkes (1970) and Helmrath and Steinitz (1978), among others, is one year after which unresolved grief is considered pathological. However, in the present sample, both resolved and unresolved mothers indicate that it is the norm to still feel unresolved within 4 years after the loss. If feeling unresolved for more than one year post-loss is the norm, then perhaps it is not pathological. Secondly, although it is speculated that neutral, angry, and sad mothers are experiencing some degree of chronic or absent mourning, and although chronic or absent mourning is considered to be pathological, these mothers do not seem to exhibit any more or less dysfunctional behavior than the resolved or bittersweet mothers. Even for those mothers who report still feeling unresolved at more than 4 years post-loss, as far as the Perinatal Loss Interview can indicate, none of these unresolved mothers are seriously impaired by their unresolved feelings of grief. Thus, by itself, lack of resolution does not appear to indicate pathology. Indeed, it can be speculated that grief resolution is a process rather than an endpoint and cannot be dichotomized into
resolution equals health / lack of resolution equals pathology. Rather than considering "unresolved" grief as pathological, perhaps feeling unresolved is simply one approach to coping with loss.

There are several arguments for viewing "unresolved" grief as simply one approach to coping with loss. Resolved and unresolved mothers differed only on (1) their current feelings about the baby and baby's death and (2) their feelings of acceptance of the death. These differences appear to be differences in perspective and degree of resignation to the loss rather than differences in grieving behavior. Indeed, resolved and unresolved mothers did not differ on grieving behaviors such as anniversary reactions, frequency of thoughts of the baby, still feeling anger or guilt, and feelings about the future, variables which are traditionally considered to indicate grief resolution or lack thereof. That the traditional indicators for grief resolution are not applicable to grief resolution for perinatal loss may indicate that grief resolution for a perinatal loss is different from grief resolution for other kinds of losses. This finding coincides with the observations of Parkes (1970), Kowalski (1984), Higgins (1977) and Peppers and Knapp (1980), that grieving the death of a baby is qualitatively different from grieving other kinds of losses. More importantly, these data may indicate that differences in feeling resolved or unresolved do not involve differences in grieving behaviors such as anniversary reactions, frequency of thoughts of the deceased, or feelings about the future. Thus, for these mothers, resolution does not mean an end to their grief, but a softening of
their sadness or anger over their baby's death and an acceptance of their loss and feelings of grief.

A second argument for viewing both resolved and unresolved feelings as nonpathological approaches to coping with perinatal loss is that both resolved and unresolved mothers describe their feelings of resolution using common terms. Both resolved and unresolved mothers talk about still having feelings of grief and not forgetting about the baby who died. For resolved mothers, feeling resolved includes grieving and remembering; similarly for the unresolved mothers, feeling unresolved includes grieving and remembering. The unresolved mothers tend to express more intense feelings of grief, anger, and sadness than do resolved mothers, but it seems that the resolved and unresolved mothers are saying the same thing about their feelings of resolution; both resolved and unresolved mothers still feel some grief and feel it is very important to remember the baby who died. Where they differ is on their perspective. Resolved mothers are able to focus on their bittersweet, accepting feelings while unresolved mothers focus on sad, angry, unaccepting feelings. An appropriate analogy is that resolved mothers see the glass as half full while the unresolved mothers see the glass as half empty. Thus feeling resolved and unresolved can simply be considered different ways of coping with tragedy rather than one being considered better than the other.

Thirdly, the similarities between resolved and unresolved mothers also extend to their feelings about the subsequent child: resolved
and unresolved mothers were very similar in their overprotective and replacement feelings with regard to the subsequent child. Thus, by itself, resolution does not appear to indicate pathology with regard to parenting the subsequent child.

Parenting of the Subsequent Child

Regardless of whether they postpone subsequent pregnancy and regardless of feelings of resolution either currently or at the time of the subsequent baby's birth, the majority of these mothers mention overprotective and replacement feelings.

Overprotectiveness

Rather than being associated with grief resolution, overprotectiveness appears to be a result of feeling vulnerable to having a child die; if it happened once, it can happen again. Overprotectiveness takes the forms of (a) fear of illness or accident turning into tragedy, (b) wanting to be a perfect, giving mother, (c) fear that the baby will simply stop breathing, and (d) being convinced the child will die or be taken away. Particularly in the first year, many of these mothers are convinced the child will die and compulsively checking on the baby, especially when the baby is asleep, is a common behavior. It is speculated that the extremely hypervigilant mothers have feelings of guilt and failure over their previous baby's death and they think that if they are hypervigilant,
the subsequent baby will not also die. Green and Solnit (1964) identify this behavior as the "vulnerable child syndrome" but it may be more appropriately referred to the "vulnerable mother syndrome".

Replacement

Rather than being associated with grief resolution, replacement feelings appear to be a result of never having had a chance to get to know the baby who died. Two mothers in this sample are speculated to be retaining idealized images of the dead baby, images which they expect the subsequent child to live up to, resulting in the mother having feelings of disappointment and resentment toward the subsequent child. This inability to reorganize the image of the dead baby, to make it more realistic, is a sign of unresolved grief cited by Rubin (1984) and Bowlby (1980). But for the 2 mothers speculated to retain idealized images of the dead baby report feeling resolved, accepting of the loss. Thus for these mothers, grief resolution does not appear to be related to this phenomenon. The other variant of replacement feelings does not appear to compromise the mother-child relationship and also appears to be the norm among these mothers. This more benign variant of replacement feelings involves, at first, having trouble separating the 2 babies and then later imposing the subsequent child's appearance and personality onto the image of the baby who died. Because the mother never had the opportunity to know the baby who died, she is left wondering what that baby would have been like. In order to fill in her vague image of the dead baby she imposes the
attributes and behaviors of the subsequent child, thinking that perhaps that baby would have been similar to the subsequent child.Replacement feelings described by these mothers are unique to perinatal loss because the mother never got to know the baby who died. It is not surprising then that the resolution indicator "wondering what the baby would be like if the baby had lived" does not discriminate between resolved and unresolved mothers as it appears to be natural for these mothers to wonder what that baby would've been like.

A Normal Developmental Model of Grief for Perinatal Loss

To summarize, resolution appears to be a process rather than an endpoint. The vast majority of mothers, resolved and unresolved, still have grieving feelings about the death of their baby, although unresolved mothers appear to be more burdened by grief. However, the unresolved mothers do not appear to be any more or less dysfunctional than the resolved mothers. Thus feeling unresolved is not associated with pathology, but rather is a different way of coming to terms with the death of a baby.

During pregnancy, parents have idealized hopes, fantasies, and expectations about their child's physical appearance, temperament, intelligence, and talents. Upon the child's birth, faced with the real child and his real appearance, temperament, intelligence, and talents, all parents need to work through giving up their idealized
Image of the child (Harmon, 1981; 1983). Different parents may have different normal responses to this adjustment. Upon the birth of a sick or premature infant, many parents cope with the discrepancy between the ideal and real child by being overprotective of the child (Harmon and Culp, 1981). Upon the birth of a physically or mentally handicapped infant, many parents feel grieved and depressed, a normal coping mechanism (Cohen, 1976). Upon the birth of a fussy or otherwise "disappointing" baby, parents may feel stressed, which is to be expected (Martin, 1976). Thus, feeling overprotective, depressed, or stressed are normal ways of coping with parental feelings of disappointment.

When a baby dies, not only do parents have to give up the idealized child but their worst fantasy is realized: The baby is dead. Working through grief over the loss of a baby can be viewed as the most extreme condition under which the parents must give up the idealized child. Feeling resolved or unresolved grief may simply refer to different long term approaches to coping with this loss. Mothers who feel resolved report bittersweet, accepting feelings about the baby and baby's death while mothers who feel unresolved are not able to recognize happy feelings and/or feel unaccepting toward the loss. But there is no particular pathology associated with resolved or unresolved feelings, and resolution is not related to feelings about the subsequent child.

The fact that many mothers have overprotective or replacement feelings with regard to the subsequent child simply appears to be a
normal adaptation to the stressful situation of having lost the previous child. The passage of time does seem to diminish overprotective feelings, a fact that many of these mothers recognize. These mothers feel that as they become accustomed to having a child who is healthy and doesn't die, their intensely overprotective feelings fade, although the recognition of the possibility that the child could die does not fade. Thus, these mothers' feelings of vulnerability to tragic death of a child and their response of overprotectiveness with the subsequent child appears to be an adaptive coping mechanism. As time passes, feelings of vulnerability fade and overprotectiveness diminishes in intensity as it's adaptive utility diminishes.

The replacement feelings experienced by a majority of these mothers may also be viewed as an adaptive coping mechanism. As having a child who dies robs the mother of the opportunity to know this child, placing the appearance and personality of the subsequent child onto the image of the dead child may be a way to facilitate giving up the Idealized image of this child. Indeed, it is possible that for the 2 mothers speculated to have difficulty giving up their Idealized image of the dead baby, they may have had this difficulty even if the baby had not died. In this way, difficulty giving up the Idealized image of the dead baby can be viewed as an issue unrelated to grief resolution.

There are many factors that may differentiate between "resolved" and "unresolved" mothers which are not addressed in this study,
Including previous experience with loss, social and familial expectations, personality, or emotional temperament, all of which may lead to these different coping/grieving styles. Of course, prolonged acute grief which leads to incapacitating depression, disruption of relationships, or financial or social irresponsibility can be considered to be pathological grief as it compromises normal functioning. Indeed it is likely that there is a population of such mothers but these mothers would be unlikely to volunteer to participate in a research study. But among the mothers in the present study, there is no evidence that feeling unresolved is any more or less pathological than feeling resolved. Interestingly, although not severely compromised, these unresolved mothers describe their feelings in ways that Rubin (1984) and Bowlby (1980) define unresolved grief. That Rubin (1984) and Bowlby (1980) also consider unresolved grief to be a pathological variant of the grief reaction is not supported by the present research.

Practical Applications

Contact with and Momentos of the Baby

Satisfying contact and momentos are very important to these mothers. Satisfying contact for most of these mothers means being able to spend as much time as possible with the baby before death, and being given privacy and permission to spend a long time with the baby after death. As proposed by Kennell and Klaus (1976), Kirkley-Best
and Kellner (1982), Kennell and Trause (1978), and Dunlop (1979) these mothers confirm that seeing the baby relieves fears that the baby was not normal, satisfies curiosity about what the baby looked like, and helps mothers grasp the reality that the baby did exist and did die. Holding the baby gives the mothers a chance to express their love in a physical way and give them a chance to say goodbye. Similarly, as suggested by Harmon, Glicken, and Siegel (1984) among others, these mothers confirm that having mementos, especially having a photograph, helps them to remember what the baby looked like and acknowledges the baby's existence and the mother's loss in a tangible way. Altogether, satisfying contact and mementos give the mother memories where memories are scant, and memories the mother cherishes.

Similar to what Lewis (1979), Stringham et al. (1982), and Solnit and Green (1959) observed, mothers report that they treasure these few memories of the baby they never knew. But because this study does not follow mothers from the time of the loss until several years have passed, it cannot be determined whether contact and mementos facilitate grief, other than the mothers reporting that it has helped them. However, in general the 6-10 years post-loss mothers who feel unresolved regret that they have no photograph, and they are very dissatisfied with not being able to hold their baby at all. In contrast, mothers with more recent losses also report being dissatisfied with contact but they were at least able to hold the baby, even though they wish they could've held the baby longer or with more privacy. So, although satisfaction with contact and mementos is
not statistically related to resolution for these mothers, the mothers do emphasize how important and treasured satisfying contact and momentos can be. Indeed, the lack of satisfying contact and momentos may explain why half of the 6-10 years post-loss mothers still feel unresolved in spite of the passage of time.

Additionally, these mothers made suggestions, citing hospital interventions that are or could be very helpful. These mothers indicate that it is important to them to have a good quality photograph of the baby, both after death and before death whenever possible. Other momentos such as hospital bands, birth and death certificates, footprints, and a lock of hair are much treasured and appreciated. And of course if the mother refuses these momentos, they should be kept and offered later. Some of these suggestions are also interventions proposed by Kennell and Trause (1978) and Harmon et. al. (1986) among others.

Regarding contact, if the baby is live born, these mothers agree that the more time they are able to spend with and hold the baby, the better, as it is their only chance to know the baby while s/he is alive. After the baby dies or if stillborn, the mothers appreciate being encouraged to see and hold the baby although the few mothers who were encouraged and declined agree that a mother should be given the option to see her baby but not be pressured. As Harmon and Graham-Cicchinielli (1985) suggest, the mothers adamantly feel that offering the baby to the mother more than once is often helpful, as the mothers need time to recover from their shock and particularly for mothers
recovering from cesarean section. After recovering a little, mothers are able to spend a more meaningful time with the baby. And giving mothers permission to spend as much time as they want with the baby is permission mothers need to hear because for many it feels awkward and morbid to want to spend a long time with the baby, something also suggested by Furlong and Hobbins (1983). Mothers also mention that they would appreciate quiet privacy when they are with the baby. And a couple of mothers mentioned that they would have liked to have been able to dress the baby which was for them, a very "mothering" thing they would've liked to have done for the baby. Thus, although hospital interventions have vastly improved over the last 10 years, the mothers indicate that there is still room for more improvement with regard to providing mementos and contact with the baby.

**Doctor's Advice**

A majority of the mothers' doctors gave specific advice on how long to postpone subsequent pregnancy. However, every mother decided for herself how long to wait, with only 4 mothers ultimately agreeing with their doctor's advice and the remaining mothers waiting a shorter time than was advised. Mothers in general felt an overwhelming emptiness which they wanted to fill by having another baby. Some of the mothers regret that they did not wait a little longer to conceive another pregnancy, but all the mothers feel that it should be a personal decision, because only the mother can weigh her own needs and desires. And many mothers mentioned that they would have appreciated
a doctor who could facilitate this decision by educating them on the advantages and disadvantages of waiting or not waiting to conceive again; Indeed, both mothers whose doctors educated and left the mother to make her own decision were very satisfied. Many mothers also mention that making their own decision gives them a renewed sense of control over their lives.

In light of the fact that mothers mention overprotective and replacement feelings regardless of feelings of resolution and regardless of the amount of time between the loss and subsequent child's birth, it is not clear that doctors have any grounds for advising mothers to wait 6 months or a year before conceiving another pregnancy. A couple of mothers in retrospect feel that the subsequent pregnancy interfered with their grief work, but other mother's do not feel that grieving precludes another pregnancy. In fact, the variety of the mothers' responses to the timing of the subsequent pregnancy indicates that every mother is an individual and there is no prescribed amount of time that is best to wait, for even a majority of mothers.

Besides individual responses to loss and ways of grieving, this individuality may also be due in part to the many variables that these mothers considered in deciding how long to postpone another pregnancy. The mothers weighed the following reasons for not waiting long to conceive: maternal age, spacing of children, intolerable feelings of emptiness, thinking it might take a while to conceive, thinking that if another loss happens, it'll feel none the worse, and simply that it
Is emotionally impossible to use birth control. The most popular reason for waiting was the belief that physical recovery would increase the chances for success. Other than that reason, one mother wanted to wait so that she would not be pregnant during the upcoming cross-country move, and one mother waited because she had a surviving twin to care for. Again it seems that if doctors can lay out for mothers the advantages and disadvantages of waiting or not waiting, both in terms of their grief work and their feelings for the subsequent child, then each mother can weigh for herself what she needs and wants to do. Because she can know what consequences to expect, she can be better prepared for whatever difficulties may arise. And whatever her decision, the mother was able to make an informed decision about what is best for her.

Directions for Future Research.

Two of the short comings of the present study have been mentioned—(1) the high probability of the sample of mothers being biased toward being relatively healthy, high functioning mothers and (2) that the PLI does not address issues of previous experiences with loss, familial or cultural expectations, personality, or temperament and the role these variables may play in grieving as well as parenting a subsequent child. Three more major short comings of this study are the interpretation of gratuitous denials, lack of data on observable behaviors, and the retrospective nature of the data.
It was assumed that if a mother mentioned an issue with regard to the subsequent child, even if she denied that it was an issue relevant to her, that it probably was an issue with which she had wrestled. This assumption does not take into account that many of these mothers may have been exposed to these issues not through their own experiences but through their doctors, reading, or attending parent support groups. Some mothers who denied the relevance of certain issues to them may have brought them up because they were aware of the issue and thought that the interviewer would be wondering about how the issue applied to them. This may be particularly true of overprotective and replacement feelings as these have been popularized by the literature. Thus it may be too strong an assumption that a mother who denies an issue is a mother who is or has wrestled with an issue. In a follow-up study it would be useful to probe these mothers directly on their experiences with overprotectiveness, replacement, setting limits, and emotional investment with regard to the subsequent child in order to get more detailed descriptions of their thoughts and feelings about these issues.

Because this was an exploratory descriptive study, it was not feasible to choose behaviors which should be manipulated and observed. Thus, maternal self-report was the appropriate data to collect, but it is unclear how much the mothers' reports coincide with actual maternal behavior. Thus, a purpose of a follow-up study might be to obtain both maternal self-report as well as observations of interactions with the subsequent child.
In addition to observing interactions, a longitudinal study following a mother and her subsequent child from the third trimester of the pregnancy, at birth, and at 6 month intervals through the second year would be of use in tracing the development of certain interactions. A longitudinal study would eliminate the need to rely on retrospective reports. At every interval, mothers could be interviewed on their feelings about the baby's death and their feelings of grief and resolution, as well as their current perceptions of the effects of the loss on their relationship with the subsequent child. In early infancy, observations of synchrony in face to face mother-infant interactions would be useful to determine the quality of the early relationship (Brazelton et al., 1975). Later, attachment paradigms could be used to determine separation-individuation of the child and mother, on which overprotective mothering may have bearing (Mahler, Pine, and Bergman, 1975). Tasks which give the mother opportunities to set limits or help the child solve a problem may also be useful ways to observe parenting styles of discipline and emotional support. Of course, a control group made up of mothers who had not lost a baby would be useful for determining if mothers who had lost a baby were more or less likely to be observed engaging in certain interactions with their children. Mothers would be matched for age, pregnancy complications, education, marital status, and race, while children would be matched for age, neonatal health status, sex, and birth order.

Although the present study was exploratory and descriptive and
therefore had limitations, several important conclusions can be reached: (1) contact and mementos of the baby are very important for bereaved mothers as these constitute some of the few memories they have of the baby who died; (2) even years after the loss, mothers report still having feelings of grief, although for mothers who feel resolved, i.e., bittersweet and accepting, the grief is not viewed as a burden, while for mothers who feel unresolved, i.e., sad or angry and unaccepting, their grief appears to be somewhat of a burden; (3) nevertheless, feeling unresolved does not appear to indicate pathological grieving or dysfunction particularly in light of the fact that resolved and unresolved mothers do not differ in grieving behaviors such as anniversary reactions; (4) resolution or time between loss and subsequent birth do not affect the mothers' perceptions of their relationship with the subsequent child, rather a majority of mothers have overprotective and replacement feelings as a way of coping with their tragic loss and the birth of a healthy baby; (5) regarding how long to postpone subsequent pregnancy, a doctor can be of the most constructive help to a mother by informing her of some of the advantages and disadvantages of waiting and educating her on some of the normal feelings of overprotectiveness and replacement that she may have with regard to the subsequent child. It is helpful for the mother to be encouraged to make her own decision based on her own needs and preferences, and for her decision to be supported.
APPENDIX A

MOTHERS' VERBATIM STATEMENTS ON RESOLUTION AND FEELINGS ABOUT THE BABY WHO DIED

MOTHERS WHO FEEL RESOLVED AND FEEL BITTERSWEET

JESSIE
The baby: "I feel like I'll always be changed and I'll always remember her and be sad that she's not living with us but happy that we had her for a while and had the experience."
Resolution: "Her life and death feel like a very integrated part of my life right now and not something I could or would change, just something that happened and I'm going to cope with it. I don't feel as though it's limiting any more, it's just part of my life."

CINDY
The baby: "I wish it wouldn't have happened still. I mean that was a terrible time in my life. If I could go back and change it, I would, I know I would. I feel thankful that I have Emily and I know that if Nicole would've lived, I wouldn't have got pregnant 2 months after and had Emily. So I'm glad that it happened in that respect. I'm not glad that it happened but something good came out of it because I learned so much and I grew so much and I gained so much knowledge about life in general and death and all kinds of things. So really a lot of good did come out of it because you can use that, you can take the bad and turn it around or you can let it be bad, that's your choice."
Resolution: "I don't feel pain anymore, not like I did. Sometimes I do, sometimes I want her. Now I feel like I just know God took care of her and she's alright. In a way I feel better about Nicole because she doesn't have to suffer, she's in heaven, she is a little angel."

ROSE
The baby: "Sometimes real happy, real proud, and other times just real sad and real missing you feelings, it's all mixed."
Resolution: "I can have good thoughts about her, kind of a resolved thing- I'm comfortable with the grieving feelings. Even when I feel grief it's not a desperate feeling, it's kind of a comfortable feeling. It's like I know she's dead and I can't get her back. I don't have those real 'Oh I can't stand it- get her back here!' [feelings] like I could pull her out of the air if I had enough faith, if I gritted my teeth hard enough or whatever. I don't have those feelings anymore- it's like, well, she's gone. [Although], every once in a while I do. I can't describe exactly how I feel because it's always up and down but resolved means I can look at her picture and not burst into tears. All 3 of them are together, she's just one of my daughters. The subject is pretty much closed, there's nothing to say, it's all over. I can't bring her back, that type of thing,
resolved. But it's definitely not like I've put her in a closet and closed the door or anything like that."

SARA

The baby:  "When I think about it, it's always going to be sad. I think I can feel the time that we had with him was really the only real time I ever had with him. I can look back on that and smile. And I didn't think I'd ever [smile]- every time I thought about that, I'd make me cry. That doesn't make me cry anymore. That makes me real grateful that I had that time and I feel really really grateful that I had him for 3 days. And I didn't think I'd ever feel that way."

Resolution: "Finally getting that [guilt] off my back and stopping to ask why all the time. Instead of being on your mind all the time, it becomes part of your history. You know, you don't meet new people and discuss your dead baby any more. I mean, I actually know people that don't know that I've lost a baby and it wasn't because I'm hiding it, it's just because it isn't part of my conversation. It just happened to me and I'll always be sad and I'll always have one less child."

DES

The baby:  "I feel thankful that I was pregnant with the infertility, to be able to feel that and, oh, there's nothing like pregnancy. I feel I love him and the pain is gone. I feel older than 31. I feel like I've lived longer than 31 [years]. I feel pretty peaceful about him. I got In the habit right after he was born of saying to myself, rather than out loud, 'I miss my baby' over and over, a hundred times a day. I still do that and here I've got Sam. I don't know if I really miss him or if it's a habit for saying it."

Resolution: "It's a relief. I think I feel peaceful. I know he's with God and that tormenting is over but I still love him, he's not forgotten. That's another thing I was afraid of. I thought, I've got to keep this up [grieving] so that I don't forget him. I don't want anybody to forget him. But you don't have to be miserable to remember."

MERYL

The baby:  "I have thought about having 2 sons, growing up together and wondered how that would be and wishing that it could've been that way. The birth of Cary has erased alot of my grief and it's not that he [Casey] isn't there, but I just don't feel the yearning that I always have, or the little bit of grief that's still there, that will always be there but I don't feel it that much any more. [I feel] at peace I guess. It's not that I don't feel anything, it's just accepted I guess. It's OK."

Resolution: "While I don't want to live through it again, and I wish it could've been otherwise, there are alot of good things that came out of it; In a lot of ways I think I came out of it a better person. That's not the way I want to come out a better person but, everything's OK now, it's alright."
JANE
The baby: "It's hard to say- your feelings are so different after you hold them than when you didn't ever have it in your arms- I felt empty. I believe that we have a life after death, in my religion; I believe that I will see him again some day, so I have that thought."
Resolution: "I feel that God gives us the children He wants us to have and so through that I was able to accept that that was not the one He wanted for me to have. So I was able to accept what had happened to me in a very short amount of time."

MOTHERS WHO FEEL RESOLVED AND FEEL SAD

ANYA
The baby: "I hope that I've put it a little more in perspective as far as how it impacts on me on a day to day kind of thing. It's not something I think about every day but it's obviously something I can get real unhappy thinking about which will probably always be the case. It's something I feel real sad about and I have regrets about because it happened but it's not anything I feel angry about any more or guilty about. I feel wishful that we had her with us and wondering what she'd be like. Mostly just sadness and wishful that things hadn't gone the way they did."
Resolution: "Just gradually over time it felt for the most part that I could accept it, I could live with it, it was not nearly as painful. It hurts but it's OK which was an important point to get to and was not a point I would have ever been able to understand, I think, before she died, that something can hurt horribly but it's alright."

MOTHERS WHO FEEL RESOLVED AND FEEL NEUTRAL

BRYN
The baby: "There are times that I'll never forget him but there are also times when I am totally free of any memories."
Resolution: "It's a very sad thing but you don't feel like such a victim after you get to a certain point. Like it's OK."

ELAINE
The baby: "Intensity. I remember it like a drama with lots of detail, even nitty gritty detail."
Resolution: "I think it's resolved. As far as resolution, an experience like that, you never forget it. But it's got to be resolved or else I would be troubled by it. I don't think I would've had another baby if I didn't feel that that was resolved. I don't think I could've. I think if I hadn't resolved it I would've been afraid to have another baby."

KITTY
The baby: "I don't really think about it as much as I used to because now I have a baby to keep me busy [Julie is 7 months old]. When I got the card to come here [to the interview], I thought, well,
It been almost 2 years, I feel like I've forgotten and I opened my box [of momentos] and it all came back to me."

Resolution: "It's getting to the point where it's just a memory now, like I'm thinking about somebody else. It doesn't even feel like it was me."

LIZA

The baby: "I like to be remote from it because it was so intense that it gives me a good feeling to be able to feel like that was almost, that was me but it was another person. It's a nice feeling to know that someday that there'll be real understanding where now maybe there's just a little acceptance."

Resolution: "At this point, mostly just acceptance that this was part of my life and he's gone. Still sad but it's such a part of my life to think of him and be sad that it's not the level of emotion or feelings, it's just acceptance."

MOTHERS WHO FEEL RESOLVED AND FEEL ANGER

NONE

MOTHERS WHO FEEL UNRESOLVED AND FEEL NEUTRAL

NONE

MOTHERS WHO FEEL UNRESOLVED AND FEEL BITTERSWEET

SOPHIE

The baby: "It's kind of mellowed. I still miss her, sometimes I feel sad, other times I can feel much more peaceful about it all and can look at the positive effect she had on me and other people."

Resolution: "I don't think I'll ever completely accept it but it's kind of a gradation - you never really get over it but you hopefully learn to cope with it better."

KELLY

The baby: "I just feel like he was mine and I'm grateful I had him for that long. Better to have him for that short a time than not at all. I think of him alot and sometimes a smile goes on my face and other times I sit down and cry."

Resolution: "No. I don't know how to explain it - I'm still working on it."

KARA

The baby: "Sad just because we miss him, sad that the life he had was just painful for him. But I feel fuller because we've grown so much too, Nick and myself."

Resolution: "I feel at peace with him although that doesn't keep me
from feeling emotional about it and having a tear now and then. I do feel OK about it and I still feel my love for him. I don't feel great that it happened to me, I wish it had never happened.

LUANNE
The baby: "Most of the time I think he's really lucky where he is. I have this in my imagination that he's up there with my grandparents. I have no idea what happens after [death] like if we know anybody but if we do I'm sure my grandparents are having fun with him and I know he's happy. He has the best babysitter [God]. Resolution: "It will always be there, I'm sure, even in 50 years I'll still remember. I'm not grieving like you do right afterwards. But you still have sadness and pain. It still bothers me but not everyday."

MOTHERS WHO FEEL UNRESOLVED AND FEEL SAD

BESS
The baby: "How do I feel now, 7 years later, about the loss? That there is a missing part in our life, that the family is incomplete. (tears) I still miss him and I don't know that that ever goes away. It's less now- it used to be every minute of every day and then it was just a few days a week and then a few weeks in the month. Sometimes, I'll be like this only once in a year. Sometimes it's worse and sometimes it's not. I just wish it had never happened, never, ever, ever."
Resolution: "I don't think I've reached a state of acceptance... I've put the loss of the baby in it's place in my life, but I don't think I could say I've accepted it. Because accepted it means you go along with it."

MARTINA
The baby: "Sometimes it's sad and lonely. Sometimes it seems like it just happened yesterday and other times it seems like it's been alot longer than it has been. We remember him and try not to remember everything we went through, just try to remember him. We still talk about him all the time so we remember him. It's alot easier to think about him now than then. I can keep on doing what I'm doing. When I think about him it's not something that is so bold like it was before, that when you start thinking about him you just gotta stop everything because you're in a daze for a week. It's not like that. It's gotten alot better."
Resolution: "There's no final phase of grief, I know that. It's just not as hard as it used to be. It's alot easier to sit and talk about and think about him and every time you talk about him and think about him you don't go into a hysterical fit."

HANNAH
The baby: "I just think it's always going to be sad. Having a baby die is just never going to change into a happy experience. And I
can't put it into, 'well, it means something or other and it was meant to be'—that just doesn't fit for me. So when I think about it, it's always going to be sad. It's not as intense and I have Michael to focus on and that helps a lot. But I think time is probably one of the biggest things that resolves things and it doesn't do it in any particular way, it's just distance. Somehow it just changes and you start getting involved in other things because you have to and it's farther away."

Resolution: "I think basically that I'm functioning and I have things that are happy in my life and that I can see more happy things occurring. But I'm never going to be happy about losing her. So I'm never going to just totally put it away and say 'That's over and done with and I'm never going to think about it again' or 'I'm just going to go on and be strong and never cry about it'. I don't feel that way at all. Resolution sounds like you're supposed to say, you don't think about it or you don't be sad, or I don't know what it means exactly. Yeah, I think I'm resolved in terms that I'm not in a psychiatric hospital and I'm functional. When people say that [resolved] it's almost like you're saying you forgot."

PEG

The baby: "I do still think about them [the twins]. I think it's something that you think about it and it makes you sad but it's not nearly as sharp or as definite as it was at the time or even a year ago or 2 years ago— it fades a little bit to the background. You know, you think about them and you're sad and you wish that it hadn't happened."

Resolution: "I'm at a point where I can think about them, it doesn't bother me like it used to. Certain things bother me but generally— I don't know how you can ever really resolve something like that in your mind. To me it's something that happened and it's something that I have to live with and something that just doesn't hurt as much as time goes on."

MOTHERS WHO FEEL UNRESOLVED AND FEEL ANGER

DARA

The baby: "I feel cheated at the way things were done, sad obviously at times, curious as to what she really did look like, wishing I'd done things differently. (tears)...curious about what she looked like, what she would be like now."

Resolution: "Obviously we've had more kids and pulled our lives together and things go on. I think there's times when I still have some work to do in terms of my own reactions but I wouldn't say it's been a psychological hang up. I think I've been pretty honest with myself and it's OK to cry."

HOLLY

The baby: "A lot of sadness. Sadness in terms of loss of being together and potential. Still frustration at not knowing the cause,
having no control, anger still about the hospital and what happened afterwards but much more perspective about the situation. It is frustrating to me to think that although I know the pain or the caring never goes away, in a sense I think it should be easier for me now, or I wonder, 'am I hanging on to it, am I hanging on to this and being more negative or sad than I should be?'.

Resolution: "In some sense I feel it coming. I feel that I'm coming closer to dealing with the medical community. I feel sort of an acceptance of the sadness, I'm not fighting it, or denying it, or overdoing it. I just feel like it's there and I'm getting towards integration- not something I want to deny or overuse or overdo."

LYNN

The baby: "I feel sad not only at my loss but also his loss that he didn't get to see this beautiful world. I didn't get to take him fishing and he didn't get to take swimming lesson, he didn't get to throw rocks in the pond and make snowballs that hit me in the face."

Resolution: "I feel that alot has been resolved but I'm sure there's still some that needs to be resolved. I have always been one to hide emotions- I'm able to talk about it almost as if I had detached myself from the situation. I know there's still more to be resolved but I don't know how it's going to be resolved."

ERIN

The baby: "I feel sad that she can't be around. I feel fortunate that she didn't have a traumatic couple of months of life, like maybe have a heart defect and have to go through surgery. I feel angry that she didn't live, like with modern medicine, why didn't she live? But I don't have an anger to go around telling other people not to have babies because it hurt. And it didn't stop me from having another baby. I really wanted 3 children and my first one, If she'd lived, I'd have 3 children because I felt like by the time Wendy came along I was too old to continue. So sometimes I'm a little resentful to Barbie for doing this to me. It wasn't very fair of her."

Resolution: "I don't know that there is resolution. I just feel like I've met a happy medium of how I'm going to deal with it. I'm going to deal with it because I've got other children at home and life goes on and I can't bring her back. I've tried. When she first died, I tried my best. But there was no way I was going to get that little baby out here. So I just kind of moved on. A lot of that, that's the kind of person I am, I'm soppy, sad, cry'y person. I knew I couldn't but I tried my best to bring her back. I screamed at the doctor to do something, I tried mouth to mouth on her, put her up to my lips to try to suck out that little life in her."
Amniocentesis: Amniotic fluid is drawn from the placenta after the 16th week of gestation. Certain types of anomalies and the sex of the child can be detected by examining this fluid.

Apnea: Transient cessation of respiration.

Cerclage: A band or strings tied around the cervix during the first trimester of pregnancy to prevent premature dilation of the cervix and premature birth.

Cord accident: When the umbilical cord is constricted in some way that restricts the flow of nutrients and oxygen to the fetus, resulting in fetal death.

Craniosynostosis: A congenital defect where the bones of the skull do not properly expand as the baby grows, causing pressure on the brain. Surgery can correct this defect and prevent brain damage.

Diaphragmatic hernia: A congenital defect where the baby’s organs are pushed up into the chest cavity, depriving the heart and lungs of space and proper development.

Fetal distress: When fetal heart beat cannot be detected, or is slow or irregular.

Hydrocephaly: An abnormally high accumulation of cerebrospinal fluid in the cranial cavity causing expansion of the cerebral ventricles and atrophy of the brain.
Hyperbilirubinemia: A common condition, also known as 'newborn jaundice' where there is an excess of bilirubin in the blood.

Meningitis: An inflammation of the membranes covering the brain caused by any septic blood condition which may carry infection to the brain.

Neonatal: Of or relating to the first month after birth.

Neonatal intensive care unit (NICU): A hospital intensive care unit which contains the equipment, technology, and medical specialists necessary to care for seriously or critically ill newborns.

Placental abruption: The placenta separates prematurely from the uterus, causing bleeding and abdominal pain. Small separations can heal without complication but repeated or large separations require attention. The danger is fetal distress and death.

Preeclampsia: A toxemic disease of pregnancy that occurs during the last trimester. The mother has many symptoms, some of which include headache, vomiting, swelling of different parts of the body, large weight gain, high blood pressure, dizziness, and kidney malfunction. The danger is fetal death in the last 4 to 6 weeks of pregnancy.

Prematurity: When a baby is born before term, there are a number of problems that an arise because the baby is too immature. The most serious problem of prematurity is that lungs are too immature to breath air. A number of life-threatening complications can occur If In spite of intensive careful management, the baby's body cannot make the transition from the
Rh disease: When the mother's blood is Rh negative and the fetus's blood is Rh positive, the mother's antibodies act against the baby's blood, causing it's destruction and making the baby severely anemic. The danger is fetal or neonatal death.

Sepsis: A generalized poisoning of the body from bacterial infection. Because the infant's immune system is immature, infection can spread quickly throughout the body and result in sepsis and death within hours.

Sudden infant death syndrome (SIDS): Sudden unexplained death, most common in infants under 6 months of age, occurrence peaking between 2 and 4 months. The only real symptom of this disease is death, and the cause is unknown.

Twin-twin transfusion: With a twin gestation, when one twin deprives the other of nutrients and oxygen from the mother.
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