Coping With Grief After Involuntary Pregnancy Loss: Perspectives of African American Women

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Objective: To present the coping strategies used by African American women following their miscarriages, ectopic pregnancies, fetal deaths, and stillbirths, which the authors have termed involuntary pregnancy losses or IPLs.

Design: Semistructured audiotaped interviews; grounded theory methods used to collect and analyze the data.

Setting: Urban community-based sites in the Western United States.

Participants: 20 African American adult women who reported a history of involuntary pregnancy loss within 3 years of interview.

Results: In this study, the women’s responses to their IPL were grouped into four areas. They coped with personal reactions, reactions of others, memories of the baby, and subsequent pregnancies.

Conclusion: The women in this study used inner resources to develop self-help strategies to cope with reactions following IPL. Nurses are challenged to harness the influence of family, friends, religion, and cultural traditions to assist women in processing the cognitive, emotional, and social traumas associated with IPL. Educating women to recognize grief responses after IPL and to manage these responses effectively may prevent adverse outcomes to their physical and mental health. A culturally sensitive framework of clinical assessment and intervention for African American women experiencing IPL has been developed. JOGNN, 32, 28–39; 2003. DOI: 10.1177/0884217502239798

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African American women experience fetal deaths at rates at least twice those of any other racial or ethnic group in the United States (Ficenec, 1997, 1998; Gates-Williams, Jackson, Jenkins-Monroe, & Williams, 1992; Roth et al., 1995). In 1996, the U.S. fetal death rates were 12.5% for African Americans, compared with 5.9% for Whites and 6.9% for the population as a whole (Peters, Kockanek, & Murphy, 1998). The reported rates are based on government statistics that track fetal deaths at 20 weeks or greater gestational age (National Vital Statistics System, 2001). Researchers report that 15% to 20% of known pregnancies end in miscarriage (fetal death before 20 weeks gestational age) (Bansen & Stevens, 1992; Beutel, Willner, Deckardt, Von Rad, & Weiner, 1996; Mahan & Calica, 1997). This racial disparity in fetal death rates has been documented since 1950 (National Vital Statistics System, 2001).

Despite a racial disparity, there is scant literature on the perspectives and experiences of African American women after these losses. The purpose of this article is to present the coping strategies used by African American women following involuntary pregnancy loss. We have constructed the term involuntary pregnancy loss (IPL) to refer to miscarriages, ectopic pregnancies, fetal deaths, and stillbirths.
Background

Grief After IPL

There is overwhelming agreement among authors that a grief response is probable and appropriate after a woman experiences IPL. That response, however, is varied, dynamic, and highly individualized (Brown, 1993), with unique features that may be invisible not only to others but to the woman herself (Patterson, 2000).

Many invisible factors influence a woman’s responses following an IPL. These include self-blame (Harris, 1984; Kavanaugh, 1997), searching for answers (Harris, 1984; Kavanaugh, 1997), lost hopes for the future (Harr & Thistlerehwalit, 1990; Welch, 1991), shattered dreams of parenting (Carroll-Frey, 1997), lack of a tangible person for whom to grieve (Mahan & Calica, 1997), perceived loss of self (Harrigan, Naber, Jensen, Tse, & Perez, 1993; Theut et al., 1989), silence from others (Lindberg, 1992; Mahan & Calica, 1997), lack of appropriate rituals (Bansen & Stevens, 1992; Lauterbach, 1993; Layne, 1990), questioned legitimacy of grieving (Bansen & Stevens, 1992; Lauterbach, 1993; Layne, 1990), unknown cause of death (Toedter, Lasker, & Alhadeff, 1988), and a variety of emotional triggers (Carter, 1989). Grief reactions may appear years after the loss (Conway, 1995), stimulated by memories or related situations, such as becoming aware of anniversaries of the events surrounding the IPL or encountering pregnant women (Carter, 1989; Hammersley & Drinkwater, 1997).

There has been an ongoing dialogue about who may legitimately grieve after IPL (Hammersley & Drinkwater, 1997; Hutti, dePacheco, & Smith, 1998). Women who experience a late IPL (20+ weeks of gestation) receive more support for their grief than those with earlier IPLs. Society’s rationale for sympathizing with women who experience later IPLs is that in such cases an actual human being, a baby, has been lost (Lee & Slade, 1996; Mahan & Calica, 1997). Commemoration of the brief life and precipitous death of the late IPL or baby is often manifested in the form of a funeral or memorial service or an informal gathering between family and friends (Lauterbach, 1993; Mahan & Calica, 1997). The late IPL or deceased baby takes a real place in the family, is often given a name, and may even be baptized. Tangible memories and mementos of the life are created in these processes.

In contrast, minimal, if any, support is extended to women who experience early IPLs (Bansen & Stevens, 1992). Health care professionals have been reported to treat such occurrences as only biological or medical events, with limited awareness and sensitivity to the potential short- and long-term effects on the women’s health (Cuisinier, Janssen, de Graauw, Bakker, & Hoogduin, 1996; Lindberg, 1992; Patterson, 1998; Peppers & Knapp, 1980). The woman’s grief may be compounded by the responses of family and friends who treat the loss as a nonevent (DeFrain, Milspaugh, & Xiaolin, 1996; Woods & Woods, 1997).

The Influence of Culture on Grief Experiences

Culture has been reported to be an important element in shaping grief reactions (Cowles, 1996; Hutti, 1992; Mechanic, 1976; Outlaw, 1993). Death usually represents a major life event for all persons. However, grieving and mourning among African Americans are as diverse as the multiple hues of their skin. Some African Americans may be acculturated to White traditions; others may integrate ancient African traditions with more current family and religious practices (McDonald, 1973). African Americans confront a multitude of invisible experiences that have historically influenced their daily lives and their management of life changes such as IPL. The influencing factors include religious and cultural values and beliefs, racism, health status, and other issues related to morbidity and mortality. Another factor is the typical role of African American women within the family structure (Ahijeavych & Bernhard, 1994; hooks, 1996). Although some social contexts and personal conditions are the same for all women, coping strategies may differ based on culture and racial or ethnic background (Allen & Marks, 1993; DeFrain et al., 1996; Van, 2001; Zeimer, 1982). Thus, although women of different racial/ethnic backgrounds may manifest similar physical and emotional responses to IPL, how they cope with it is probably different.

Coping With IPL

Coping has been defined as a set of conscious or unconscious behaviors directed toward managing stressful life events (Mengel, 1982; Zeimer, 1982). The current literature on coping with IPL has been developed predominantly around the experiences of White women. Most reports center around the differences in coping demonstrated by the women and their husbands or partners, with the men being generally less expressive (Beutel et al., 1996; Mahan & Calica, 1997). Women in these studies have described both effective and ineffective coping strategies.

The effective strategies far outnumbered the ineffective ones. DeFrain et al. (1996) reported that 73% of their
sample found religious beliefs effective after their loss. Allen and Marks (1993) reported that participants in their study used self-improvement activities, including exercise and weight reduction, self-pampering, and other activities such as shopping and redecorating the house to cope with their IPL. Common themes among these reports were discussing the loss experience with others (Reed, 1984); keeping busy at work (Allen & Marks, 1993; Reed, 1984); reading about IPL (Allen & Marks, 1993; DeFrain et al., 1996); crying (Allen & Marks, 1993; Bansen & Stevens, 1992); going to therapy or support groups (Allen & Marks, 1993; DeFrain et al., 1996); and spending time with immediate family members, which included taking vacations with husbands (Allen & Marks, 1993) and spending special time with young children (Bansen & Stevens, 1992).

Ineffective coping strategies included avoiding discussion surrounding the loss (Kavanaugh, 1997; Reed, 1984); avoiding any expression of feelings about the loss (Kavanaugh, 1997; Reed, 1984); considering suicide (DeFrain et al., 1996); and overeating, spending money excessively, or using illicit substances (Allen & Marks, 1993). Whether these effective and ineffective strategies differ from one racial/ethnic group to another is not addressed in IPL literature.

Integrated Theoretical Framework

The theoretical framework for this study evolved from three grief theories (Horowitz, 1990; Parkes, 1972; Toedter et al., 1988). Each theory and model contributes distinct features toward the enhancement of knowledge and understanding of grief reactions and coping. Parkes (1972) emphasized the importance of life experiences, both past and present, as well as religious, cultural, familial, societal, and socioeconomic factors, in predicting outcomes following IPL. His work with pregnant women clearly described the tragic influence of sudden and unexpected deaths and associated marital relationship disruptions. Toedter et al. (1988) identified pregnancy-specific variables (e.g., gestational age at the time of loss) as predictors of grief response intensity and duration. Horowitz (1990) developed an information-processing model that is purely cognitive but is nevertheless important for understanding the invisible cognitive processing of grief.

Methods

Design and Setting

Grounded theory methods (Strauss & Corbin, 1990) were used as the qualitative research approach to collecting and analyzing the data. The urban community-based sites in the western United States were selected for recruitment of participants for three reasons: (a) there were several cities in the area within which large groups of African American women of childbearing age resided or worked; (b) the authors had professional contacts in public and private health care and community-based organizations who served the target population and were willing to help recruit participants for the study; and (c) the pilot study (Van, 2001), conducted with a similar target population, demonstrated that an adequate number of participants could be successfully recruited in this area.

Participants

Women were recruited from group meetings in health care settings, social service agencies, church activities, and organized community-based functions such as health fairs. Two nonprobability sampling techniques, convenience and snowball, were used to recruit participants (Powers & Knapp, 1990).

Women were recruited for participation in the study who identified themselves as English-speaking adult African Americans (or Blacks or of African descent) with a history of IPL within the past 3 years. Seventy-four women met these criteria and completed the written questionnaires. The first 10 women who completed the questionnaires also participated in semistructured interviews that were audiotaped. Another 10 women from the remaining 64 were interviewed based on purposive sampling (Strauss & Corbin, 1990) according to gestational age at loss and elapsed time since the loss. This was done to obtain equal representation of those who experienced early and late IPLs at short and long intervals between the time of loss and the semistructured interview.

The 20 women who participated in the semistructured interviews can be described as follows. Their mean age was approximately 32. Most lived in California, were married or living with a partner, reported Baptist as their religious affiliation, had a college degree or advanced technical education, were employed outside of the home, reported a family income between $50,000 and $100,000, and had health insurance coverage (see Table 1). More than half of them had one living child and had experienced at least one previous IPL or therapeutic abortion; a third were childless; most of them had experienced loss during the 1st trimester of pregnancy; and the average elapsed time since IPL was about 2 years (see Table 2).

Instruments

A semistructured interview guide was used to assess and explore the coping strategies used by the participants (see Table 3). This guide was flexible, designed to become more specific as the interview progressed. Different probes were prompted by the nature of the responses. Additional responses were elicited from the participants to enrich the properties and dimensions of coping that were emerging from their comments.
Before each semistructured interview, consent procedures that had been approved by the committee on human research at the affiliated university were reviewed verbally with the participants and given to them in the form of an information sheet. The average length of each interview was from 45 to 60 minutes. The audiotapes were professionally transcribed and then carefully proof-read by the authors while listening to the audiotape. Each interview was read several times by one or both of the authors to develop an overall understanding of the entire experience. The interviews were structured to solicit descriptions of the course followed by the participants to manage and resolve their grief during the time interval between the IPL and their participation in the study.

Grounded theory techniques were used to analyze the transcribed interview data. The grounded theory method, also known as the constant comparative method of analysis (Strauss & Corbin, 1990), is a qualitative research method designed to develop theory. Words, phrases, or sentences spoken by the participants were used by the authors to develop the theory.

### TABLE 1
Profile of Participants (N = 20)

<table>
<thead>
<tr>
<th>Variable</th>
<th>f ( % )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial/ethnic group</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>20 (100)</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>20 (100)</td>
</tr>
<tr>
<td>Current residence</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>15 (75)</td>
</tr>
<tr>
<td>Other states</td>
<td>5 (25)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married or living with partner</td>
<td>12 (60)</td>
</tr>
<tr>
<td>Single or living alone</td>
<td>8 (40)</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td></td>
</tr>
<tr>
<td>Baptist</td>
<td>9 (45)</td>
</tr>
<tr>
<td>Christian</td>
<td>5 (25)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (25)</td>
</tr>
<tr>
<td>No response</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Educational level completed</td>
<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>1 (5)</td>
</tr>
<tr>
<td>High school graduate or some college</td>
<td>7 (35)</td>
</tr>
<tr>
<td>College graduate</td>
<td>12 (60)</td>
</tr>
<tr>
<td>Current employment status</td>
<td></td>
</tr>
<tr>
<td>Employee for wage</td>
<td>12 (60)</td>
</tr>
<tr>
<td>Work without pay in family</td>
<td>4 (20)</td>
</tr>
<tr>
<td>Student</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Unemployed/other</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Family income</td>
<td></td>
</tr>
<tr>
<td>&lt; $10,000</td>
<td>4 (20)</td>
</tr>
<tr>
<td>$10,000-29,999</td>
<td>3 (15)</td>
</tr>
<tr>
<td>$30,000-49,999</td>
<td>2 (10)</td>
</tr>
<tr>
<td>$50,000-99,999</td>
<td>9 (45)</td>
</tr>
<tr>
<td>$100,000 or more</td>
<td>2 (10)</td>
</tr>
<tr>
<td>Type of insurance</td>
<td></td>
</tr>
<tr>
<td>Health maintenance organization</td>
<td>13 (65)</td>
</tr>
<tr>
<td>Private</td>
<td>2 (10)</td>
</tr>
<tr>
<td>MediCal</td>
<td>4 (20)</td>
</tr>
<tr>
<td>Medicare</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>

Note. Mean age of participants is 31.8 years (SD = 6.82, range = 22.63-49.97).

### TABLE 2
Reproductive Profile of Participants (N = 20)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Yes ( % )</th>
<th>No ( % )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior loss at time of index loss</td>
<td>12 (60)</td>
<td>8 (40)</td>
</tr>
<tr>
<td>Living children at time of loss</td>
<td>13 (65)</td>
<td>7 (35)</td>
</tr>
<tr>
<td>Living children at time of interview</td>
<td>14 (70)</td>
<td>6 (30)</td>
</tr>
<tr>
<td>Pregnant at time of interview</td>
<td>4 (20)</td>
<td>16 (80)</td>
</tr>
</tbody>
</table>

Note. Index loss is the focal involuntary pregnancy loss reported in this study. Mean elapsed time since loss = 23 months (SD = 15.07, range = 6.3-43.07). Gestational age at loss by trimester [f (%)] first = 14 (70), second = 4 (20), third = 2 (10).

### TABLE 3
Semistructured Interview Guide

The semistructured interview guide included questions such as

1. Please tell me the story of the loss of your pregnancy (or baby).
2. Please share the things that were helpful and not so helpful to you after the loss of your pregnancy (or baby).

Several specific probes were used when needed to solicit additional information about the grief experiences. These included

1. What did the loss of your pregnancy (or baby) mean to you?
2. How did you feel after the loss of your pregnancy (or baby)?
3. How long did these feelings last?
4. What advice would you give other Black women who have lost a pregnancy (or baby)?
5. What else, related to the experience of losing your pregnancy (or baby), would you like to have been asked about while completing the questionnaires or during this interview?
authors to identify phenomena through coding or labeling those that were pertinent to the research questions posed. The codes were then compared and grouped to form categories, which were further developed or collapsed as the analysis progressed. The computerized software program Non-numerical Unstructured Data Indexing Searching and Theorizing (also known as NUD*IST) (Richards, 1997) was used to facilitate the analyses and management of the data. Selected techniques from grounded theory methods were used to identify concepts, themes, and categories of responses that would allow us to describe and explain the phenomena involved in coping after IPL. Beck's (1993) three criteria for assessing and promoting rigor in a qualitative study—credibility, fittingness, and auditability—provided the framework for the present study.

Results

Analyses of responses from the semistructured interviews revealed strategies for coping with several aspects of the grief experience following IPL. These aspects are grouped in the following categories of responses: Coping with (a) personal reactions and responses after IPL, (b) reactions of others, (c) memories of the baby, and (d) subsequent pregnancies.

Coping With Personal Reactions and Responses After IPL

How the women coped and managed their myriad personal grief reactions and responses composed the largest category of responses. Their strategies included I Talked, Haven't Dealt With It, I Prayed, and Going Inside Myself.

I Talked. The participants expressed the importance of the support they received from people with whom they were able to speak about their loss. Supportive family and friends were reassuring and comforting; they talked and cried with the bereaved mothers. The participants spoke of the importance of having someone to listen to them without judgment or criticism.

Family and friends were most frequently cited as individuals the participants spoke with after their IPL. When friends and family were available and supportive, their presence was so significant that the women felt no need to go outside this network for counseling from professionals or support groups. A participant who experienced a 1st trimester miscarriage illustrated a typical response: “I have received all of the reassurance and love [from my family], and I didn’t need to go outside. My family really can relate to me because they know me.”

Some participants reported that when they talked about their IPL they felt relieved and better about it, even for a brief period. Talking to others helped them gain a better understanding of the experience, and it made them feel that they were healing. What one participant said illustrates the value of talking with others who shared their experiences:

If I talk to people who have had losses or miscarriages, then it doesn’t bother me 'cause I feel like I'm related to somebody who's been through the same thing that I've been through... It feels better at the time. It may not last for a long time, but at least for that moment or a little while after you'll feel a little better.

Talking with living children was also a source of comfort. The children’s responses to news about the loss tended to be honest, clear, innocent, and hopeful. Their words of encouragement were comforting to the woman and helped bring a new perspective to the loss.

About one third of the participants reported having obtained counseling from support groups or individual therapists for a limited time. Participation in a support group was helpful because it provided not only an opportunity for interaction with other women who had experienced IPL but also an environment in which a tacit understanding existed, and the participants believed that they did not have to feel embarrassed to talk about their loss when the listeners were others who had shared similar experiences. However, the participants indicated that groups they attended had few or no other African American women, which made their sharing somewhat constrained. They also wanted the opportunity to talk with women of their culture within that setting. The comments of one participant are typical:

I attended MEND [Mothers Enduring Neonatal Deaths] meetings and met people that know how you feel and know nothing is a solution. Very few African Americans attend. Support groups and counselors are thought to be only for White women with money. Cultural differences make our grieving that much harder. We are not expected to go to counseling and [are] brought up to make it on our own, to try to be strong, but can't. [We’re taught that] the only thing you need to do is get on your knees [to pray] and you’ll be okay.

Haven't Dealt With It. More than half of the participants reported not having dealt with the loss at varying intervals or periods of time after their IPL and participation in this study. Six of the 20 women who participated in the semistructured interviews reported that this was the first time they had recalled the loss or spoken about it since it occurred. Some participants described how they avoided grieving for their loss for a variety of reasons, including the desire to prevent physical and emotional pain from memories of the loss, lack of support for grieving, guilt feelings, and the presence of competing life challenges. “Competing challenges” as a barrier to grieving, a
common theme among this group of participants, is exemplified by a participant who experienced an early loss of one triplet and the death of her father on the same day, events which occurred about 3 years before the study:

I have never really thought about it until now. (Tearful) Gosh, I'm sorry. I'm sorry. . . . And after that [loss of triplet and death of father], um, life went on. It was just about maintaining, being able to hold on to the other two [babies]. . . . And after that I never really dealt with it or thought much of it because, it was a real traumatic experience for me to lose my father. And then I had these two new babies who were unexpected, and one of them had a heart condition. And then my mother was in an accident and couldn’t care for herself, and I had to care for them. So I just have never, until you just brought it to me, I really had, I guess, the time to really reflect on the actual loss. I think I was just numb. There was no help and I just kind of picked up and just dealt with what else was happening in my life.

**I Prayed.** Relying on religious and spiritual beliefs and values was another strategy frequently used by the participants. Developing, renewing, or maintaining a relationship with God was paramount. They spoke of having faith and putting their trust in God. Believing that God does everything for a reason, can fix anything, and is a protector was a source of strength for those who held these beliefs. A participant's individual relationship with God was demonstrated by praying regularly. Participants were asked about what they prayed for and about. The scope of the prayers included (a) apologizing for their sins (some believed their loss was retribution for sins they may have committed); (b) asking for support, guidance, peace, strength, increased understanding, or a subsequent healthy pregnancy; (3) professing their trust in God; and (d) requesting the strength to increase their faith and trust to “let go and let God.” A prayer asking for personal peace and guidance is exemplified by this participant’s petition:

I prayed that God not take any more babies. I said, “Please, don’t put anyone through this kind of pain, even if this is the cross I had to bear.” I prayed for peace and guidance, and to remove hatred. I prayed that my child doesn’t see me down here crying and grieving for her.

**Going Inside Myself.** This group of strategies is related to the influence and role of prayer in the spiritual lives of these participants. The *going inside myself* strategy includes responding to internal promptings to cope with reactions and responses after IPL. These women used strategies that, although similar to prayer, may be more commonly referred to as meditation, to find peaceful time alone and to go inside themselves to figure out a way to get through the tumultuous times after their IPLs. The efforts to use internal resources or, as one of the author's labeled it, the “inner voice of healing” (Van, 2001, p. 236) were said to be an instinctive but, at the same time, conscious response to the women’s situations. A participant who had a 3rd trimester fetal loss shared a typical response illustrating the use of internal resources:

I just would try to figure out ways, I guess, to try to forgive myself for—I don’t know. I felt like I should have done more, but I don’t know what I could have done. So I would just sort of sit and talk with myself. Spend some time just being quiet.

**Reactions of Others**

Participants who dealt with insensitive comments from others tended to excuse or overlook the unsupportive behavior because they felt that others who did not have the experience did not understand it. These women prayed for the unsupportive individuals and did not dwell on the negative comments. A woman who experienced the stillbirth of a full-term infant reported an example:

Someone said to me, maybe it is a sign, and just wasn’t meant to be. I just overlooked it, because they haven’t gone through it. They can’t give me advice, if you haven’t gone through it. I feel like I bonded with her [the baby] in the womb.

A few participants experienced insensitivity during interactions with coworkers in the early period after IPL. A participant whose first pregnancy ended in a miscarriage recounted the following events:

I had a coworker call me at home about a timecard and [she] was really rude to me and it just totally stressed me out because they weren’t even considering the fact that I had just lost my baby. [She] hung up in my face, and so I really felt hurt. . . . But things like that happen, and I felt stressed out about it, and I would call my mom or whoever I could speak with about the situation to try and get some comfort. But some people may not know what to say to a person who has just had a miscarriage or a loss, and you just have to excuse that and just pray for them.

Returning to work was a challenge for many participants because their clients or patients, who were unaware of the pregnancy, made natural inquiries about the progression of the pregnancy. One participant quit her job in a prenatal clinic, but another loved her job and chose to learn to manage the inquiries until they subsided. A participant who experienced the loss of two pregnancies, one singleton and twins, in quick succession offered the following account:

When I returned to work, a lot of patients knew of my pregnancy and asked what did I have. . . . I finally
Religiosity and spirituality should be assessed on two levels, a cognitive level on which the extent to which religion is important in their lives is noted, and a behavioral one on which the extent to which they engage in religious activities is determined.

Memories of the Baby
Some participants who experienced 2nd and 3rd trimester losses had memorabilia (e.g., pictures, pieces of hair, and baby blankets) and memories from their babies that seemed to be helpful, when recalled, during their experiences after the IPL. The items would be taken out periodically and were a source of comfort because it made the women feel connected to their babies. A participant who experienced a stillbirth and had a video of her fetus said, “We have a videotape of my sonograms with her. So it was also helpful for me to—sometimes I’ll watch that. Just to remember what she looked like when she was healthy.”

Some women recalled the funeral services held and rituals enacted. Others related their experiences of touching and holding their babies as being comforting, as reflected in the following account:

I have pictures of Steven. . . . They’re kind of scary because . . . he looked like a normal baby, but he was just really red and real tiny. . . . I don’t know if anybody’s ever held a 12-ounce baby, but . . . they’re real tiny. . . . But I put him up to my face, and you know, I caressed his face, rubbed his face, and the nurse took pictures. . . . And he had a burial. And it was . . . it was just a maternal thing. That if he had been born alive I would have done the same thing. But I just wanted him to know, even though he really didn’t know that I loved him.

Subsequent Pregnancies
Fear of failure or another IPL was prevalent among the participants who maintained the desire to have children at the time of the study. This fear led some women to decide not to attempt to conceive again but to use other options, such as foster parenting or adoption. Participants who did have subsequent pregnancies displayed higher levels of pregnancy-related anxiety, lower levels of attachment to their unborn fetus, and some denial of the pregnancy. A woman who experienced a 3rd trimester loss described her fears during a subsequent pregnancy with twins, which was typical of other responses:

There was never a point where I relaxed. Never. . . . I was just pleased to be pregnant, but really scared to go through it all over again. My attitude towards the pregnancy was, “No; I’m not really pregnant.” So I would just sort of like be in this little denial of like, they’re [her unborn twins] just . . . I don’t know. But I was always nervous, very cautious, and I just rested as much as I could. I was very bound and determined to be much more careful this time around.

A participant who was pregnant at the time of the semi-structured interview stated:

I feel like I’m paranoid. Every time something happens I call the advice nurses or make an appointment. I keep a diary of all the advice I’m given from the doctors and nurses. I’m taking command of my body. I have become more forceful and in charge of my health. My health is a priority. I visit the MD at the slightest hint of a problem.

Discussion
The women in this study experienced varied and dynamic responses after their IPL. First of all, the participants viewed their IPLs as the death of their baby, as opposed to the loss of their pregnancy. It is important for the nurse to assess which way the woman views her IPL so that the two can use a common language in referring to the experience. If the woman has named the baby, the nurse should refer to him or her by that name, assuming the woman agrees (Robertson & Kavanaugh, 1998).

The women in this study used inner resources to develop self-help strategies to cope with their IPLs by deliberately connecting with others and with their religious and spiritual beliefs and practices. These same strategies are reflected in the results of a study by Smyth and Yarandi (1996) of a cross-section of employed African American women and in the results of other studies in which one or both of the strategies were used by women of other racial and ethnic groups, such as Hispanics and White pregnant homeless women (Killion, 1995; Smyth & Yarandi, 1996).

Many of the participants in the present study indicated a preference for connectedness with particular individuals in their lives who helped them to cope—usually their mates or their closest female friends. Although husbands or partners are often portrayed by post-IPL women as silent, distant, and unsupportive (Kavanaugh, 1997; Reed, 1984), in this study there were far more reports of sup-
portive husbands and partners than of unsupportive ones, a finding also reported by Conway (1995). However, Conway (1995) also found that Australian women who had had IPLs turned most frequently to their close female friends for support in coping with their grief, even more than to their mates—again, a finding confirmed by the present study.

The women in this study did report many incidents of insensitivity from other persons who were not their husbands, partners, or best friends, a finding reported by other researchers (e.g., Bansen & Stevens, 1992; Carroll-Frey, 1997; DeFrain et al., 1996; Hammersley & Drinkwater, 1997; Malacrida, 1999; Woods & Woods, 1997). In most cases, the women chose to cope with the unsupportive reactions and responses of others by ignoring their remarks or by forgiving them, rationalizing that the responses were due to lack of knowledge about how to support a person after an IPL.

Most of the participants in this study reported that religious and spiritual beliefs and practices were important in their lives, especially when they had to deal with traumatic events such as IPL. Connectedness to spiritual or religious beliefs and activities as a source of strength and guidance is vital for many African American women (Killion, 1995). Even African American women who report a lack of formal religious affiliation use spiritual beliefs and practices to cope with IPL (Van, 2001). The women in this study took time alone to reflect, seek guidance from the source of their strength, and pray about their situations and how to regain control and quality in their lives. Whether women from other racial backgrounds use these practices to a similar extent is not adequately addressed in the current literature. But these strategies were found to be important in this population.

Memories of the baby may initiate painful physical and emotional responses (Lauterbach, 1993). In this study, however, the participants reported that such memories were healing and helped them to deal with their grief. This finding is similar to that reported by White and Hispanic family members who experienced the death of children at ages 3.5 months to 9 years of age (Gudmundsdottir, 2000-2001). The participants in this study, who had memorabilia from their IPL such as an ultrasound video, footprints, or the baby’s blanket sometimes used these items to connect with the baby and facilitate their personal grieving experience.

The women in this study who became pregnant after their IPL experienced pregnancy-related anxiety and low levels of attachment to their unborn fetus until they passed the point at which the previous loss occurred or, in some cases, until they delivered a healthy newborn. This finding has also been reported by other researchers (e.g., Armstrong & Hutti, 1998; Cote-Arsenault & Mahlangu, 1999; Robertson & Kavanaugh, 1998). The anxiety and emotional distance experienced by these women may be due to their reluctance to relive the previous IPL and to their sense of helplessness and lack of control in producing a healthy baby. Feelings of vulnerability during subsequent pregnancies may be an impetus for the compulsive manner in which the participants in the present study sought medical care or advice during their pregnancy for the slightest indication of what they believed might be abnormal. A similar finding was reported by Cote-Arsenault and Mahlangu (1999). This vulnerability seemed to put the women on edge at all times, not only over their pregnancy but over other aspects of their lives in which they perceived themselves to have minimal control, such as their jobs. Their emotional distancing may have been self-protective to avoid extreme hurt if an IPL occurred again (Smyth & Yarandi, 1996).

Implications

Nurses have an opportunity to provide a culturally sensitive framework for supporting women who have experienced an IPL by assessing how these women usually manage stressful encounters with others and guiding them by identifying their preferred and most effective coping strategies. The results of this study indicate that personal relationships and religious, spiritual, and cultural beliefs are significant factors that may influence post-IPL experiences in this group of women. Nurses can be most effective by conducting assessments and constructing interventions consistent with these factors.

Women in this study described their strong needs and desires to speak about their IPL experiences, expressing their feelings, thoughts, and responses. Women who spoke with individuals who were nonjudgmental and supportive listeners were comforted and gained a new understanding of their loss, which helped them to cope with it. The nurse should explore the woman’s desire to discuss her experience. And if indicated, encourage her to express herself in ways that may be helpful in dealing with the loss. These discussions should include identifying specific friends and family members, including living children, who can give the woman compassionate support. The nurse should, with the permission of the woman, talk to
TABLE 4

<table>
<thead>
<tr>
<th>Personal responses</th>
<th>Memories of baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do you usually handle stressful situations (e.g., talking to others or</td>
<td>1. What are some of the memories you have about your baby?</td>
</tr>
<tr>
<td>working it out by yourself)? What specifically do you usually say or do?</td>
<td>2. When do the memories come and how do they come to you?</td>
</tr>
<tr>
<td>2. When in a stressful situation and you talk to others, are they willing to</td>
<td>3. What are the memories expressing?</td>
</tr>
<tr>
<td>listen to your concerns?</td>
<td>4. How do you feel and what do you think when the memories of the baby come to you?</td>
</tr>
<tr>
<td>3. Do you have religious or spiritual beliefs or values? What are the major ones?</td>
<td></td>
</tr>
<tr>
<td>How do these beliefs or values influence your behavior during stressful situations?</td>
<td></td>
</tr>
<tr>
<td>4. Do you participate in religious or spiritual practices?</td>
<td></td>
</tr>
<tr>
<td>What are the most frequent ones? How do these practices influence your behavior</td>
<td></td>
</tr>
<tr>
<td>during stressful situations?</td>
<td></td>
</tr>
<tr>
<td>5. What did the loss of your pregnancy (or baby) mean to you?</td>
<td></td>
</tr>
<tr>
<td>6. How do you feel about the loss of your pregnancy (or baby)?</td>
<td></td>
</tr>
<tr>
<td>7. What has helped you the most in dealing with your feelings and responses, from</td>
<td></td>
</tr>
<tr>
<td>immediately after the loss until now?</td>
<td></td>
</tr>
<tr>
<td>Interactions with others</td>
<td></td>
</tr>
<tr>
<td>1. How do you handle negative comments from someone who isn’t sensitive to your</td>
<td></td>
</tr>
<tr>
<td>loss?</td>
<td></td>
</tr>
<tr>
<td>2. Who would you choose to speak with about your loss?</td>
<td></td>
</tr>
<tr>
<td>What is it about this (these) person(s) that would make you feel comfortable with</td>
<td></td>
</tr>
<tr>
<td>sharing your personal feelings?</td>
<td></td>
</tr>
</tbody>
</table>

these individuals, emphasizing the normalcy of grief after IPL and the therapeutic effects of talking about the loss. In addition, the nurse should recommend other sources of support, including (a) social workers and volunteers who are trained in perinatal bereavement care; (b) parents who have had similar loss experiences; or (c) members of local religious organizations or support groups that provide services to women who have experienced an IPL.

The nursing assessment of the woman’s religion and spirituality should be conducted on two levels, cognitive and behavioral. On a cognitive level, the nurse determines how important religion is in the woman’s life. On a behavioral level, the nurse determines the extent to which the woman actually engages in religious activities. Mindful that the woman who has had an IPL is most likely experiencing spiritual distress and may be ambivalent about her faith and religious associations, the nurse can remind and encourage her to use relevant resources such as prayer. It would also be valuable to maintain a selection of religious and spiritual references, including a Bible. The results of religious and spiritual assessments and strategies should be part of the discharge planning report and documentation. Ideally, the nurse should discharge the woman with a list of books, audiotapes and videotapes, and Internet sites concerning pregnancy-specific grief.

As noted by Robertson and Kavanaugh (1998), women who experience IPL should be given the opportunity to gather memorabilia that will allow them to connect to memories of the loss when they desire to do so. The nurse should advise the women of the value of rituals, such as a formal funeral, informal memorial service, or informal gathering of family and friends to recognize the loss. Women who experience subsequent pregnancies after an IPL need special recognition of the milestones they achieve during the current pregnancy. These milestones include hearing the heartbeat, sensing fetal movement, or viewing normal fetal growth in an ultrasound picture.

Women may re-experience grief over the IPL at different times in their life. Table 4 provides a culturally sensitive framework for clinicians to use in assessing grief among African American women across their life span. We developed these questions based on data from this study (e.g., four aspects of their coping experiences) and recommendations by the study participants. These questions have not been piloted in clinical settings. Clinicians are encouraged to use these questions selectively as indicated by each patient’s or client’s circumstances.

Larger samples are needed to support the categories of responses that emerged in this study. In addition, larger samples could provide data to describe the dimensions, pat-
terns, and distinct properties of coping with one's own grief, insensitivity from others, and subsequent pregnancies. Racially and ethnically diverse samples could provide comparative data to elucidate the effects of culture on the experience of coping after IPL. Issues that need to be researched in the future include the conscious and unconscious modes of coping that women use to deal with IPL, the resources they prefer to mobilize, and the conditions in which they mobilize them. This information could be used by nurses to develop assessment strategies to guide women, their partners, and their families in ways to anticipate and deal with the inevitable grief that follows IPL.

To date, this study is the only one to address the issue of coping after IPL among the African American population. However, the small sample size may limit the generalization of the findings, both to other populations and to the larger African American population itself. As Bountain (1999) noted, there is great diversity of perspective within the African American community, which may not be well represented in this study.

Conclusion

Knowledge about responses of African American women to such invisible losses as IPL remains limited and should be examined further. In this study, the women's responses to their IPL was grouped into four areas. They coped with personal reactions, reactions of others, memories of the baby, and subsequent pregnancies. Nurses are challenged to harness the influence of family, friends, religion, and cultural traditions to assist women in processing the cognitive, emotional, and social traumas associated with IPL. Educating women to recognize grief responses after IPL and to manage these responses effectively may prevent adverse outcomes to their physical and mental health. A culturally sensitive framework of clinical assessment and intervention for African American women experiencing IPL has been developed.

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