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RECURRENT PERINATAL LOSS: A CASE STUDY*

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Abstract

To date, investigators have not demonstrated a clear relationship between a parent's history of prior perinatal losses and intensity of grief response following a subsequent perinatal loss. Examining this relationship for low-income, African-American parents is important because they are a vulnerable population due to the high incidence of perinatal mortality in Blacks and their other life stressors that can impact on grief response and caring needs. The purpose of this case study was to examine the impact of recurrent perinatal loss on a low-income African-American parent. The research design for this study was case report, using interview data collected from a mother who had recently experienced her fourth perinatal loss, which occurred at twenty-five weeks of gestation. Transcripts from two open-ended interviews were analyzed. The theoretical framework used to guide analysis of this case study was Lazarus and Folkman's stress and coping theory. Results demonstrated that the prior perinatal losses did not appear as critical components of the way the mother responded to her most recent loss. Instead, perception of the care she received from healthcare providers and how that care related to her experiences with her one living child who was born at the same gestational age was an important determinant in how she responded to her loss. The results of this case study demonstrate the importance assessing a person's perception of their experience and those factors which contribute to the way they respond.

Recurrent perinatal loss is the occurrence of two or more perinatal losses, which includes miscarriages, stillbirths, and neonatal deaths. Parental response to recurrent perinatal loss is not clearly understood. To date, results of studies of perinatal loss have not demonstrated a clear relationship between a parent's history of prior perinatal losses and quality, intensity, and duration of grief response following a subsequent perinatal loss. Whereas some studies have illustrated that a parent's history of a prior perinatal loss intensifies the grief response (Bradshaw, 1985;Hunfield, Wladimiroff, Verhage, & Passchier, 1995;Kennell, Slyter, & Klaus, 1970;Peppers, & Knapp, 1980), other studies have not produced similar findings (Benfield, Leib, & Vollman, 1978;LaRoche et al., 1982;Lasker & Toedter, 1991;Neugebauer et al., 1997;Nicol, Tompkins, Campbell, & Syme, 1986;Smith & Borgers, 1988–89;Toedter, Lasker, & Alhadeff, 1988;Turner et al., 1991;Zeanah, Danis, Hirshberg, & Dietz, 1995).

Cordell and Thomas (1997) have described a model of parental grief that accounts for the intensity and ongoing nature of grief. However, as an emerging model, it does not allow for a complete understanding of the influence of factors, such as prior loss, on the grief response. Understanding the impact of prior loss on a parent's response after a subsequent loss is important because clinicians and other individuals who interact with bereaved parents need a better appreciation of factors which impact on a parent's grief response after a perinatal loss in order to care for and support parents.

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Examining recurrent perinatal loss in low-income, African-American parents is particularly critical because these parents are an especially vulnerable population. Although data are not available on the incidence of recurrent perinatal loss in African Americans, perinatal mortality data for Blacks demonstrate that the incidence of perinatal loss is greater than twice that of Whites (Guyer, Martin, MacDorman, Anderson, & Strobino, 1997). Furthermore, African Americans have a tendency to have other life stressors (Hale, 1992), particularly if they are low-income, that may affect their responses and caring needs when dealing with their loss; thus, making African Americans a "vulnerable population." Therefore, the purpose of this case study was to examine the impact of recurrent perinatal losses on a low-income, African-American parent.

REVIEW OF LITERATURE

Numerous investigators have examined the relationship between a prior perinatal loss and a parent's response after a subsequent perinatal loss, but findings have been contradictory. A number of investigators have demonstrated that prior perinatal loss is predictive of a more intense grief reaction in parents after a subsequent loss (Bradshaw, 1985;Hunfield et al., 1995;Kennell et al., 1970;Peppers, & Knapp, 1980). However, other investigators have found no relationship between a prior perinatal loss and response after a subsequent loss (Benfield et al., 1978;LaRoche et al., 1982;Lasker & Toedter, 1991;Neugebauer et al., 1997;Nicol et al., 1986;Smith & Borgers, 1988–89;Toedter et al., 1988;Turner et al., 1991;Zeanah et al., 1995).

In one of the first studies of perinatal loss, Kennell et al. (1970) observed reactions of mothers who had lost a newborn infant, and explored the strength of affectional ties between mothers and infants after first physical contact. The sample consisted of twenty women who were interviewed after the death of an infant: eleven were White and nine were Black. High mourning was characterized by sadness, loss of appetite, and inability to return to normal activities. The parents in the high mourning group had a combined total of nine previous miscarriages and four deaths of living children, whereas only one parent had one miscarriage in the low mourning group. The conclusion was that high mourning was associated with the previous loss of a baby either through miscarriage or death of a liveborn infant.

Other investigators have also demonstrated more intense grief in mothers who had a history of prior perinatal loss (Bradshaw, 1985;Hunfield et al., 1995;Peppers & Knapp, 1980). In a study that examined maternal reactions to involuntary fetal/infant death, Peppers and Knapp (1980) proposed to demonstrate similarities and differences in maternal response to the three categories of fetal/infant death: miscarriages, stillbirths, and neonatal deaths. The sample consisted of sixty-five White women, and results showed that women who had previous complications in pregnancy, including loss, experienced a more intense grief reaction that was statistically significant. Bradshaw (1985) found similar results when examining the effect of prior perinatal losses on the grief response. In that study, the sample consisted of twenty-six women who experienced a miscarriage or a stillbirth, of whom eleven were Black. Data were collected through various methods including an interview encompassing the Grief Response Inventory, the Beck Depression Inventory, and two questionnaires on attachment to the baby and helpfulness. The results showed a trend toward a significant positive correlation between number of losses and grief, suggesting that women who had experienced recurrent losses tended to show more grief symptomatology.

More recently, Hunfield et al. (1995) examined previous stress, such as a history of perinatal loss, and acute psychological defense as predictors of grief. The sample consisted of forty-six women whose infants were diagnosed with lethal fetal malformations at twenty-four weeks gestation. Data were collected from in-home interviews and questionnaires two to six weeks after the anomaly was diagnosed, and at three months after the loss. The results showed that

women who had experienced major life events, including prior perinatal loss, showed more intense grief than women without history of major life events.

In contrast, results of a number of other studies do not demonstrate that a prior perinatal loss is related to the intensity of a parent's grief in a subsequent loss (Benfield et al., 1978;LaRoche et al., 1982;Lasker & Toedter, 1991;Neugebauer et al., 1997;Nicol et al., 1986;Smith & Borgers, 1988–89;Toedter et al., 1988;Turner et al., 1991;Zeanah et al., 1995). Benfield et al. (1978) evaluated grief response of fifty Caucasian mother-father pairs who experienced a neonatal death. Data were collected through a questionnaire and semi-structured interview. Results demonstrated that the grief scores were not significantly related to variables such as previous perinatal loss. The authors suggested that a parent's grief response was highly individualized and may be most dependent on the perception of supportive care from healthcare providers than any other factors.

A number of other investigators have examined the effects of a number of variables, including prior perinatal loss, on the grief response (Lasker & Toedter, 1991;Nicol et al., 1986;Smith & Borgers, 1988–89;Toedter et al., 1988;Zeanah et al., 1995). Using the Perinatal Grief Scale, Toedter et al. (1988) collected data six to eight weeks after the loss from a sample of 138 women and fifty-six men. Results demonstrated that variables such as previous loss were not significant in predicting grief response. Furthermore, in examining acute and chronic grief in these parents, Lasker and Toedter (1991) found that history of previous losses did not appear to be related to the most severe long-term outcomes. Nicol et al. (1986) also demonstrated that there was no relationship between previous perinatal losses and the maternal grieving response in a sample of 110 women; thirty-seven had previously miscarried, and four had experienced a previous perinatal death.

In a study that examined adaptation in mothers and fathers following perinatal loss two months after the death of their infant, Zeanah et al. (1995) utilized a sample of eight-two mothers and forty-seven fathers. Several tools for data collection were used including the Grief Experience Inventory, Beck Depression Inventory, and the Life Experience Survey. Results of this research showed that the number of previous perinatal or pregnancy losses that couples had experienced was unrelated to the intensity of their grief responses. Using the Grief Experience Inventory and Perinatal Loss Questionnaire in a sample of 115 mothers and sixty-one fathers six months to seven years after a perinatal loss, Smith and Borgers (1988–89) also found that no differences occurred in grief response based on number of previous losses. Based on their findings, these authors proposed that the individual personality variables of the parent and the parent's perception of being understood and supported were important determinants of the grief response.

LaRoche et al. (1982) demonstrated that previous loss was not a factor associated with increased risk of unusual grief reactions. For this study, a sample of thirty-one women who had lost babies before birth or during the first month of life were interviewed one to two days after the loss of their child. Assessments of grief were based on criteria from Parkes and Lindemann, including preoccupation with an image of the deceased child, somatic distress, and feelings of guilt or hostility toward others. The investigators concluded that the mourning process was a complex one with individual differences in reaction over time.

Finally, in a recent study of women who had miscarried, Neugebauer et al. (1997) examined whether or not these women were at risk for a first or recurrent episode of major depressive disorder in the six months following loss, and whether risk varied by gestation or attitude toward pregnancy. A sample group of women who had experienced a miscarriage consisting of 229 women was compared to a control group of 230 women who had not experienced a miscarriage. Major depressive disorder was measured using the Diagnostic Interview

Schedule, and results showed women who experienced a miscarriage demonstrated greater risk for major depressive disorder compared with the control group. However, relative risk did not vary significantly by history of prior reproductive loss. In another study with women who experienced a miscarriage, Turner et al. (1991) found that prior perinatal loss was not predictive of prolonged grief.

METHODOLOGY

The case study method (Yin, 1994) provided a thorough, in-depth investigation of a parent who experienced recurrent perinatal losses. This case study is part of a larger phenomenological study that is examining the experience of low-income African-American parents surrounding perinatal loss and how other life stressors influence the parents' response and caring needs (Kavanaugh, 1997c).

Data Collection

This case study focused on one low-income, African-American mother who had experienced four perinatal losses. Her husband was approached for participation in the study but was not willing to participate, and also would not talk about the loss with his wife. The couple's first three losses occurred between twelve and eighteen weeks of gestation, and their most recent loss occurred at twenty-five weeks of gestation.

After obtaining informed written consent, two open-ended interviews were conducted with the mother in her apartment between seven and nine weeks after her most recent loss. These interviews were open-ended to generate a description of the experience from her viewpoint. The interviews were conducted by a researcher (Kavanaugh) who had extensive knowledge and expertise in working with parents who had experienced a perinatal loss. Due to the sensitive nature of the topic, strategies were used to minimize harm to the parent (Kavanaugh & Ayres, 1998), such as limiting the interview to two hours, collecting data over at least two interview sessions, and using process consent, which is the renegotiation of consent throughout the study.

The first interview was initiated by asking the broad question, "What has it been like for you to lose your baby?" This mother described her experience freely during the interviews; thus, minimal probes were needed to generate further description of the experience. The interviews were audio taped, transcribed onto computer files, and then written transcripts were generated. The written transcripts of interviews and the investigator's field notes were used for this case study.

Data Management and Analysis

Lazarus and Folkman's theory of stress and coping served as the organizing framework for data analysis because of its usefulness and focus on the individual's perception and meaning of an event (Lazarus & Folkman, 1984). This theory of psychological stress and coping proposes cognitive appraisal and coping as two major processes that act as mediators of stress and stress-related adaptational outcomes. Cognitive appraisal is a process through which the meaning or significance of an event is determined and perceived by the individual. Coping is the person's constantly changing cognitive and behavioral efforts to manage external and/or internal demands that are appraised as taxing or exceeding the person's resources. Variables in this theory of stress and coping theory include causal antecedents, mediating processes, and both immediate and long-term effects. Causal antecedents are those factors or variables motivated by stimulus producing a stress impact. Mediating processes are the flow of events implying a specific change over time, and are generally viewed as an antecedent variable that interacts with other antecedent variables. Immediate effects are the short-term adaptational

responses, whereas long-term are the evolution of short-term responses into illness or impairment of function.

The variables of interest for the case study were causal antecedents, mediating processes, and immediate effects. For purposes of analyses of the data for this case study, causal antecedents were defined as those variables which occurred prior to the current loss, and mediating processes and immediate effects were those processes and effects which were observed within the first nine weeks after the loss. Long-term effects were not observed for this case study because the interviews were conducted in the first few months after the loss.

The data management tasks entailed developing a matrix consisting of coding categories from Lazarus and Folkman's theory of stress and coping: causal antecedents, mediating processes, and immediate effects. Descriptive information and direct quotes from the transcripts were charted in the appropriate sections of the matrix. The data analysis involved identifying trends and patterns noted in the matrix to describe stress and coping of the mother and how variables, such as the recurrent perinatal losses, affected her and other family members.

Trustworthiness is a central component of rigor in qualitative research (Lincoln & Guba, 1985). Key components of trustworthiness for this project included peer debriefing, which was meeting with an expert consultant, establishing an adult trail by maintaining a journal of thoughts of self and method, and collecting thick, descriptive data, which included detailed information about the mother and her family (Lincoln & Guba, 1985).

RESULTS

Description of Case

Ellen, a thirty-year-old woman and Paul, her thirty-one-year-old husband have one child, a twenty-three-month-old daughter, Lisa. Ellen and her husband had experienced three perinatal losses prior to the current loss over the last three years. Ellen's first pregnancy resulted in a loss at eighteen weeks of gestation. Her second pregnancy reached twenty-six weeks, at which time she experienced preterm labor and subsequently delivered Lisa who weighed one pound and three ounces at birth. Her third pregnancy resulted in a perinatal loss at twelve weeks of gestation, and the fourth pregnancy resulted in a loss at eighteen weeks of gestation. Ellen sought prenatal care with each of these pregnancies with the exception of the third one, in which she experienced a miscarriage before she started her prenatal care. Her fifth pregnancy, which was also her fourth loss, was carried to twenty-five weeks gestation at which time she delivered a girl, Renea, despite efforts to treat her preterm labor and intrauterine infection. Renea weighed 1 pound and 7 ounces and was stillborn. Ellen was able to see and hold Renea in the delivery room.

Application of Stress and Coping Framework

Causal Antecedents—Ellen and Paul are both unemployed, and their annual income is between $5,000–$10,000. Ellen is a recipient of Medicaid, and also receives food stamps and social security benefits to provide for the family's needs. They live in a small, one-bedroom apartment in a multi-unit apartment building. Ellen indicated that the living situation adequately meets her family's needs and that she feels safe in her environment, despite her description of several recent murders which had occurred close to her apartment building, including the drive-by shooting of a seven-year-old boy just outside the entrance to her building.

Ellen reflected that her most recent pregnancy was "different for some reason." She recounted the feelings that "I guess because she was more active like moving and everything and I kind of bonded with her early." In spite of her high-risk status because of her recurrent losses, Ellen

was not prepared for experiencing another loss. She said, “I was eating the right foods, getting rest, and I just can’t understand what happened. I guess I was caught off guard.” She remembered feeling “I figured it was difficult but I’m going to make it this time. And it just didn’t happen.”

Ellen reflected that her mother-in-law was a major part of her social network, that she was emotionally supportive during her pregnancy, and a source of strength to her. One person in her life who was not emotionally available during her pregnancy was her father. He had colon cancer, and was hospitalized for medical treatment. Ellen reflected that her father was at the same institutional facility where she delivered and she perceived that he received inadequate care. She noted how the stress of her father’s medical treatment added to her own burden. She recalled, “I put unnecessary pressure on myself because I was running to the hospital when my father was sick.” Upon discharge from the hospital, her father was transferred to an “unfit, unclean nursing home” and died four days later. She reflects that she felt the experience with her father and the hospital was negative, and that she tried to believe in the hospital and the care provided.

Ellen stated she was dissatisfied with much of the care she received from the beginning of her pregnancy until she delivered her infant. She received prenatal care at the high-risk clinic of a perinatal center. Her illness risk factors included three prior perinatal losses and weight loss during the pregnancy. A cervical cerclage was placed early in this pregnancy to prevent preterm labor because of her obstetrical history, and no genetic factors had ever been identified as causative for her prior losses. She had a total of four prenatal visits and voiced concern about the lack of continuity in her prenatal care. She said, “I never saw the same one (physician).” Her general feeling was that the physicians did not know her history; she never had a personal physician. According to Ellen, the physicians were not concerned about her. For example, when she was losing weight at each visit, she explained that the physician instructed her to consume more nutrients which she said was not correcting the weight loss.

Ellen was hospitalized around twenty-four weeks of gestation because her bag of waters had ruptured and she was developing an infection. Initially, she was admitted to a hospital near her apartment but then was transferred to the high-risk perinatal center where she was receiving her prenatal care. She recollected, “Like when I first got to the (nearby) hospital, they were nice because the nurses they sent (for the transport), I knew them.” She explained that the nurse was nice, made her comfortable during the transfer, and knew how to use humor appropriately to ease her anxiety. Ellen assumed that she would receive good care because the perinatal center was a reputable high-risk facility. However, once she arrived at the perinatal center, her experience became negative.

Ellen recalled one encounter with a nurse who displayed a negative attitude from her initial contact with Ellen. Ellen overheard this nurse’s conversation outside of her room, the nurse saying, “I’m not going to be delivering a twenty-four week baby.” The nurse continued to say, “the baby is not going to make it and if it does it’s really going to have a hard time.” To Ellen, this nurse lacked compassion, which created a particularly hard situation for Ellen because her husband was not able to be with her when she was admitted to the perinatal center.

Ellen was equally displeased with the care she received from physicians. In spite of requesting a cesarean section, which she believes could have provided a more optimal outcome for her infant, she did not receive one because she was told by the physicians that it was not necessary. However, once her infant demonstrated signs of distress, a decision was made to perform an emergency cesarean section, but her infant was born before the procedure could be done. With anger, she recollected the ambiguity of the physicians in determining her plan of care, and how the physicians indicated that she was the one with reservations about the cesarean section.

Mediating Processes—During her hospitalization, Ellen spoke with a social worker, whom she described as warm and helpful. She had spoken to the same social worker after one of her other losses. Ellen felt as though the social worker generally cared about her, and provided her with information regarding such things as option of autopsy and burial arrangements for her infant. The social worker also provided her with information on a support group. Ellen, however, determined that the location of the support group was too far away from her apartment. She later commented, “I felt like I should have went for some counseling, but I didn’t.”

When Ellen appraised her situation and contemplated future pregnancies, she stated that she told the social worker, “I should just forget having babies and have my tubes tied and deal with the one I’ve got.” However, a physician advised her against making that type of a decision so soon after a loss. Ellen felt this was good advice because she was ambivalent about trying to have another baby.

Ellen compared this situation to her birth experience when she had her daughter who was born at twenty-five weeks of gestation. She delivered her daughter at another high-risk perinatal center, but had a positive experience at that facility. She recalled that in her previous experience a health care professional, whether a nurse or a physician, was always physically available. She recalled being continuously monitored and having several ultrasounds. She recalled an incident involving a physician who accompanied her to the ultrasound. She said,

> So the doctor when I got down there and I seen he was breathing all hard, he said, “I had to make sure that you didn’t deliver on the way down here.” He come out and had the little suction thing and he’s following me wherever I go. So that was kind of funny. That stuck in my mind. So like I said, they were always around.

She also explained, “I was never fed any negativity,” and was given the option of a cesarean delivery. When contrasting the two facilities, she perceived that the atmosphere was totally different. She explained that she changed facilities for her most recent pregnancy because of her belief that she would have her own physician and thus more continuity of care, which was not possible at the last facility where she delivered.

Immediate Effects—Following her discharge home from the hospital, Ellen reflected further on her feelings following her current perinatal loss. She recalled being in the hospital alone during her loss, as Paul was unable to be with her. When elaborating on Paul’s feelings concerning the loss, Ellen reflected, “My husband, he don’t feel like we need to talk about it, but that’s his feeling. That’s the way he chooses to deal with the situation is don’t talk about it.” Ellen did not feel that their lack of communication concerning the loss had any effect on their relationship. After her loss, Ellen received social support from siblings and church members. Ellen stated she called her sister every day, and also talked to one of her six brothers regularly. She explained that she and her brother related well and that she could express herself freely to her brother. Church members were also supportive and helpful, and Ellen commented that one church member brought dinner for her family once she returned home from the hospital.

Ellen stated she did not receive many telephone calls from family and friends once she returned home. She believed that was due to the fact that her family and friends did not know what to say, and therefore did not say anything. She recalled wishing that her loved ones would have called more often, even if it was just to let her know they were thinking of her, or even brought a card and fruit basket to convey that they cared. She identified religion and prayer as an instrumental form of support to her. She commented, “I talk to God. I just tell how I feel like. People say I’m talking to myself, but I’m talking to God. Sometimes you don’t have anybody to talk to so I just talk. It don’t hurt. It helps to get it out.”

Ellen described her feelings during the first few weeks at home. “I’ve thought about it and I don’t know. I just really came to grips with that I wasn’t pregnant anymore. That’s really how long it took me to come back to my senses that could there have been things that I could do still in the pattern of being pregnant.” She recalled how she continued to do “these right things,” such as drinking milk. Her morale remained low in that she had few opportunities to express her feelings concerning the loss, although she had the desire to do so. She reflected again on her disappointment with her medical care, she admitted after experiencing negative feelings, she would look in the telephone book for listings of lawyers. She had thoughts of suing the hospital and physicians, and did call an attorney and left a message. She commented that she never received a return call, and expressed the thoughts ‘They could call sometimes. I know doctors are busy, I understand that.” However, she concluded that getting a phone call from healthcare providers approximately two weeks after discharge would have conveyed caring and concern.

The depth of Ellen’s pain after her loss was evident in her statement, “at times I could see how people really ponder suicide and stuff of that nature when you are alone and you just, well its no use.” She noted experiencing feelings of hopelessness, but later told herself she had made it so far and could go on. Ellen reflected on positive and negative feelings experienced as a result of the loss. She recalled taking time to think and sort through her feelings. Then she commented how she took her hurt and turned it around. “I took the disappointment of the loss I felt and said I’m just going to give more attention to her, which she really needs anyway.” She explained how her daughter spent almost the first year of her life in the hospital, and didn’t walk until almost two years of age. She identified her daughter’s need for additional love and attention.

In terms of her follow-up with the healthcare system, Ellen had required a short readmission to the hospital for treatment of a medical complication shortly after returning home. She was familiar with this complication and the type of treatment required because of her prior losses. Ellen also had one clinic appointment since the loss occurred. She explained that her cervix was cut during delivery to allow delivery of the infant, and that she returned to the clinic to make sure that she was healing. She also commented that she meant to seek further follow-up, but had not done so because of her dissatisfaction and mistrust with the perinatal center. Also, she felt that she should have gone for counseling, and was still contemplating going. At her request, Ellen received information on resources for support from the interviewer: a support group that was close to her apartment, and the names of two clinical psychologists; however, Ellen had not followed up on counseling or attending the support group.

Ellen viewed the experience as a learning one, and offered advice to prospective parents. She recommended that anyone who is having a baby should carefully consider their options for health care, and investigate the hospital where they are going to have their baby. She advised, “If you can, see if you can get a personal doctor where they know your history.” Ellen expressed that nurses need to be caring and compassionate, and felt she possessed those qualities, and was considering becoming a licensed practical nurse. As Ellen spoke of her future, she also indicated that she planned on purchasing an automobile which would have enhanced transportation opportunities for her and her family.

Ellen spoke of being glad to have the opportunity to communicate her feelings concerning her loss during the interviews. She noted, “It was really good to be able to ventilate and let things out.” She identified the fact that she really had not had the chance to sit and discuss her feelings and the loss, and was unaware of the depth of her feelings. For Ellen, the interview was helpful because it provided her the necessary opportunity to ventilate.

DISCUSSION

The case study design did not allow for statistical analyses of prior loss as a variable related to grief intensity and comparison with other studies that have examined prior perinatal loss as a predictor of grief response. However, the in-depth focus of this case study using a stress and coping framework did illustrate important determinants of the mother's perception of her experience. For this mother, her prior history with her one living child who was born under similar conditions, rather than her prior losses, was an important determinant in how she responded to her most recent loss. Specifically, the perception of the care she received from healthcare providers and how that care compared to the care she received with her one living child, who was born at the same gestational age, influenced her response. Thus, findings of this case study are consistent with earlier research (Benfield et al, 1978;Smith & Borgers, 1988–89) that suggest that a parent's perceptions of being cared for, rather than history of prior loss, are an important influence in the grief response and emerging models of grief which propose that the personal history of the person and the individual nature of that history are critical for understanding that person's response (Carter, 1989;Solari-Twadell, Bunkers, Wang, & Snyder, 1995).

It is not surprising that this mother expected a similar type of treatment with her most recent pregnancy. She was knowledgeable about options for care and potential outcome based on her experience with her daughter and expected to receive the same attentive care. The caring behaviors that she described from her prior experience, such as being physically present for the parent, keeping the parent informed of treatment plans, giving information on burial options, and providing competent care are important noteworthy because they are similar to the caring behaviors described in other perinatal loss research (Calhoun, 1994;Kavanaugh, 1997b;Lemmer, 1991;Sexton, 1991), and in an emerging model of caring (Swanson, 1993). Instead, this mother was dissatisfied with her care because the healthcare providers did not demonstrate these caring behaviors, know her obstetrical history, or listen to her concerns and request for treatment. The lack of one consistent care provider contributed to the problems with her care. These findings are also noteworthy because of their similarity to another study of satisfaction with hospital care and intervention after pregnancy loss (Lasker & Toedter, 1994). In that study, clinic patients were found to be more dissatisfied with care they received than private patients, which was partially explained by the lower number of interventions experienced by the "early loss" (less than 16 weeks of gestation) group of clinic patients.

In order for this mother to cope with her experience, she relied heavily on prayer and her spirituality. She was unable to ventilate her feelings with family and friends as freely as she would have liked, and, thus, turned to prayer and talking to God. This finding is consistent with literature that describes the importance of religiosity and spirituality of African Americans for emotional support during stressful times, such as bereavement (Eisenburch, 1984;Turner, 1993). Furthermore, other findings from this case study are similar to other research on perinatal loss, such as not being prepared for the loss despite prior history, and the father's inability to talk about the loss with her (Kavanaugh, 1997a).

Finally, the finding that this mother described the interview as a therapeutic, unique opportunity to talk about the loss was also reported in a study of parents' responses to participation in sensitive research (Kavanaugh & Ayres, 1998). Kavanaugh and Ayres (1998) found that even though the research interviews were not intended to be a form of therapy, many respondents view them as therapeutic. This finding underscores the importance of the availability of an impartial listener to hear the story of the parents' loss, which is especially important for parents who might not have other forms of support or utilize available resources, such as parent support groups.

IMPLICATIONS FOR FURTHER RESEARCH

Research that has examined the effects of prior perinatal loss on parents' response to subsequent loss has been limited and has produced contradictory findings. Furthermore, most of the research in this area has examined prior perinatal loss as one of a number of variables affecting the grief response. Therefore, an in-depth examination of recurrent perinatal loss is necessary. Methodologies, such as phenomenology, that allow for the examination of the experience from the parent's perspective, would enable parents to define and describe those factors which are critical determinants of response after a subsequent loss. Additionally, further research should be done to test the emerging models of grief that propose that the individual nature of the personal history is a crucial element in understanding each person's experience. Further studies on recurrent perinatal loss could also serve to expand developing models of parental grief, such as the one described by Cordell and Thomas (1997).

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