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Parental Grief Responses to Perinatal Loss

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ABSTRACT

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An exploratory, descriptive design was used to examine parental grief and coping responses to perinatal loss. Florence Selder's Life Transition Theory (1989) was used as the conceptual framework. A survey approach was used for data collection. This included basic demographic questions, the Perinatal Bereavement Scale and the Jalowiec Coping Scale. A convenience sample was obtained, consisting of 24 women and 6 men in northern Michigan communities who had experienced a perinatal loss at some time in the past. Data were collected by an anonymous mailed survey. The results of the study revealed that all parents in this sample did exhibit bereavement after a perinatal loss and that the most frequently used and most effective style of coping was the optimistic style.

Dedication

I would like to dedicate this study to my parents, James and Rosemary Blashill, who have always shown me through their example, the importance of persistence and hard work.

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CHAPTER 1

INTRODUCTION

Perinatal loss is a significant problem affecting many Americans. It encompasses all losses during and immediately after pregnancy. Included in the definition of this term are miscarriage, stillbirth, and neonatal death. Miscarriage is the loss of a pregnancy prior to 20 weeks gestation, stillbirth is the death of a fetus after 20 weeks gestation but before birth, and neonatal death is the death of any infant born alive in the first 28 days after birth (Hutti, 1988, p. 338). Ten to twenty out of every 100 pregnancies end in miscarriage, two end in stillbirth, and over 40,000 neonatal deaths occur annually in the United States (Brost & Kenney, 1992, p.457).

More recent research has indicated that the grief response evoked by these events is severe and intense. However, authors are now recognizing that this has not always been the perception. According to Hutti in 1991, only in the last 10 to 15 years have miscarriages, stillbirth, and neonatal death been recognized as grief-inducing events. How parents adapt to this type of a loss and go on with their lives has been studied more and more frequently but continues to be poorly understood and undervalued by health care providers and others. Early pregnancy losses tend to be the least valued by health care providers (Hutti, 1988, p.338).

Areas that have not received adequate attention in the literature include: differences in the grieving and coping behaviors of mothers and fathers and differences between the behaviors of parents dealing with early and late losses. As indicated by

Miron and Chapman in 1994, most writings devoted to the event of miscarriage pertain only to women's experiences. Theut, et al., 1989, hypothesized that women who experienced a late perinatal loss such as stillbirth or neonatal death would display more unresolved grief in a subsequent pregnancy than women who had experienced a miscarriage. The support received from health care providers may have a significant impact on parent's perceptions of their loss experience and grief reactions.

This study built upon the study by Theut, et al., 1989, which examined characteristics of parental bereavement in early and late perinatal loss. They also studied the implications for attachment in subsequent pregnancies as well as compared the grief responses of fathers and mothers. This was a partial replication of the Theut study including the use of instrumentation, sampling, and overall purpose. An examination of parental coping behaviors after perinatal loss was added. A conceptual framework was developed and sample size, methodology, and research questions varied slightly.

The purpose of this study was to describe the grief responses and coping behaviors of mothers and fathers experiencing early and late perinatal losses.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

Florence Selder's Life Transition Theory (1989) was used in this study to explore the grief responses and coping behaviors of parents who have been faced with a perinatal loss. Life Transition Theory (LTT) evolved from research conducted to examine persons' responses to a disrupting event (Kachoyeanos & Selder, 1993, p. 42). Selder (1989) describes the process as one in which the affected person forms a "bridge" from a disrupted reality to a newly surfacing reality. She proposes that this restructuring allows the person to create new meaning in their life when the old meanings have been fractured (p. 437). This disruption of reality must be determined as such by the individual experiencing it, and they must be aware of a choice. If this occurs, then a transition is initiated. If the individual does not recognize the disruption or the choice, he or she will not move through the transition. The individual may also conditionally acknowledge the changed reality but hope for a reversal to the previous reality.

The key concepts in Life Transition Theory are *transition, reality, uncertainty, reality restructuring,* and *identity constancy. Transition* is the process undergone by the individual when their reality is disrupted and a new one is constructed. *Reality* is a person's "picture of things." It is made up of their own values and meanings and usually consists of stable patterns which may be modified over time in response to changes within the person or the way they see the world. *Uncertainty* is the experience of feeling

outside of reality. It occurs following a reality disruption and causes the experiencing person to feel isolated from his or her environment and unsure of what is happening. *Reality restructuring* is the process of relinquishing the old reality and forming a new one in which the individual can find meaning and maintain self-integrity. *Identity constancy* is the person's sense of self while their reality is intact and is the goal of successful transition (Selder, 1989, pp. 437-440).

A life transition begins with a disrupting event which changes the individual's reality. The person must confront the irrevocability of the situation or become aware of the permanency of the changed reality. Experiencing reactivation may reinforce the awareness of the disrupted reality. This occurs when the individual experiences thoughts, feelings, or sensations that occurred at the time of the disruption (Kachoyeanos & Selder, 1993, p. 43). The individual may also identify missed options by becoming aware of what is no longer accessible since the reality disruption.

A profound characteristic of a life transition is uncertainty. The human response is to try to resolve this in some way. The person's environment has changed so dramatically in some cases, and they are motivated to resolve this because their former mechanisms for managing their reality no longer seem to work. LTT describes several processes the person may engage in to resolve uncertainty. Information-seeking tends to reduce uncertainty initially (Selder & Steckler, 1991, p. 9). Nurses may represent some of the sources that individuals will turn to for information and, therefore, need to understand this behavior. This information-seeking, however, does not continue. The individual then engages in other processes to continue to reduce the uncertainty. One of

these is normalization, engaging in behaviors that mirror the standard established by the core society (Selder, 1989, p. 449). The individual is trying to stabilize their environment, at least the outward appearance, hoping that this will actually accomplish stability.

Another behavior the individual may engage in is comparative testing or measuring oneself against an identified model. The individual may then test his or her competency in relation to a skill held prior to the disrupting event to determine their ability to handle certain situations. Persons whose reality has been disrupted may also employ strategies that substitute or redefine missed options as another method of reducing uncertainty. When one's reality is disrupted there is no ability to project the future. LTT proposes that many of the above processes help the person to reshape their future by incorporating the disruption into their life and work toward identity constancy which is the goal of a successful transition.

The loss of a much wanted infant during pregnancy or after delivery is a major disruption of a parent's reality. Grief responses vary but within the context of LTT, this event is viewed as a precursor to transition. The parent's task within this framework is to incorporate the loss which has disrupted their life in a way that allows for their sense of self to remain intact. Their stable state of being has been shattered and the future may become uncertain. It is this uncertainty which characterizes the life-disrupting event.

According to LTT, parents must first confront the irrevocability of the event. If they have had the opportunity to have contact with the infant after its death, they may be more able to confront the reality of the event and move forward into the transition. This

is often the case when a loss occurs at a later gestation and may explain why a difference in coping behaviors would be expected between early and late loss. Acknowledgment of the situation reduces uncertainty and promotes realization that their current reality has been altered permanently. It may also account for a potential difference in grief responses to early or late perinatal loss.

The parent may also engage in information-seeking behavior to reduce uncertainty. They may ask many questions or read about the condition that caused their loss. This examination of the circumstances generally stops when the information is no longer useful.

Once the disruption of reality has been acknowledged, parents begin to structure a new reality. According to LTT, they may begin this process by engaging in comparative testing. For example, in the initial period following their loss, parents may not know how to act or what to do. Fathers and mothers may behave differently at this point partly because there are more social specifications for how mothers may act after a loss than for fathers. For example, women may behave the way they feel society expects them to behave and tend to talk about their feelings more than men. Many parents participate in support groups where they can talk with other parents who have been through similar situations. Their feelings and reactions can be compared to others and, therefore, verified as normal. This knowledge that they are not insane and that others have survived similar situations is very therapeutic and helps them to acknowledge the disruption and the need for a restructuring of reality.

Another important part of the process of reducing uncertainty and restructuring

reality according to LTT is normalization. This involves engaging in behaviors which are viewed as normal by those in one's own environment. An example of the normalization process is returning to work. Other examples include participating in activities which are similar to those that are engaged in by in their environment. Although this is a difficult step, it is seen as therapeutic within the context of LTT.

Competency testing may take place by determining the presence of a skill previously held by the person. The parents may reflect on their own behavior before and during pregnancy, seeking reassurance that they had performed adequately. Competency testing may also be evident in future pregnancies to assist them in feeling more sure of themselves.

Missed options is a term used within the context of LTT to describe those aspects in which a person discovers they no longer hold competency. The goal of this part of the transition process is either to incorporate or relinquish the missed options by avoiding, substituting, or refocusing the behaviors. This may be most evident in those behaviors parents engage in to keep the memory of their infant alive. They incorporate the event into their lives by keeping mementos, pictures, or by not changing the nursery, for instance.

In summary, five of the main concepts of Life Transition Theory were used in this study to look at the experience of perinatal loss. The disrupting event corresponds to the loss event experienced by the study subjects and when in the pregnancy the loss occurred. Grief responses of fathers and mothers to early and late perinatal losses were studied in terms of the concepts of uncertainty and disrupted reality. Reality restructuring describes

the coping behaviors of the parents and identity constancy is congruent with the resolution of grief or stability of the person's environment.

Review of Literature

The variables of interest in this study include the grief responses of parents to perinatal loss. This includes a review of any overall similarities between all types of perinatal losses. Another variable of interest is parental coping through the processes of perinatal grief and the process of life transition that follows. Finally, this study investigated the completion, if any, of the life transition process or resolution of perinatal grief. Many studies have looked at parental perceptions of support after a loss, and a body of knowledge is beginning to be evident regarding the ultimate effects of losses such as these on one's state of health. Possible predictors of grief have also been initially identified.

Grief responses of parents. Several studies have investigated the experience of perinatal loss and different aspects of parental grief responses. In reviewing the literature, a significant portion of research examining individual parental feelings in general after perinatal loss was noted. Many of these are qualitative studies. Pilkington (1993) used Parse's research methodology to examine the lived experience of grieving the loss of an important other. The convenience sample consisted of five mothers who had lost their babies at birth. The study participants described intense suffering and feelings of emptiness and shattered hopes and dreams. They also acknowledged their blessings in life and spoke of the importance of the support of family and friends. They described struggling to go on living without the child.

Covington and Theut (1993) conducted a qualitative analysis of 413 responses of women to the 1989 National Maternal and Infant Mental Health Survey. Their findings identified major themes of individual experience and made general recommendations for care of these women. The major themes identified in the responses included reactions to medical care, the mourning process, unresolved questions, subsequent pregnancy, the affective response of the individuals to the survey, and requests for information or survey results. Twenty-three percent of respondents reported negative perceptions of medical care, 23% also wrote about the mourning process, and 21% reported unresolved questions about why their baby had died. Twelve percent indicated concerns regarding subsequent pregnancies, 12% gave positive affective responses to the survey while 15% gave negative affective responses. Finally, a large number of respondents (51%) requested additional information on related issues.

Moriarty, et al. (1996) examined differences in distress within couples who had experienced the sudden death of a child. These authors recognized the past difficulty obtaining large enough samples to study differences within couples. Two independent samples (N=50 couples and N=60 couples) were drawn from two previous studies (Moriarty, 1991 & Carroll, 1990) for the purpose of comparison of grief responses to the loss of a late term pregnancy or newborn child between two separate groups with different demographic characteristics. These groups were compared using two instruments which measured global psychological distress and distress in nine symptom dimensions. Both samples were found to be similar in their responses, despite differences in sampling procedures and demographics. Paired t-tests were used to determine

differences within couples. Global distress was found to be significantly greater in women than in men as well as greater distress in most of the symptom dimensions. This study also found that hostility was a significant factor within couples which may point to relational problems between couples following a loss.

A strength of this study is that there were differences in sampling procedures and demographic data between the two samples. Despite these differences, paired t-tests still revealed similar findings within couples. These findings suggest that gender differences are statistically significant and not related to error as they have been often attributed to in past studies.

Zeanah, et al. (1995) conducted a longitudinal study which explored grief characteristics of their sample. In the first report of this study they examined the characteristics of mothers and fathers (n=129, 82 mothers and 47 fathers out of a total of 205 who had experienced a perinatal loss) two months following a perinatal loss. These characteristics include intensity of grief, relationship support, personality characteristics, other stressors, and demographic variables.

One finding that made this study somewhat unique was the sample to population comparison which indicated that those who participated in the study were more likely to be socially advantaged. Overall, the intensity of mothers' grief exceeded that of fathers' but in 25% of cases fathers' intensity of grief exceeded mothers'. Ego strength was found to be the most important predictor of grief intensity for both mothers and fathers, with a higher self-report of ego strength corresponding to a lower intensity of grief. Other characteristics such as less relationship support and more stressful life events were also

important predictors of higher grief intensity for fathers. This study also found no significant differences in intensity of grief related to characteristics of the loss such as gender of the infant, gestational age, or stillborn versus liveborn infants.

A response bias was identified related to a minimizing responses style. A group of respondents was identified that appeared to have "minimized" their grief response to their loss, that is, reported a level of distress that was lower than expected by investigators. It is not known whether this indicates an adaptive coping style or a style of mourning that is not progressing toward healthy resolution. However, it was felt that despite this bias, the self-report method of data collection was still a very important and reliable method that should not be changed in future studies. The authors also identified the smaller number of fathers than mothers who participated as a limitation of the study.

Mekosh-Rosenbaum and Lasker (1995) conducted a longitudinal study which compared the marital satisfaction of couples who experienced a perinatal loss to that of couples who experienced a successful pregnancy and birth. Two samples were used, the loss group (n = 138 females and 56 males) and the pregnancy group (n = 215 females and 102 males). Data were collected at two different times, during pregnancy for the pregnancy group and two months post-loss for the loss group. Data were also collected one to two years later. This study found no significant differences in marital satisfaction between the groups at either time. These study findings indicate that perinatal loss is not a risk factor for decreased marital satisfaction.

Mamman (1995) studied the reactions of women to perinatal loss in India. This author identified that most of the research regarding perinatal loss has been conducted in

the West. A qualitative study was conducted (n = 9) and found that all subjects experienced significant distress after their losses, most being similar to those reactions of women in the West. A widely held belief in India is that women who experience perinatal loss are seen as failures by their families for not producing offspring. This belief was not found to be evident in the women of this study. Rather, families tended to be supportive.

The author encouraged replication of this study to promote generalization of results. This study, having a small sample size and qualitative format, provides good initial information but does not allow generalization of the results to other women in India or the rest of the world.

Few studies have specifically examined the responses of fathers to perinatal loss. Miron and Chapman (1994) identified that most writings devoted to the event of miscarriage pertain only to women's experiences. Their qualitative, retrospective study used unstructured interviews and a constant, comparative method to develop a grounded theory of the experiences of eight men whose partners had experienced a miscarriage. The researchers found that men defined their primary role as being the supporter for their partners. They identified loss feelings as being intensified by being shut out by health professionals, and also felt the need for follow-up and support. The men also described fear of their partner's mortality as threatening their supporting role.

A larger study had been conducted by Hughes and Page-Lieberman in 1989 using a retrospective descriptive design to qualitatively describe fathers' perceptions of preventability of loss, closeness to fetus, experiences with significant others during

grieving and to describe their bereavement experience. A larger sample size (n = 51) was used in this study. These authors found that fathers reported a grief experience that was shorter and milder than that which they perceived as the mother's grief experience. The fathers also reported that they perceived that family life was altered for a longer period of time than that reported by mothers. Variance in degrees of attachment to the fetus was expressed.

Two more recent studies have examined father's responses to perinatal loss. Wagner, et. al, (1997) conducted an exploratory, qualitative study of 11 fathers who had experienced a perinatal loss at some time in their past. Fathers were asked to describe their grief using a scale of one to ten in relation to the amount of time that had passed since their loss. In general, intensity of grief appeared to decrease as the amount of time since the loss increased. More severe grief was reported in second and third trimester losses. Mild to moderate grief was reported in first trimester losses. The author felt these study findings suggest that fathers indeed bond with their child in utero. These fathers also identified differences between the support received from others for them and their partners. Fathers suggested that their needs were overlooked by potential supporters.

Worth (1997) identified that most previous research on grief and perinatal loss focused on mother's perceptions of father's grief. Using an exploratory descriptive approach, she then examined the experiences of eight fathers who had a stillborn child within the past five years. She reported that it was apparent in her sample that two processes were occurring simultaneously and interactively. These are fathering and grieving. All but one of the fathers in this study saw or held their child. These fathers

reported that this contact helped them to acknowledge both the reality of the child and the loss. They also described acting as supporters to their wives and ignoring their own feelings. Both studies were severely limited in generalizability of results because of the small sample sizes, however, they do provide important descriptive information about fathers and their loss experience.

These studies have opened the door to a body of knowledge regarding the gender differences in grief responses, but they are only a beginning. The use of small sample sizes in many studies has allowed for an in-depth description of individual grief responses but does not allow generalization to a larger population. Qualitative approaches help to define the parameters of the phenomenon but do not provide a means for determining the commonalities of the experience. More research is needed to determine if there are differences in the way parents respond to early and late perinatal losses.

Coping behaviors. A small number of studies were noted that specifically used Life Transition Theory to examine grief responses and coping behaviors, although these were not directly related to the experience of perinatal loss. Selder and Steckler (1991) conducted a qualitative study (n = 9) to examine the variables of uncertainty, reality restructuring, regaining of sense of self, information-seeking, and trigger events in the experiences of family members of a patient with end-stage renal disease. Uncertainty was reported by all subjects related to personal factors and disease/treatment. All subjects initially sought information to reduce uncertainty and engaged in comparative testing, normalization, and minimizing missed options. Experiences of specific family members and the family as a whole were described and it was concluded that Life

Transition Theory provides a framework which is appropriate for understanding grieving as an ongoing process.

Kachoyeanos and Selder (1993) studied parents' responses to the unexpected death of a school-age or older child using semi-structured interviews of 27 mothers and fathers of 11 deceased children and mothers of 5 deceased children. These authors found that there was no identifiable time line for resolution of grief, and that Life Transition Theory was useful in understanding the grief process. Several processes described in this theory seemed to recur over time, such as presencing the child, reactivation, and identification of missed options. However, no closure was reported. They also found that men and women differed in reactions to their loss; men viewed themselves as supporters and perceived the experience as worse for women. Although neither of these studies examined the parental experience of perinatal loss directly, they contribute to the current body of knowledge of the usefulness of Life Transition Theory in understanding the experience of any type of loss.

Some factors have been identified in the literature as increasing the complexity of the grief situation, but the basic grief responses and coping behaviors are similar. One of these is the loss of an infant from a multiple gestation pregnancy. Harrigan, et al. (1993) conducted an exploratory longitudinal study which examined parental responses to these types of losses. A convenience sample (n = 27) of mothers and fathers was used. In contrast to the studies mentioned earlier, mothers and fathers reported similar grief responses. All reported anxiety, depression, and an alteration in activities of daily living. Coping strategies were also identified; these tended to vary depending on time since the

death and the age of the infant at time of death. Confrontative, self-reliant, and supportant coping were identified as the most effective types of coping behavior. Although this study provided some quantitative data which strengthens the body of knowledge slightly, it was limited by a small convenience sample, lack of sensitivity of tools used, and lack of representation of minority populations.

Another aspect of perinatal grief that has seen little acknowledgment in the literature is the timing of the loss. It would be extremely useful for health care providers to understand the differences, if any, in parental grief response to early versus late perinatal loss. Theut, et al. (1989) studied this aspect of perinatal loss in a convenience sample of 25 pregnant women and their husbands who had previously experienced perinatal loss. Using a quantitative exploratory design, they found that parents suffering late losses registered more bereavement on the Perinatal Bereavement Scale (PBS) than those suffering early losses and that mothers tended to grieve more than fathers. These authors also examined the impact of a subsequent pregnancy on the degree of bereavement experienced. All couples registered less bereavement on the scale after the birth of a viable child.

Theut, et al. (1990) also conducted a follow-up investigation of their 1989 study to examine unresolved grief following the birth of a healthy child subsequent to a perinatal loss. Again, the PBS was used to measure bereavement in mothers and fathers ($n = 25$ couples). Data collection was completed 16 months following the birth of the subsequent child. Findings indicated that late group mothers registered higher bereavement scores on the PBS than early group mothers or fathers. The authors

concluded that the findings indicate that perinatal loss has a stronger impact on mothers than fathers. They also concluded that parents undergo a gradual resolution of grief for the previous child and that this process is even more gradual for mothers who have experienced a late loss.

In a 1992 study, Theut, et al. examined maternal attitudes toward a subsequent child (16 months old) after a previous perinatal loss and compared these attitudes to those of mothers of a child of the same age who had not experienced a loss. The loss group (n = 25) continued to display effects of their perinatal loss 16 months after the birth of a subsequent child. The mothers in the loss group described heightened concern about their child's health. The authors indicated more research is needed to determine if parents who have experienced a loss and their subsequent children suffer more separation anxiety than those parents who have not experienced a loss.

Armstrong and Hutti (1998) used a comparative, descriptive design to determine differences in levels of anxiety and attachment during pregnancy between primiparas and women who had previously experienced a late pregnancy loss. Anxiety and attachment were measured when the women were in their second or third trimester of pregnancy. The loss group (n = 16) showed greater levels of anxiety and lower levels of attachment than the primiparous group (n = 15) during their current pregnancy. The difficulty in recruiting subjects with the specific loss criteria is addressed in this study. All of the women with a history of loss were recruited from support groups and therefore cannot represent women who may not seek this support.

Resolution of grief. Several authors have studied the interventions used by health

care providers in situations of perinatal loss to determine what is viewed by bereaved parents as helpful. Sexton, et al. (1991), conducted a descriptive study (n = 30) of bereaved mothers who had lost neonates from 17 to 41 weeks gestation. They attempted to determine maternal perceptions of emotional support and nursing interventions following and during perinatal grief. They found that the interventions that were generally described in the current literature were perceived as helpful by the women in the study. This study was somewhat limited by a small sample size.

Rajan, in two separate studies in 1992 and 1994, used larger samples (n=483 and n=248, respectively) to identify specific interventions that mothers perceived as helpful or that facilitated grieving. She found that mothers perceived it to be helpful when health care providers approached all practical tasks with understanding of the process and transitions of mourning. Social support interventions, such as home visits and follow-up calls, were considered to be effective and enabled the woman to deal with grief and anxiety. Letting the woman decide what kind of support was needed was also identified as helpful.

Other studies contribute to the general body of knowledge of perinatal grief as well. The general conclusion of these authors (Calhoun, 1994; Kavanaugh, 1997; Malacrida, 1997; Radestad, 1996; Schlomann & Fister, 1995;) is that a direct acknowledgment of the death of the infant and assistance to the parents in becoming empowered in this environment are the most beneficial interventions. The interventions that are perceived as helpful seem to be well supported in the literature regarding their contribution to the resolution of grief.

Another area that was identified in the literature as a possible contributor to the completion of the grieving process is the physical and emotional health of the person experiencing grief. Health was a predictor of grief and of the possible sequelae. Ney, et al. (1994), in a large correlational study of the effects of grief on women's health, identified a positive correlation between pregnancy loss and deleterious effects on women's health. Women who had experienced an elective abortion appeared to require more counseling for their grief than the women who had experienced other types of losses. This study also reinforced the importance of partner support. No discussion was included on the possible limitations of study method or instruments. However, the questionnaire used included seven visual analog scales upon which the respondents rated different aspects of their health. It was recognized by the author that these types of scales are subjective in nature. Therefore, a sub-scale was checked for correlation between the woman's and her doctor's estimate of her health. In 84% of cases, correlation was within two points. This type of instrument is a limitation to the study however, because it is subjective in nature and no further testing was documented.

In a number of other studies, traits have been identified which may be predictors of the grief that one experiences (Hunfeld, et al. 1995, 1997; Toedter, et al. 1988;). Included in the traits found to be significant predictors of grief are the overall physical and mental health of the mother, individual tendency toward feelings of inadequacy, previous life events which may intensify grief several months after the perinatal death, and the quality of marital and other supportive relationships. There has been some question raised in studies of this type as to whether some coping behaviors actually

reflect healthy coping or delayed grieving. Although further study may be needed in this aspect of perinatal grief, it does point out some possible factors that must be considered in examining completion of the grieving process.

Summary and Implications for Study

The current body of knowledge surrounding perinatal bereavement is quite broad in the area of maternal grief responses. Many studies have been conducted that indicate that mothers suffer intense grief after the loss of a child. However, much of the available literature is in the form of qualitative analysis. This has been very helpful in developing an understanding of the specific experiences of individuals suffering grief. Quantitative studies using larger, more diverse sample sizes need to be undertaken in this area to allow for generalization of findings with empirical support.

The grief experience of fathers has not received as much attention in the literature. Some of the current studies have focused on paternal grief response, but again this has most often been in the form of qualitative analysis. Although this is a necessary beginning to developing a body of knowledge, more quantitative analysis is needed for generalization of findings to the population. Studies should be conducted comparing the grief response of fathers to those of mothers in order to develop a useful knowledge base that nurses can refer to when planning interventions in times of perinatal grief.

Another factor that has been identified as important but lacks support in the literature is the impact of the timing of the loss on parental grief response. Do parents who suffer a late perinatal loss grieve more or differently than parents who suffer an early loss? It is imperative that studies identifying the differences and similarities, if any,

between different types of perinatal loss be conducted to provide empirical support for nursing practice in these situations.

How one moves through the grieving process has received some attention in recent literature. Life Transition Theory is a relatively new framework for examining the grieving and coping process. Some initial studies have used this framework for qualitative analysis which have provided support for its use in looking at grief and coping in general. However, the theory had not yet been applied specifically to perinatal bereavement situations and appears to provide a useful framework for this as well. Application of this theory in examining the process of perinatal grief and the resolution of the process will hopefully provide more support in the literature for its use in this area.

Some authors have examined other areas of grief such as the effects on one's health and possible predictors of grief. This information has provided a contribution to our understanding of the grief experience as a whole. These areas continue to be studied to gain further understanding of the grief experience and what lasting effects on one's overall health there may be.

This study contributes to the existing body of knowledge by examining mothers' and fathers' grief responses and coping behaviors related to perinatal loss. Life Transition Theory was used as the conceptual framework. This study contributes to the use of this theory as a useful framework for nursing practice in the area of perinatal bereavement. It is important that nurses understand the process of perinatal grief and the coping behaviors of parents who experience this. The continuing expansion of this body of knowledge will allow us to further understand the grief process as well as to provide

the research support needed to make any necessary changes in practice. Further support for clear, useful theories such as Life Transition Theory could be very helpful in providing a practical way in which nurses can understand the complex grieving process in parental bereavement.

Research question

This study was designed to use Florence Selder's Life Transition Theory (1989) to examine the responses of parents experiencing perinatal loss. The following question was specifically examined: What are the grief responses and coping behaviors reported by parents who have experienced perinatal loss?

Definition of terms

This study focused on the event of *perinatal loss.* This was defined as the event of miscarriage, stillbirth, or neonatal death which disrupts the reality of the parent and triggers the process of life transition. An *early loss or a miscarriage* is defined as the loss of a pregnancy up until 20 weeks gestation, a *late loss* is defined as the loss of a fetus or neonate at or after 20 weeks gestation including stillbirth and neonatal death. These are well-accepted definitions in the field of perinatal loss.

The dependent variables that were studied include *parental grief responses, coping behaviors*, and *stability or resolution of grief. Parental grief responses* were defined as the feelings a parent experiences in response to a loss or disrupting life event, inherent in this is the intolerable feeling of uncertainty. *Coping* was defined as the process of acknowledging the loss and relinquishing the old reality followed by restructuring reality in a way that is meaningful. *Stability or resolution of grief* was

defined as the ability to exist in their new reality having integrated the loss and it's consequences into one's life in such a way that self-integrity is maintained.

CHAPTER 3

METHODS

Research Design

Description of design. Originally, a survey approach to determine and describe the differences between early and late perinatal loss with respect to the grief responses and coping behaviors of mothers and fathers was the planned design. However, recruitment of fathers and parents with late perinatal losses was too difficult to enable the planned comparison. Therefore, a simple descriptive approach was used to examine parental grief and coping responses. This study provides straightforward information about the degree of bereavement and coping parents experience after a perinatal loss. The results of the study provide some preliminary data for future studies.

Threats to internal and external validity. Some potential threats to validity were identified. Those factors which may have threatened internal validity include extraneous factors which may have influenced subject response. Subjects were recruited from various sites including local gynecologic clinics and a perinatal loss support group. Because of the differences in the settings, subjects recruited from the support group may display a variation in grief and coping behaviors that is not due to study variables. For example, the subject who has sought assistance from a support group may be dealing with his or her grief in a different way than a one who has never sought support. In this case, the variation in behavior may be related to factors other than the study variables.

However, only a very small percentage of participants reported participation in a support group and no obvious variations in their responses were noted. Another factor that could potentially influence study results is that if a couple participated, they may have discussed the questionnaire items with each other.

It was planned to control for these extraneous factors by instructing participants not to discuss the study with each other and by attempting to recruit equal proportions of subjects from the various sites used. However, the response rate was much lower than expected and did not provide a sample that was diverse enough to determine any differences in their methods of dealing with grief.

The use of a convenience sample also presents a threat to external validity. For example, it was hoped that a large number of subjects would be recruited. For this reason, study exclusions were kept to a minimum. The resulting sample was very homogenous in characteristics and responses. Because of this, the results may not be generalizable to a larger population that includes fathers or parents with late losses. These groups were just not well represented in the sample obtained. However, a convenience sample was necessary for this study due to the limited time and resources available. It was also noted that there are also inherent differences between those who choose to participate and those who do not. Therefore, this also presents a threat to the external validity of the study.

Sample and Setting

Setting. The initial group of subjects were recruited from local health clinics that provide health care to women and from a local perinatal loss support group. These sites

were unable to provide an adequate sample size within the desired time period, so recruiting was continued at a local health department and physicians' offices.

Data collection was begun at two women's health care clinics in northern Michigan. These clinics provide women's health care, education, and advocacy. Approximately 20 to 30 women are seen daily at each site for a variety of needs, including annual exams, pregnancy testing and counseling, sexually transmitted disease testing and treatment, and midlife care.

It was thought that this setting would provide a large number of subjects willing to participate as well as provide a sample representing all stages of perinatal loss. Recruiting from a clinic setting where many women are seen each day would potentially provide subjects who represent much of the general population experiencing perinatal loss. Since perinatal loss happens so frequently, a setting such as this where large numbers of women are seen was thought to logically provide a diverse sample.

The perinatal loss support group is a part of a national program that was developed in 1981. This organization provides a hospital-based perinatal bereavement program to assist families who have experienced perinatal loss. Resources are available through the national program to educate professionals and the community on the needs of parents who have experienced perinatal loss. This organization also provides training for bereavement counselors. The support group is operated locally through a regional medical center which serves most of northern Michigan and is coordinated by a registered nurse who specializes in perinatal bereavement. The services offered through the local program include counseling, support groups, and therapeutic, as well as educational

resources. The services are offered to any parent who has experienced a perinatal loss, as well as interested professionals and community members.

The subjects recruited from the perinatal loss support group represented the members of the population who seek support after a perinatal loss. These subjects are those who have identified the need to seek support in dealing with their grief. Those who do not feel they are grieving would not be likely to seek out a support group. It was thought that this segment of the sample would also be more likely to provide subjects who have experienced late perinatal losses such as stillbirth and neonatal death. However, the number of responses obtained from parents who had participated in a support group was so low that this population is not well represented in this study.

The combination of subjects from these settings did not provide a diverse enough sample to allow some generalization of results. For this reason, data collection was extended to additional sites. However, that still did not result in the desired differentiation in stages of perinatal loss.

Sample. A convenience sample of approximately 50 individual subjects including mothers and fathers who have experienced early and late perinatal losses was desired. The main advantage of using a convenience sample was that it would allow for a larger number of available subjects. The main disadvantage of this sampling plan was the sampling bias involved. That is, the sample was limited to those parents who sought health care or support. Another disadvantage that must be recognized is the difficulty recruiting fathers. Because the main source of subjects for this sample was a women's health care clinic, recruitment of fathers was extremely dependent upon the mothers'

continued contact with them.

The weaknesses of this study include the inability to generalize the results to the members of the population who do not seek health care or support and that there was not an adequate number of fathers participating to provide a representative sample. Another weakness is that there was not a sufficient number of parents who had experienced a late loss to allow for those parents to be adequately represented in the sample. Both of these latter factors also contributed to the inability to perform the desired comparisons.

Selection criteria for the sample were quite broad to allow for the largest number of eligible participants possible. These criteria included mothers and fathers, not necessarily married, who were at least 18 years of age, had experienced a perinatal loss at any time in the past, and could read and understand English. Participants were instructed to complete the questionnaires based on their recollections of their feelings in the first following their loss.

Instruments

Demographic Questionnaire. The demographic questionnaires used in this study were developed by the researcher. There were separate questionnaires for mothers and fathers, each worded appropriately (Appendices C and D). They were designed to elicit information which would characterize the sample in terms of their social characteristics as well as specific items about their loss. This allowed determination of any similarities or differences in characteristics of study participants and enabled the sample to be accurately described in terms of these characteristics. This questionnaire was included in the packet directly following the cover letter.

Perinatal Bereavement Scale. The Perinatal Bereavement Scale (PBS) (Appendices E and F) was developed by Theut and Pederson (1989). It is a questionnaire consisting of 26 items with responses scored on a four point scale. Responses range from "almost never" to "almost all the time". Items are worded both positively and negatively to minimize response set bias. There are parallel questionnaires for mothers and fathers and each are worded appropriately.

Reliability has been established for this instrument. Alpha coefficients in the Theut, et al. study (1989) were computed at .88 (prenatal) and .91 (postnatal) for mothers and .84 (prenatal) and .83 (postnatal) for fathers. This indicates adequate internal consistency. To establish the validity of this instrument, Theut, et al. (1989) conducted interviews before it's development with seven women who had experienced perinatal losses and three of their husbands. They also reviewed the work of other authors regarding the assessment of perinatal mourning and adapted some items from this to complete the instrument development. To further establish it's content validity, the tool was reviewed by experts including a perinatal social worker, a perinatal loss support group coordinator, and nurses with experience in the area of perinatal bereavement.

In the current study, reliability was further examined. Cronbach's alpha was computed at .91 using the data for this study (N of cases = 27 and N of items = 26). Because one participant didn't answer an item, the missing response was replaced with the statistical mean for that item. This allowed maximization of the small sample.

Jalowiec Coping Scale. The Jalowiec Coping Scale (JCS) (Appendix G) consists of 60 coping strategies. The subject is asked to rate how often he or she has used each of

the coping strategies to cope with the specified stressor. A four point (0-3) scale is used with responses ranging from "never used" to "often used". The subject is then asked to rate the effectiveness of each coping strategy used on a four point (0-3) scale. These responses range from "not helpful" to "very helpful".

The coping strategies have been grouped into eight different coping styles by the author. The styles consist of confrontative coping style, evasive coping style, optimistic coping style, fatalistic coping style, emotive coping style, palliative coping style, supportant coping style, and self-reliant coping style. Separate adjusted mean scores for use and effectiveness were computed for each coping style and for the overall scale for each subject. This allowed the researcher to determine whether subjects have found an effective method of coping to resolve their grief. The higher use and effectiveness scores correspond to more frequently used and more effective methods of coping. A combined mean use times effectiveness score was computed for each coping style and for the overall scale for each subject. This score was used to determine degree of stability as it relates to life transition theory. A higher use times effectiveness score corresponds to a higher degree of stability for that subject.

The Jalowiec Coping Scale has been used extensively for many different topics of research. It has been previously used in studies examining perinatal grief and reliability and validity have been well established for this instrument. Psychometric support for the JCS is provided by 26 studies.

Cronbach alphas were used to determine internal consistency and ranged from .57 to .97 for total use scales and ranged from .84 to .97 for total effectiveness scales. Retest

correlations were used to determine stability reliability using data from the Jalowiec heart transplant study (1987 - 1997), using retest intervals of 3, 6, 9, and 12 months. Stability of total use score ranged from .56 - .69 (mean for all retest intervals = .61); stability of total effictiveness score ranged from .43 - .63 (mean for all retest intervals =.52). Stability of use subscales ranged from .37 - .70 (mean for all retest intervals = .55); stability of effectiveness subscales ranged from .22 - .65 (mean for all retest intervals =.47). All use subscales showed moderate stability over 3-12 month time intervals and effectiveness subscales showed low to moderate stability over the same range of time intervals.

Validity has been established based on significant correlations of JCS with other tools. Content validity of the JCS is supported by the broad literature and empirical base from which the items are drawn, the inclusion of diverse types of coping behavior, and the large number of items used to tap the conceptual domain of coping. Mean percent agreement between 25 nurse researchers for all eight subscales was 75% and ranged from 54% to 94% for each individual scale which establishes empirical construct validity. Kuiper (1991) found concordance on types of coping strategies used when JCS results were compared with qualitative coping interviews. This indicates concurrent validity. Concurrent / predictive validity is supported by the Jalowiec heart transplant study (1987-1997) which indicates that patients who used less desirable ways of coping (evasive, emotional, and fatalistic) had more stress, felt that they weren't coping well, rated their health worse, had more psychological symptoms, were less satisfied with their life, and had poorer quality of life. People who used more optimistic coping felt they would do

better post-operatively and in fact needed less help with illness-related tasks.

Reliability was further examined using data from this study. Cronbach's alpha computed for the overall scale for use was .91 and for the overall scale for effectiveness was .97. Cronbach's alphas were also computed for each of the subscales for use and ranged from .44 to .81 and for each of the subscales for effectiveness which ranged from .66 to .97. The low alpha coefficients for the subscales are consistent with previous testing of this instrument and probably relate to the low number of responses to some of the individual items.

Measurement of Variables

Grief responses of parents. The grief responses of parents to early and late perinatal losses correspond with the concepts of uncertainty and disrupted reality within the context of Life Transition Theory. These responses were measured using the Perinatal Bereavement Scale (Theut, 1989). Responses to individual items range from 1 to 4 and were summed to create a total scale score. These scores correspond to an interval level of measurement. A higher score indicates a higher degree of bereavement.

Coping behaviors of parents. Resolution of grief or stability was determined by measuring parental coping behaviors using the Jalowiec Coping Scale (Jalowiec, 1987). This is also in the format of a questionnaire. Coping behaviors correspond to the theory concept of reality restructuring and stability corresponds to the concept of identity constancy. Items have been rated for two different domains: coping strategy use and coping strategy effectiveness. Individual responses for each domain were summed to create two separate scale scores, one for use and one for effectiveness. Both scores

correspond to an interval level of measurement. The coping strategy use and effectiveness scores have been compared to criteria that categorize them into coping styles. The first is the confrontative coping style. Here, one demonstrates behavior which indicates confronting the situation, facing up to the problem, and constructive problem-solving. The evasive coping style includes evasive and avoidant activities, the optimistic coping style includes positive thinking, a positive outlook, and positive comparisons. Other coping styles include fatalistic, which is demonstrating pessimism, hopelessness, feeling of little control over the situation, emotive or expressing or releasing emotions, ventilating feelings, and the palliative style which is trying to reduce or control distress by making the person feel better. The two final coping styles described are the supportant coping style which includes using support systems such as person, professional, or spiritual resources and the self-reliant style, which is depending on yourself rather than on others in dealing with the situation.

Coping style use and effectiveness scores were examined for the purpose of determining if parents have found a coping style that has been effective for them in resolving their grief. Separate adjusted mean scores for use and effectiveness were examined as well as a combined mean use times effectiveness score which was computed for each coping style for all subjects. A combined mean use times effectiveness score was then computed for the overall scale for each subject. A higher combined scale score corresponds to a higher degree of coping, therefore, indicating one is closer to stability.

Procedure

Data collection. A total of 75 questionnaires were distributed to the women's

health care clinics in northern Michigan. The clinic assistants and nurse practitioners in these settings were instructed to give the questionnaires with a cover letter (Appendix B) explaining the study to all women who had a history of a perinatal loss. If their losses had not occurred within the last year they were asked to recall their feelings within the year following their loss to complete the questionnaire items. These women were then asked to distribute a questionnaire to the person who was their partner at the time of the loss, if possible. The questionnaires were labeled and color-coded to differentiate mothers' from fathers' responses and equal numbers of each were distributed to each clinic. A self-addressed and stamped envelope was included for the subjects to return the questionnaire anonymously. Voluntary return of the completed questionnaire served as informed consent. Instructions were included in the cover letter and questions regarding demographic information were included to describe the sample and determine eligibility for the study.

A total of 25 questionnaires were distributed to the perinatal loss support group. The group coordinator was to read the purpose of the study to members of the group and distribute questionnaires to those who are willing to participate using the same process described above. Both sites were instructed to contact the researcher if they handed out all of their questionnaires so that more could be provided. No contact was received. Follow up phone calls were made to the sites to determine if more questionnaires were needed but none were requested.

Although 50 subjects was the targeted sample size for this study, questionnaires were distributed until a sample of no fewer than 30 subjects was obtained. The sample

size was evaluated after a period of two months. It was determined at that time that more subjects were needed so additional sites were contacted. An additional 25 questionnaires were distributed to a local health department and an additional 45 questionnaires were distributed to three local physicians offices. The same instructions as described previously were given to these additional sites. Study sites were instructed to keep a list of those to whom questionnaires were distributed including a method of contacting them.

Self-addressed, stamped postcards were included with the questionnaire packet. Study participants were instructed to mail these postcards when they were mailing the completed questionnaire but to mail them separately. They were asked to indicate their name and address on the card and whether they would like a summary of the study results. This allowed for a summary to be mailed to participants if they request it. There was no way to correlate a participant's identity with a questionnaire. If a postcard was returned, it was assumed that the questionnaire was returned. It was originally planned that after a period of two weeks, a reminder note would be sent to those participants whose postcards had not been returned. However, most subjects requested no contact by mail and were reluctant to leave their name and address; therefore, this process was not implemented. This may have been due to the private nature of the setting where they were coming to receive health care. They preferred no contact from that site and possibly related the study to the site.

After data collection continued for a period of six months and a total of 195 questionnaires had been distributed, thirty completed questionnaires had been received. It was decided at that time that data collection would be completed. The minimum

number of subjects had been obtained and since the response rate of 15% had been so low, it was determined that continuing with the current method of data collection would not be beneficial.

Ethical considerations. Risks to the subjects involved in this study were minimal. Physical risks were non-existent. Psychological risks were possible through an aggravated emotional response while thinking of the loss. Action was taken to reduce this risk by including the phone number of Resolve Through Sharing, a perinatal loss support group, in the cover letter. A potential social risk existed involving a loss of privacy. Access to study records was restricted to only those people directly involved in the study to reduce this risk. Identification numbers were used for data analysis and anything including names was destroyed upon completion of the study. Again, voluntary return of the completed questionnaire served as informed consent.

Each participant was offered a copy of the results summary and was asked to indicate their desire for this on postcards mailed separately from the questionnaires (Appendix I). There was no identified link between the postcards and the questionnaires. The researcher had no way of identifying which participants gave which responses.

Institutional review boards. Approval of the study by three institutional review boards was required to carry out this study. Approval was obtained first from Grand Valley State University. The local regional medical center required that the proposal with a request letter be submitted to the Vice President of Nursing for approval, and this was obtained. Human subjects approval was also obtained from the agency within which the women's health clinics were affiliated. Permission from the health department and the

physician's offices was obtained. All necessary approvals were obtained before data collection was begun (Appendix J).

CHAPTER 4

DATA ANALYSIS

An exploratory, descriptive design was used to characterize the sample and describe grief and coping behaviors of parents who had experienced a perinatal loss. The statistical software package that was used in this study was the Statistical Package for Social Studies (SPSS) for Windows. The research question addressed in this study was: What are the grief and coping responses reported by parents after they have experienced a perinatal loss?

Sample Characteristics

The data for this study were collected over a six month period of time, from March of 1998 to September of 1998. The sample consisted of 30 participants, including 24 women and 6 men. All had experienced a perinatal loss in their lifetime. Their ages at the time of questionnaire completion ranged from 18-55 years (M = 32.67, SD = 8.57). The age at the time of the loss ranged from 16-40 years (M = 27.17, SD = 6.48). Study participants reported their partner's age at the time of the loss also and this age ranged from 18-41 years (M = 28.57, SD = 6.43).

Most of the respondents were married at the present time (66.7%) as well as at the time of the loss (63.3%). Almost half (40%) reported that they were no longer in a relationship with the person who was their partner at the time of the loss (Table 1.). The majority of the respondents were Caucasian (86.7%) and religious preference was varied.

Occupations were also greatly varied but the majority of participants were

Table 1.

Demographic Characteristics

Characteristic	Mothers	Fathers
Mean age (years)		
Present	31	38
At time of loss	25	34
Married		
Present	62.5%	83.3%
At time of loss	54.2%	100%
Currently in a relationship with partner at time of loss	54.2%	83.3%
Type of loss		
Miscarriage	83.3%	100%
Stillbirth	4.2%	0
Neonatal death	16.7%	0

employed (90%). Most had attended at least some college (86.6%). Of these, 33.3% had completed college and 13.3% had undertaken graduate studies. Yearly household income was reported as less than $20,000 by eight respondents and greater than $70,000 by three respondents. The remaining 19 respondents fell in the range in between ($20,000-

$69,000).

The female respondents reported having been pregnant between one and seven times. Of the total, men and women combined, 26 had experienced miscarriage, one had experienced a stillbirth, and four had experienced a neonatal death. Several (n = 10) had experienced more than one loss; one person had experienced five miscarriages. Most had occurred within the past six years (n = 21) but two had occurred as long ago as 1967. Six of the study participants had experienced an elective abortion. Many respondents (70%) reported they had not experienced a live birth. Ten reported a successful pregnancy since their loss and one participant was 14 weeks pregnant at the time of the study.

Very few study respondents (16.7%) had participated in counseling related to their loss. Of these, all received only short-term counseling (< 6 sessions). The type of counselor was varied. A psychiatrist, social worker, and clinical nurse specialist had been consulted. There was very little participation in support groups reported (3.3%) which also appears to indicate that few subjects were recruited from the perinatal loss support group.

Research Findings

Bereavement scores were computed by summing the scores for individual items on the Perinatal Bereavement Scale (PBS) to create a total scale score for each participant. A higher score corresponds with a higher degree of bereavement. A range of scores from 26 to 104 were possible for the PBS. Actual scores for the sample as a whole ranged from 26 to 72 (M = 46.4, SD = 12.1). The mean bereavement score for men was 37.2 (SD = 7.4) and the mean score for women was 48.7 (SD = 12.0).

Separate mean scores for coping use and effectiveness were computed for the total Jalowiec Coping Scale (JCS). Mean scores for the total coping use scale for each subject ranged from .34 to 2.33 (SD = 1.37). A higher coping score indicates a coping style that is used more frequently. Mean scores for the total coping effectiveness scale for each subject ranged from .00 to .98 (M = .98, SD = .40). The possible scores for total use and effectiveness range from 0 to 3. Coping use and effectiveness scores were then computed for each of the eight coping styles (Table 2).

Table 2.

Coping Style Use and Effectiveness Scores

Coping Style	Use			Effectiveness			Combined		
	Total	Moms	Dads	Total	Moms	Dads	Total	Moms	Dads
Optimistic	1.89	1.89	1.89	1.54	1.53	1.57	4.28	4.05	5.19
Self-reliant	1.57	1.67	1.17	1.06	1.13	.76	3.84	3.96	3.36
Supportant	1.50	1.50	1.53	1.44	1.42	1.51	4.16	4.03	4.69
Confrontative	1.28	1.24	1.44	1.06	1.03	1.18	4.26	4.13	4.78
Fatalistic	1.23	1.24	1.21	.77	.72	1.00	3.43	3.20	4.38
Evasive	1.15	1.21	.92	.65	.64	.70	3.13	3.18	2.95
Emotive	1.14	1.22	.83	.32	.30	.37	2.58	2.65	2.30
Palliative	1.13	1.15	1.07	.93	.96	.81	3.36	3.47	2.92

The possible scores for each coping style also range from 0 to 3. The most frequently used coping style was the optimistic style, with scores ranging from .33 to 3.00 (M = 1.89, SD = .58). The most frequently used coping style reported by men was the optimistic style, with a mean of 1.89 (SD = .74). The next two most frequently used styles by men were the supportant style (M = 1.53, SD = .56) and the confrontative style (M = 1.44, SD = .85). Women also reported the optimistic style as the one most frequently used, with a mean of 1.89 (SD = .55). The next two most frequently used styles reported by women were the self-reliant style, (M = 1.67, SD = .55) and the supportant style, (M = 1.50, SD = .68). The least frequently used coping style was the palliative style with scores ranging from .00 to 2.14 (M = 1.13, SD = .57). Men reported the emotive style as least frequently used with a mean score of .83 (SD = 50) and women reported the palliative style as least frequently used with a mean score of 1.15 (SD = .55).

A higher coping effectiveness score indicates a coping style that is more effective. The coping style found to be most effective was the optimistic style, with scores ranging from .33 to 2.3 (M = 1.54, SD = .57). The next two most effective styles reported by men were the supportant style, (M = 1.51, SD = .67) and then the confrontative style, (M = 1.18, SD = .83). The next two most effective styles reported by women were the supportant style, (M = 1.42, SD = .82) and the self-reliant style, (M = 1.13, SD = .56). The least effective coping style for the sample as a whole, appeared to be the emotive style. For this style, the scores ranged from .00 to 1.40 (M = .33, SD = .36). Both men and women separately reported the emotive style as the least effective coping style for them with mean scores of .37 (SD = .53) for men, and .30 (SD = .31) for women.

The final scores that were calculated were the combined use times effectiveness scores (Table 2). A higher combined score correlates with a more frequently used and more effective coping style. The combined scores for the overall scale ranged from 1.07 to 8.00 (M = 3.94, SD = 1.64) out of a possible range of 0 to 9. Combined scores were also computed for each of the eight coping styles. The most frequently used and most highly effective coping style overall was found to be the optimistic style, with a mean of 4.28 (SD = 1.73). The confrontative style scored very closely to the optimistic style with a mean of 4.26 (SD = 2.10). The style used least often and found to be least effective was the emotive coping style with a mean of 2.58 (SD = 1.82). There was slight variance between the groups of men and women. The style used most often and found to be most effective for the men was also the optimistic style with a mean of 5.19 (SD = .81) and the least often used and least effective style reported by the men was the emotive style, mean 2.30 (SD = 1.34). Women reported the style most effective and most frequently used was the confrontative style with a mean of 4.13 (SD = 2.10). Women also reported the emotive style as least frequently used and least effective with a mean of 2.65 (SD = 1.9).

Other Findings of Interest

In the questionnaire packet at the end of the JCS, participants were given an opportunity to identify other coping methods they may have used that weren't listed in the questionnaire. Eight of the participants did identify additional coping methods. Many of the methods listed were more specific to this type of loss than those already included in the JCS. These included: writing in a journal, reading books, reading the bible, believing that this was "meant to be", avoiding intimacy, looking at pictures,

staying positive, letting time heal, calling their lost child by name, having a memorial or burial, and allowing themself to grieve.

Respondents were also encouraged to write down any feelings about their loss that they felt were important and hadn't had the opportunity to express in the questionnaires. Six participants did include this information. Two expressed that they felt relief when they had a miscarriage because of life circumstances at that time. The others described various feelings about the experience including how they felt about the care they received from health professionals, others felt that it was difficult to answer the questions because the loss was very recent. They also described how their partner responded to the loss, and how it felt to have children already.

Summary

The aim of this study was to describe parental grief and coping behaviors in the context of Selder's Life Transition Theory. Most of the scores of the parents participating in the study registered in the low to middle range of the Perinatal Bereavement Scale. This indicates low to moderate levels of bereavement. Women registered higher bereavement scores than men. Most participants had found a coping style that was effective for them which therefore indicates they are moving through the stages of life transition toward constancy. These results add to the findings of previous research which are descriptive of parental grief behaviors. This study also describes specific coping styles which appear to be effective in coping with perinatal loss.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The research question addressed in this study was: What are the grief and coping responses reported by parents after they have experienced a perinatal loss? The study was intended to add to the current body of knowledge formed by previous studies on the subject. It was also hoped that some comparisons could be drawn between responses of fathers and mothers. The main purpose of the study was to increase the knowledge and understanding of health professionals in relation to parental grieving and coping responses related to perinatal loss.

Relationship to previous research

There were similar studies noted in the literature review. Several studies previously conducted were qualitative in design. This information is an excellent start for building a foundation upon which to develop practice guidelines. The qualitative studies examined individual parent's grief responses extensively (Covington & Theut, 1993; Hughes & Page-Lieberman, 1989; Mamman, 1995; Miron & Chapman, 1994; Pilkington, 1993; Wagner, et. al, 1997; Worth, 1997). They give a wealth of descriptive information which helps us to understand the meaning of subsequent quantitative data. The participants in this study also volunteered some qualitative information. The remarks they made were similar to statements of parents in other studies. For example, Pilkington (1993) described parents who acknowledged their blessings in life and spoke of the importance of family and friends and the current study participants did as well. They described the importance of their spouse being there for them and the blessings of their

other children. Three participants (two who had experienced early losses and one who had experienced a late loss) also described the intense feelings of loss they experienced and described how important it was for them to acknowledge the reality of their child and their loss and allow themselves to grieve. These findings are also similar to Pilkington's study (1993). There were, however, varied reactions found within this study. Two participants described feeling relieved when they experienced a miscarriage due to their current life situation and desire not to have a child at that time.

This study provides quantitative data about the degree of bereavement parents experience after perinatal loss. These data support the findings of previous studies and add to the foundation upon which to build future studies. The study also provides support for the Perinatal Bereavement Scale as a useful tool in determining degree of bereavement.

A limitation encountered in this study was also present in previous studies (Mekosh-Rosenbaum & Lasker, 1995; Zeanah, et al., 1995). This limitation is the smaller number of fathers participating as compared to mothers. This presents a barrier to understanding the feelings and experiences of fathers in relation to perinatal loss. In future studies, sampling methods specifically aimed at recruiting fathers would be advisable.

A small number of studies have used Life Transition Theory to examine grief and coping (Kachoyeanos & Selder, 1993; Selder & Steckler, 1991). However, none of these were related to perinatal loss. The findings of this study do support some of the general themes found in these previous studies that report there is no time line for grief, that

reactions are very individual and may recur over time, and that acknowledging the reality of the loss is very important. Life Transition Theory was found in this study to be a very useful framework in trying to understand the process of parental grieving and coping when faced with a perinatal loss.

The identification of coping behaviors was a strength of this study and of previous studies. Harrigan, et al. (1993) found that the participants in their study identified confrontative, self-reliant, and supportant coping as the most effective styles. In this study, the participants found the optimistic style to be the most often used and most effective for them (M = 4.28) but the confrontative style was also identified by almost as many participants as most often used and most effective (M = 4.26). Also similar to Harrigan's findings are that in this study the next most often used and most effective styles reported were the supportant and self-reliant styles respectively. The identification of coping styles helps health care providers to identify behaviors which may be helpful or not helpful in the process of grieving and coping. This will allow for appropriate intervention to be planned. For instance, a parent who is exhibiting a coping style which has been found through research to be ineffective or detrimental may be offered extra support or guided toward a more effective method of coping. However, for this to be possible, more research needs to be conducted to identify coping styles used and their effectiveness in perinatal loss so that we can empirically support changes in practice.

Several authors have reported on interventions by health professionals that parents have found to be helpful during and after perinatal loss (Malacrida, 1997; Radestad, et al. 1996; Sexton, et al. 1991). Most parents report that the most helpful interventions are to

provide prompt honest information about what is happening and what will happen and to guide parents through the process, offering suggestions which may facilitate the grieving process. Avoidance is identified in many of these studies as the least helpful and actually most harmful behavior exhibited by the medical community. Although this study did not specifically address this issue, many participants offered comments similar to these previous findings. One respondent reported frustration with the medical community for minimizing the impact of her miscarriage by telling her "it was for the best", and she "could try again". Many participants reported that acknowledging the reality of the loss by naming the baby, creating a memorial, taking pictures, and having a burial were very instrumental in helping them cope. These statements support the findings of the previous studies and reinforce the need for health professionals to be aware of and use effective interventions during this time of crisis.

Relationship to conceptual framework

The theory this study was based upon is Florence Selder's Life Transition Theory (1989). It has been used in previous research to describe persons' responses to a disrupting event. No research was found, however, that specifically describes responses to a perinatal loss using Life Transition Theory (LTT).

In this study, the disrupting event is the perinatal loss. Within the framework of LTT, the parent's task is to incorporate the disruption in a way that allows for their sense of self to remain intact. The current state of their life has been disrupted and the future has become uncertain. The uncertainty is what characterizes the life-disrupting event.

One of the first steps of the transition is to confront the irrevocability of the event.

This is demonstrated when the parent recognizes the event as a loss. The bereavement scale used in this study helps to describe how parents feel about their loss. Many of the coping behaviors described by parents in the coping questionnaire also involve confronting reality. When the parent recognizes the loss as a disruption of their current reality, only then can they begin the next part of the process. Within the context of LTT, this is called reality restructuring. This restructuring is described by the coping behaviors identified by parents.

Information-seeking is an aspect of the transition that is often begun early in the process of restructuring. Parents in this study demonstrated this by identifying certain coping behaviors such as talking the problem over with a professional person or learning about what happened. Some parents also reported that it was helpful to them to compare themselves to others in the same situation such as members of a support group or a friend or acquaintance. According to LTT, this helps them to identify the need to begin restructuring reality. This is called comparative testing. Returning to their normal routine is also described by parents through the coping behaviors they identified. These behaviors could include returning to work, social activities, or family activities. Within the context of LTT, this is therapeutic and is called normalization.

Competency testing and missed options are additional terms used within LTT to describe the process of restructuring reality. These steps involve the parents determining the presence of a previously held skill. They either feel they do or do not any longer hold competency. If they do not, then they either incorporate or relinquish the "missed options". In this study, some of the coping behaviors that could be identified included

those which indicated blaming one's self. This could be interpreted as evaluating one's competency during the pregnancy. If the parent felt they were incompetent and this somehow contributed to their loss then it is considered a missed option. The questionnaire used to evaluate coping in this study was designed to correlate a higher coping score with one being closer to resolution of grief or identity constancy. Most parents who participated in this study demonstrated relatively high coping scores, indicating that most had found a coping method that was useful to them and were close to identity constancy. Within the context of LTT, this means that these parents have incorporated the loss into their lives and have begun restructuring a new reality around it. Although the loss is not by any means forgotten, they have been able to make it a part of them and go on with their lives in a new reality which includes having had this experience.

Limitations and recommendations

There are several areas that present limitations to this study. The most significant limitations identified are the characteristics of the sample obtained. The sample size itself presents a limitation on generalization of the results to a larger population. It was planned that 50 subjects would be the goal for this study but that data collection would continue until no fewer than 30 subjects were obtained. As it turned out, after data collection had continued for six months, only 30 subjects had been recruited. Because of the length of time already invested and lack of additional time being available, it was decided that data collection would cease since the minimum number of subjects had been recruited.

The sample was also found to be very homogenous. The sample was entirely Caucasion, mostly married, mostly employed, similar in level of education, similar income level, and all had sought some type of health care in the settings where questionnaires were handed out. It would be impossible to generalize the results beyond this sample. Drawing a larger sample from a greater geographical area which is more ethnically and socially diverse would greatly facilitate generalizability of the results.

Another problem that was identified within the sample is that the groups intended for statistical comparison were extremely disproportionate. The great majority of respondents were female (n = 24) and only six were male. This eliminated the possibility of performing any statistical comparison of the two groups and therefore prevented the analysis of any potential differences between grief and coping responses of fathers and mothers. This probably occurred because the questionnaires were distributed mainly at clinics and offices that provide women's health care. Although the women recruited were asked to distribute a questionnaire to their partner and many questionnaires for fathers were distributed, very few were received. Several women indicated that they were no longer in contact with that partner and declined to take a father questionnaire. Several women did take the male questionnaires and one can only assume that the fathers in this case declined to participate. It is conceivable that it would be more effective to use a setting for data collection that would allow for males to be asked directly to participate.

Another example of the disproportionate groups are the early and late loss groups. The majority of respondents, as well as being female, were also those who had experienced early losses. Of the 30 study participants in the sample, 25 had experienced

a miscarriage, one had experienced a stillbirth, and three had experienced a neonatal death. One subject reported having experienced a miscarriage and a neonatal death. It was impossible to include this subject in either group exclusively for data analysis because of the inability to determine which loss was being considered when the questionnaire items were completed. Again, it was impossible to compare the early and late loss groups in any meaningful way because of the extreme difference in the size of the groups. This difference in the size of the groups may be explained simply by the fact that early losses just occur more frequently than late losses. A suggestion for future studies would be to recruit a larger sample so that the numbers of participants who had experienced later losses would likely be increased. It also appeared that the response rate from the perinatal loss support group was fairly low. This may have contributed to the low number of participants with late losses. Only one participant indicated on their questionnaire that they had participated in a support group and it was thought that this setting would provide many subjects with a history of late loss. It would be advisable for future researchers to use a sampling plan more specifically aimed at recruiting subjects from this type of setting. Maybe being physically present to explain the study and distribute the questionnaires would be more effective. Another suggestion would be to use several settings such as this support group rather than just one.

Another area that may have presented limitations to the study is the design of the demographic questionnaire. The question regarding the type of loss the parent had experienced did not allow for specifying which loss they were referring to if they had indeed experienced more than one loss. This aspect of the questionnaire essentially

eliminates any subject who has experienced more than one type of loss from being a part of any comparison group because the items are not mutually exclusive.

There are many possible avenues for future research. Redesigning the sampling plan and demographic questionnaire would be very helpful in continuing similar research. There is still a need for comparison studies to examine and explain any differences in grief and coping responses reported by mothers and fathers and by parents who have experienced early and late losses. Another area of importance would be to examine these groups separately to determine which interventions by health professionals, if any, are helpful to them. A comparison between mothers and fathers and between early and late losses would also be helpful in this area. It is logical that if there may be differences between the groups in their responses then there may be differences in the interventions they see as helpful.

An additional area that may be useful to look at in future research is a more specific look at coping behaviors that are useful to parents in these situations. If specific coping behaviors can be identified as consistently useful, this may identify suggestions that could be made to parents going through this type of loss in the future and would help health professionals to expand their general understanding of the loss experience.

The use of Life Transition Theory for this study proved to fit well for examining this type of loss. Future research using this theory to examine perinatal loss would be greatly encouraged. It is very simple to conceptualize the stages of the transition and relate to real experiences and appears to be very useful in understanding how one copes with perinatal loss.

Other areas for future research include examining the effects of perinatal loss on attachment in a subsequent pregnancy, effects on the relationship between the couple, and the responses of siblings to a perinatal loss. This information could be very helpful to health professionals who want to understand the long term effects of this type of loss to allow for more compassionate care for families who have had this experience. Not only is it important to understand the immediate impact of the loss, but also the longer lasting effects of the loss such as reactions during future pregnancies and the effects on family members.

Implications for nursing practice

Although the sample obtained for this study did not include the groups necessary for the intended data analysis, a good deal of descriptive information was gathered on the grief and coping responses of the parents in the study. In addition, Life Transition Theory was tested for its usefulness in examining perinatal loss. Although the results cannot be generalized beyond the sample, the information gathered adds to the current body of knowledge regarding perinatal loss. This allows for health professionals to have a greater understanding of what parents feel and what helps them cope after a loss and reinforces many previous research findings.

One of the most important findings of this particular study is the usefulness of Life Transition Theory in understanding grief and coping related to perinatal loss. This theory is very easily read and understood and it appears to provide a very concrete method of understanding how a parent moves through this life transition and incorporates the loss into their lives. This is a theory that could be easily incorporated into clinical

practice, and clinicians, administrators, and educators alike would be encouraged to become familiar with it. Further research must be conducted using LTT to examine perinatal loss so that concrete support for it's usefulness in practice can be documented. It is an excellent tool for nurses to use in understanding the transition from total disruption of one's life to restructuring a new, but meaningful reality.

The responses of the subjects in this sample indicated that they were moderately bereaved and for the most part, coping effectively. Women registered higher scores on the Perinatal Bereavement Scale than men. This indicates that the women in this sample experienced a higher degree of bereavement than the men. The specific coping style identified as most frequently used and most effective was the optimistic style for both men and women separately and as a sample. However, the women identified the confrontative style and most frequently used and effective when a combined score was computed. The least frequently used style was identified as the palliative style and the least effective style was emotive for the sample overall. Women identified the palliative style as the least frequently used of the coping styles while men identified the emotive style. Both groups identified the emotive style as least effective which is consistent with the findings for the sample as a whole. This information can be useful for nurses in understanding and identifying styles that may be effective and those which may be ineffective. Understanding certain behaviors as part of an overall coping style may give nurses some insight into a situation that they may not be overly familiar or comfortable with. Recognizing coping behaviors as expected can increase the level of comfort of health providers in dealing with loss. This in turn may provide comfort to parents at a

time when they may not understand their own behavior.

An important aspect of previous research that is supported by these findings is that parents who have suffered early perinatal losses are indeed bereaved. The health community has come a long way in the last ten to twenty years in understanding the general concept that parents do grieve after a miscarriage. There is still important research to be done to further understand differences in grief responses. It is clear that parents grieve and cope differently and health professionals need to respect the individuality of these feelings and behaviors. A proactive approach should be taken to reach out to families who have suffered losses, whether they are early or late. Since it is clear that the majority of parents do grieve, the extension of support before it is sought would logically be beneficial to most.

Summary

The purpose of this study was to further the understanding of parental grief and coping responses to perinatal loss. The results of the study revealed that most parents, whether they had experienced a early or late loss or whether they were male or female, do exhibit bereavement after a perinatal loss. It was also found that most parents reported coping behaviors which indicated an optimistic coping style, and that this was an effective method of coping for them. Because these findings support earlier research findings, it is recommended that nurses support these coping behaviors and extend support to parents proactively since most are indeed bereaved after a loss. The support may be accepted or declined by parents, but it appears that since most are experiencing grief, it would be beneficial for the majority of parents to be proactively supported by the

health community.

APPENDICES

APPENDIX A

APPENDIX A

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APPENDIX B

APPENDIX B

Dear Subject,

I am conducting a research study exploring the grief experiences and coping behaviors of mothers and fathers who have experienced a miscarriage, stillbirth, or neonatal death. The results of this study will help nurses and other health professionals to provide more supportive care for parents who experience perinatal losses such as these. I am a nurse practitioner, and a graduate student in the Kirkhof School of Nursing, Grand Valley State University. My study asks questions about how you feel about your loss now, how you expressed your grief, and how you've coped with the experience.

You have been asked to participate in this study because you have experienced a perinatal loss. If you take part in this study, you will fill out a questionnaire which takes about twenty minutes. There are no right or wrong answers. Filling out the forms will involve some exploration and evaluation of your feelings. If you find you need to discuss your feelings further or are in need of support, the phone number for the perinatal loss support group in Traverse City is (616) 935-5520. If you decide to participate, it is very important that you answer the questions independently, that is, without discussing them with anyone, including your spouse or partner, until you are finished with all of the questions.

Confidentiality will be maintained. No one will know what you answer. Completed forms will be identified by number. Completed questionnaires will be stored in a locked file. Only I will have access to them. Only group data will be reported; that is, no individual answers will be identified.

If you wish, a summary of the study findings will be sent to you. A self-addressed postcard is included for you to write your name and address on and return to me if you would like a summary of the study findings. Do not include the post card in the envelope with your questionnaire. That way no one will know who the questionnaire belongs to. However, please return the postcard when you have completed the questionnaire even if a study summary is not desired. This will allow me to have an estimate of how many questionnaires have been returned.

Paul Huizenga, Chairperson
Human Research Review Committee
Grand Valley State University
(616)895-6611

Any questions you may have during the study, or any feelings about the study will be answered and/or discussed if you call me at 616-947-4956. You may withdraw from the study at any time without explanation.

Thank you for considering this study, and for your participation.

Sincerely yours,

Lisa M. Peacock, B.S.N, R.N.C.,W.H.N.P.
Master's Student, Grand Valley State University
Kirkhof School of Nursing

Paul Huizenga, Chairperson
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APPENDIX C

APPENDIX C

DEMOGRAPHIC DATA
(MOTHERS)

Directions: Fill in, circle, or check the blanks.

1. How old are you?_____(in years)

2. How old were you at the time of your loss?_____(in years)

3. How old was your partner at the time of your loss?_____(in years)

4. Are you currently 1. ____married 2. ____divorced 3.____widowed
4.____never married 5.____separated?

5. At the time of your loss, were you 1.____married 2. ____divorced
3.____widowed 4.____never married 5.____separated?

6. Are you currently in a relationship with the person who was your partner at the time of the loss?
1.____yes
2.____no

7. Religious Affiliation
1.____Protestant
2.____Catholic
3.____Jewish
4.____Other Church
5.____None

8. Ethnic Origin
1.____Caucasian
2.____Native American
3.____Hispanic
4.____Black
5.____Asian
6.____Other

9. Are you employed?
1.____yes
2.____no

10. Occupation?
_____

11. How many years of school have you completed?
1.____no high school
2.____some high school
3.____completed high school
4.____some college
5.____completed college
6.____graduate studies

12. Family income (annual)

1.____under $20,000
2.____$20,000 - $29,999
3.____$30,000 - $39,999
4.____$40,000 - $49,999
5.____$50,000 - 59,999
6.____$60,000 - 69,999
7.____$70,000 or over

13. How many times have you been pregnant? _____

14. Which of the following types of loss have you experienced, how many times, and in what year did they occur?

	How many times	Year (s)
1.____miscarriage (before 20 weeks gestation)	_____	_____
2.____stillbirth (at or after 20 weeks gestation)	_____	_____
3.____neonatal death (within 60 days of birth)	_____	_____
4.____elective abortion	_____	_____
5.____live birth	_____	_____

15. Since your loss, have you experienced a successful pregnancy?

1.____yes
2.____no

16. Are you or is your partner currently pregnant?

1.____yes
2.____no

17. If you answered yes to #16, how many weeks pregnant?

_____

18. Have you participated in counseling since your loss?

1.____yes
2.____no

19. What length of time have you spent in counseling related to your loss?

_____

20. If you answered yes to #18, what type of counseling have you participated in?

1.____psychiatrist
2.____psychologist
3.____social worker
4.____clinical nurse specialist
5.____other (Please Specify)_____

21. Have you participated in a loss support group?

1.____yes
2.____no

APPENDIX D

APPENDIX D

DEMOGRAPHIC DATA
(FATHERS)

Directions: Fill in, circle, or check the blanks.

1. How old are you?_____(in years)

2. How old were you at the time of your loss?_____(in years)

3. How old was your partner at the time of your loss?_____(in years)

4. Are you currently 1. ____married 2. ____divorced 3.____widowed
4.____never married 5.____separated?

5. At the time of your loss, were you 1.____married 2. ____divorced
3.____widowed 4.____never married 5.____separated?

6. Are you currently in a relationship with the person who was your partner at the time of the loss?
1.____yes
2.____no

7. Religious Affiliation
1.____Protestant
2.____Catholic
3.____Jewish
4.____Other Church
5.____None

8. Ethnic Origin
1.____Caucasian
2.____Native American
3.____Hispanic
4.____Black
5.____Asian
6.____Other

9. Are you employed?
1.____yes
2.____no

10. Occupation?
_____

11. How many years of school have you completed?
1.____no high school
2.____some high school
3.____completed high school
4.____some college
5.____completed college
6.____graduate studies

12. Family income (annual)

1.____under $20,000
2.____$20,000 - $29,999
3.____$30,000 - $39,999
4.____$40,000 - $49,999
5.____$50,000 - 59,999
6.____$60,000 - 69,999
7.____$70,000 or over

13. Have you experienced with your partner, any of the following types of loss, how many times, and in what year did they occur?

	How many times	Year (s)
1.____miscarriage (before 20 weeks gestation)	_____	_____
2.____stillbirth (at or after 20 weeks gestation)	_____	_____
3.____neonatal death (within 60 days of birth)	_____	_____
4.____elective abortion	_____	_____
5.____live birth	_____	_____

14. Since your loss, have you and your partner experienced a successful pregnancy?

1.____yes
2.____no

15. Is your partner currently pregnant?

1.____yes
2.____no

16. If you answered yes to #15, how many weeks pregnant?

_____

17. Have you participated in counseling since your loss?

1.____yes
2.____no

18. What length of time have you spent in counseling related to your loss?

_____

19. If you answered yes to #17, what type of counseling have you participated in?

1.____psychiatrist
2.____psychologist
3.____social worker
4.____clinical nurse specialist
5.____other (Please Specify)_____

20. Have you participated in a loss support group?

1.____yes
2.____no

APPENDIX E

APPENDIX E

PERINATAL BEREAVEMENT SCALE
(MOTHER)

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Directions

The statements below have been made by mothers who have experienced a pregnancy loss. Read every statement and decide which response best describes your present feelings. Then circle the appropriate letter next to each statement. If your loss occured more than one year ago, please try to recall how you felt during the year following your loss.

		(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
1.	I daydream about my lost child.	A	B	C	D
2.	I worry that a pregnancy loss can happen to me again.	A	B	C	D
3.	I have felt very much alone since my loss.	A	B	C	D
4.	I have periods of tearfulness as I think about my lost baby.	A	B	C	D
5.	I feel a need to talk to others regarding my lost child.	A	B	C	D
6.	I am now able to focus on moving ahead with my life.	A	B	C	D
7.	I worried that I failed to take enough precautions during the previous pregnancy, e.g. with weight, diet, smoking, sex, drinking, activity, etc..	A	B	C	D
8.	I wonder what my lost baby would be like now.	A	B	C	D

	(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
9. I am preoccupied about why I experienced a pregnancy loss.	A	B	C	D
10. I feel that the actions of other people contributed to my pregnancy loss.	A	B	C	D
11. I have the resources to help me cope with my loss.	A	B	C	D
12. I still feel sad about my pregnancy loss.	A	B	C	D
13. I have dreams about my lost baby.	A	B	C	D
14. I feel guilty when I think about my lost baby.	A	B	C	D
15. I am preoccupied with thoughts about my lost child.	A	B	C	D
16. I think about the child I lost when I see other children.	A	B	C	D
17. Since my pregnancy loss, I don't feel interested in keeping up with day to day activities (i.e. T.V., newspapers, friends).	A	B	C	D
18. I feel helpless regarding the the cause of my pregnancy loss.	A	B	C	D
19. I feel I have come to terms with my pregnancy loss.	A	B	C	D
20. I daydream about how my life would be if I now had the baby that I lost.	A	B	C	D
21. I am overwhelmed with sadness when I think about my previous child.	A	B	C	D

	(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
22. I feel that my life has been on hold since my pregnancy loss.	A	B	C	D
23. I have fantasies about my lost child.	A	B	C	D
24. I feel partially responsible for the loss of my child.	A	B	C	D
25. In spite of my experience of a pregnancy loss, I am now engaged in my usual activities.	A	B	C	D
26. I find myself blaming others for the loss of my child.	A	B	C	D

APPENDIX F

APPENDIX F

PERINATAL BEREAVEMENT SCALE (FATHER)

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Directions

The statements below have been made by fathers whose partners have experienced a pregnancy loss. Read every statement and decide which response best describes your present feelings. Then circle the appropriate letter next to each statement. If your loss occured more than one year ago, please try to recall how you felt during the year following your loss.

		(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
1.	I daydream about my lost child.	A	B	C	D
2.	I worry that a pregnancy loss can happen to me again.	A	B	C	D
3.	I have felt very much alone since my loss.	A	B	C	D
4.	I have periods of tearfulness as I think about my lost baby.	A	B	C	D
5.	I feel a need to talk to others regarding my lost child.	A	B	C	D
6.	I am now able to focus on moving ahead with my life.	A	B	C	D
7.	I worried that we failed to take enough precautions during the previous pregnancy, e.g. with weight, diet, smoking, sex, drinking, activity, etc..	A	B	C	D
8.	I wonder what my lost baby would be like now.	A	B	C	D

PERINATAL BEREAVEMENT SCALE
(FATHER)

		(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
9.	I am preoccupied about why we experienced a pregnancy loss.	A	B	C	D
10.	I feel the actions of other people contributed to our pregnancy loss.	A	B	C	D
11.	I have the resources to help me cope with my loss.	A	B	C	D
12.	I still feel sad about our pregnancy loss.	A	B	C	D
13.	I have dreams about my lost baby.	A	B	C	D
14.	I feel guilty when I think about my lost baby.	A	B	C	D
15.	I am preoccupied with thoughts about my lost child.	A	B	C	D
16.	I think about the child I lost when I see other children.	A	B	C	D
17.	Since our pregnancy loss, I don't feel interested in keeping up with day to day activities (i.e. T.V., newspapers, friends).	A	B	C	D
18.	I feel helpless regarding the cause of our pregnancy loss.	A	B	C	D
19.	I feel I have come to terms with our pregnancy loss.	A	B	C	D
20.	I daydream about how my life would be if I now had the baby that I lost.	A	B	C	D
21.	I am overwhelmed with sadness when I think about my previous child.	A	B	C	D

		(4) Almost All The Time	(3) Frequently	(2) Occasionally	(1) Almost Never
22.	I feel that my life has been on hold since our pregnancy loss.	A	B	C	D
23.	I have fantasies about my lost child.	A	B	C	D
24.	I feel partially responsible for the loss of my child.	A	B	C	D
25.	In spite of my experience of a pregnancy loss, I am now engaged in my usual activities.	A	B	C	D
26.	I find myself blaming others for the loss of my child.	A	B	C	D

APPENDIX G

APPENDIX G

 Study # _____

JALOWIEC COPING SCALE

This questionnaire is about how you cope with stress and tension, and what you do to handle stressful situations. In particular, I am interested in how you have coped with the stress of:

MISCARRIAGE, STILLBIRTH, OR NEONATAL DEATH

This questionnaire lists many different ways of coping with stress. Some people use a lot of different coping methods; some people use only a few.

You will be asked two questions about each different way of coping with stress: ::

Part A

How often have you used that coping method to handle the stress listed above?

For each coping method listed, circle one number in Part A to show how often you have used that method to cope with the stress listed above. The meaning of the numbers in Part A is as follows:

0 = never used
1 = seldom used
2 = sometimes used
3 = often used

Part B

If you have used that coping method, how helpful was it in dealing with that stress?

For each coping method that you have used, circle a number in Part B to show how helpful that method was in coping with the stress listed above. The meaning of the numbers in Part B is as follows:

0 = not helpful
1 = slightly helpful
2 = fairly helpful
3 = very helpful

If you did not use a particular coping method, then do not circle any number in Part B for that coping method.

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
1. Worried about the problem	0	1	2	3	0	1	2	3
2. Hoped that things would get better	0	1	2	3	0	1	2	3
3. Ate or smoked more than usual	0	1	2	3	0	1	2	3
4. Thought out different ways to handle the situation	0	1	2	3	0	1	2	3
5. Told yourself that things could be much worse	0	1	2	3	0	1	2	3
6. Exercised or did some physical activity	0	1	2	3	0	1	2	3
7. Tried to get away from the problem for a while	0	1	2	3	0	1	2	3
8. Got mad and let off steam	0	1	2	3	0	1	2	3
9. Expected the worst that could happen	0	1	2	3	0	1	2	3
10. Tried to put the problem out of your mind and think of something else	0	1	2	3	0	1	2	3
11. Talked the problem over with family or friends	0	1	2	3	0	1	2	3
12. Accepted the situation because very little could be done	0	1	2	3	0	1	2	3
13. Tried to look at the problem objectively and see all sides	0	1	2	3	0	1	2	3
14. Daydreamed about a better life	0	1	2	3	0	1	2	3
15. Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	0	1	2	3	0	1	2	3
16. Tried to keep the situation under control	0	1	2	3	0	1	2	3
17. Prayed or put your trust in God	0	1	2	3	0	1	2	3
18. Tried to get out of the situation	0	1	2	3	0	1	2	3
19. Kept your feelings to yourself	0	1	2	3	0	1	2	3
20. Told yourself that the problem was someone else's fault	0	1	2	3	0	1	2	3
21. Waited to see what would happen	0	1	2	3	0	1	2	3
22. Wanted to be alone to think things out	0	1	2	3	0	1	2	3
23. Resigned yourself to the situation because things looked hopeless	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	*Seldom Used*	*Sometimes Used*	*Often Used*	*Not Helpful*	*Slightly Helpful*	*Fairly Helpful*	*Very Helpful*
24. Took out your tensions on someone else	0	1	2	3	0	1	2	3
25. Tried to change the situation	0	1	2	3	0	1	2	3
26. Used relaxation techniques	0	1	2	3	0	1	2	3
27. Tried to find out more about the problem	0	1	2	3	0	1	2	3
28. Slept more than usual	0	1	2	3	0	1	2	3
29. Tried to handle things one step at a time	0	1	2	3	0	1	2	3
30. Tried to keep your life as normal as possible and not let the problem interfere	0	1	2	3	0	1	2	3
31. Thought about how you had handled other problems in the past	0	1	2	3	0	1	2	3
32. Told yourself not to worry because everything would work out fine	0	1	2	3	0	1	2	3
33. Tried to work out a compromise	0	1	2	3	0	1	2	3
34. Took a drink to make yourself feel better	0	1	2	3	0	1	2	3
35. Let time take care of the problem	0	1	2	3	0	1	2	3
36. Tried to distract yourself by doing something that you enjoy	0	1	2	3	0	1	2	3
37. Told yourself that you could handle anything no matter how hard	0	1	2	3	0	1	2	3
38. Set up a plan of action	0	1	2	3	0	1	2	3
39. Tried to keep a sense of humor	0	1	2	3	0	1	2	3
40. Put off facing up to the problem	0	1	2	3	0	1	2	3
41. Tried to keep your feelings under control	0	1	2	3	0	1	2	3
42. Talked the problem over with someone who had been in a similar situation	0	1	2	3	0	1	2	3
43. Practiced in your mind what had to be done	0	1	2	3	0	1	2	3
44. Tried to keep busy	0	1	2	3	0	1	2	3
45. Learned something new in order to deal with the problem	0	1	2	3	0	1	2	3
46. Did something impulsive or risky that you would not usually do	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
47. Thought about the good things in your life	0	1	2	3	0	1	2	3
48. Tried to ignore or avoid the problem	0	1	2	3	0	1	2	3
49. Compared yourself with other people who were in the same situation	0	1	2	3	0	1	2	3
50. Tried to think positively	0	1	2	3	0	1	2	3
51. Blamed yourself for getting into such a situation	0	1	2	3	0	1	2	3
52. Preferred to work things out yourself	0	1	2	3	0	1	2	3
53. Took medications to reduce tension	0	1	2	3	0	1	2	3
54. Tried to see the good side of the situation	0	1	2	3	0	1	2	3
55. Told yourself that this problem was really not that important	0	1	2	3	0	1	2	3
56. Avoided being with people	0	1	2	3	0	1	2	3
57. Tried to improve yourself in some way so you could handle the situation better	0	1	2	3	0	1	2	3
58. Wished that the problem would go away	0	1	2	3	0	1	2	3
59. Depended on others to help you out	0	1	2	3	0	1	2	3
60. Told yourself that you were just having some bad luck	0	1	2	3	0	1	2	3

If there are any other things you did to handle the stress mentioned at the beginning, that are not on this list, please write those coping methods in the spaces below. Then circle how often you have used each coping method, and how helpful each coping method has been.

61.	1	2	3	0	1	2	3
62.	1	2	3	0	1	2	3
63.	1	2	3	0	1	2	3

Revised 7/80

COMMENTS: Please list here, or on a seperate page, any additional information you feel is pertinent about your loss experience. If you found the questionnaire difficult to answer please comment on this also.

APPENDIX H

APPENDIX H

SUSAN K. THEUT, M.D.

Nov 27 97

Dear Lisa -

I don't have any copies of the PBS I used for fathers - I did this study a long time ago (>10 yrs) and only have the PBS version for mothers. But it is fairly easy to change the pronouns to apply to the fathers. You have my permission to do this.

[redacted]

PERMISSION FOR USE OF JCS

PERMISSION IS HEREBY GRANTED TO

LISA PEACOCK

TO USE THE JALOWIEC COPING SCALE

IN A STUDY OR PROJECT

[redacted]

ANNE JALOWIEC, RN, PHD

LOYOLA UNIVERSITY OF CHICAGO

DATE: 2/22/97

SUSAN K. THEUT, M. D., M. P. H.
ADULT & CHILD PSYCHIATRY

2114 HUIDEKOPER PLACE, N. W.
WASHINGTON, D. C. 20007

TELEPHONE
202-338-6034

MAY 19 '97

Dear Lisa -

Nice to talk to you! You have my permission to use the PBS scale. - I have included my scale + the scoring key. I only request that you credit me in the reference regarding it.

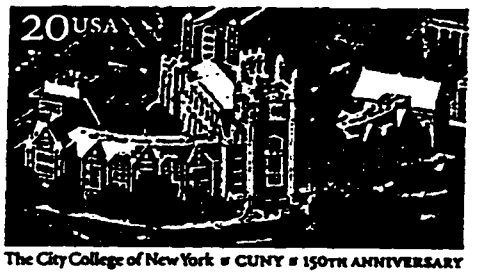
I have a series of 4 papers on perinatal loss - + will try + send them on. We renovated our home recently + my research reprints have been misplaced. If I can find them, I'll send them on — I've included my publication CV pg so you can refer to it if I can't locate them in a timely fashion.

Good luck! I'd love to hear about the results! Sorry I couldn't talk longer on Sat — I was rushed as I was on call + seeing patients + trying to give my husband instructions on taking care of our 3 yr old who had the flu!

[redacted]

APPENDIX I

APPENDIX I



LISA M. PEACOCK
9811 EAST CRAIN HILL ROAD
TRAVERSE CITY, MICHIGAN
49684

I WOULD LIKE A SUMMARY OF STUDY RESULTS
_____YES _____NO

I HAVE RETURNED MY QUESTIONNAIRE
_____YES _____NO

PLEASE PRINT YOUR NAME AND ADDRESS

_____
_____
_____
_____

APPENDIX J

APPENDIX J

GRAND VALLEY STATE UNIVERSITY
1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

February 23, 1998

Lisa Peacock
K.S.O.N.
215 Henry Hall

Dear Lisa:

The Human Research Review Committee of Grand Valley State University is charged to examine proposals with respect to protection of human subjects. The Committee has considered your proposal, "***Parental Grief Response to Perinatal Loss***", and is satisfied that you have complied with the intent of the regulations published in the Federal Register 46 (16): 8386-8392, January 26, 1981.

Sincerely,

[redacted]

Paul Huizenga, Chair
Human Research Review Committee

MUNSON
MEDICAL
CENTER
A MUNSON HEALTHCARE FACILITY

March 12, 1998

Ms. Lisa Peacock, RNC, WHNP
c/o Nurse Midwife Clinic
Munson Medical Center
1105 Sixth Street
Traverse City, MI 49684

Dear Ms. Peacock:

Your research proposal has been received. The FDA requirements for review of proposals by the Institutional Review Board are specific. The hospital legal counsel's interpretation of those requirements is that so long as the study is of a survey nature, the information is kept confidential, and that no invasive procedures occur, the IRB may waive its approval requirement.

The IRB has asked me to represent it in determining if the above guidelines are met in proposals submitted by nurses in order to fulfill the requirements of an academic nursing program. I have reviewed your research proposal, Parental Grief Response to Perinatel Loss, and find that it does meet the above guidelines. You are, therefore, authorized to proceed with your thesis proposal.

Please feel free to contact me should you have questions about this letter, or your conduct of your research in this institution.

Sincerely,

Janet Y. Jackson, R.N., M.S.N.
Vice President
Patient Care Services

ctc\irb

cc: Ralph Cerny, Chair
Institutional Review Board

Planned Parenthood®
Federation of America, Inc.

April 6, 1998

Lisa Peacock, RNC, WHNP
Northern Michigan Planned Parenthood
1135 E. 8th Street
Traverse City, MI 49684-2936

Re: Research Project #0398-818
"Parental Grief Responses to Perinatal Loss"

Dear Ms. Peacock:

This is to notify you that your request to participate in the above named research project has been reviewed and approved by the PPFA Medical Division.

The progress of all research projects in Planned Parenthood affiliates must be reported to the Medical Division at periodic intervals, not to exceed one year. The Medical Division has requested that you submit progress reports on the above mentioned project every 12 months. The form for submitting progress reports can be found in the *Manual of Medical Standards and Guidelines,* Section I-E-2. These reports must include the following:

1. Title of research project with project #, affiliate's address, as well as the name of the principal investigator.

2. Number of patients included in the study.

3. Any changes in research design or in the planned duration of the project.

4. Any conclusions already reached, with copies of papers or publications coming out of the research.

In addition, a final report including the above mentioned points shall be submitted at the end of the project.

810 Seventh Avenue New York, New York 10019 212/541-7800 FAX 212/245-1845

Prior to submission for publication, the PPFA Medical Division is willing to review and comment upon any manuscript resulting from research. If not reviewed beforehand, a manuscript involving research must be sent to the Medical Division at the time that it is submitted for publication. Comments will then be forwarded to the investigators but will not alter the content of the article or delay publication. All publications which note Planned Parenthood, whether as vendor, author, co-author, or co-investigator must include the following disclaimer: "The opinions expressed in this article do not necessarily reflect those of Planned Parenthood Federation of America, Inc."

Please do not hesitate to write or call me at (212) 261-4701 if you need any further assistance.

Sincerely,

Michael S. Bumhill, MD, DMSc
Vice President of Medical Affairs

MSB\arl

cc: Jill Cobrin, Insurance Department
Fannie Porter, Evaluation Department
Scott Blanchard, Executive Director
Daniel Verberg, MD, or current Medical Director
Affiliate Service Center

a:\approval\0398-818

LIST OF REFERENCES

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