Coping After Involuntary Pregnancy Loss: Perspectives of Spanish European Women

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Abstract

The purpose of this qualitative study was to discover the coping strategies used by Spanish (European) women to cope with a pregnancy loss. Sixteen women with miscarriages and stillbirths were interviewed. All of the women were Spanish European. The mean age of the women was 35 years, and most were university graduates, married, employed, and with living children. Audio-recorded interviews and field notes were transcribed and then subsequently coded and analyzed in individual or team sessions. Construction and confirmation of the categories and related themes derived from the data was a collaborative process. Two themes emerged regarding the coping strategies used by women: *talking* and *avoiding*. This study expands the theoretical model "Multicultural Model of Coping after Pregnancy Loss" and guides health providers regarding interventions used in practice.

Keywords

"perinatal grief," bereavement, coping, miscarriage, "qualitative research"

Introduction

Grief is defined as the *normal* psychological process that occurs through the loss of a loved one's death. It is a universal, unique, and painful human emotional experience, which can be delimited in time, presents a predictably favorable evolution, and requires the need to adapt to the new situation (Barreto, de la Torre, & Pérez-Marín, 2012; Consonni & Petean, 2013; Koopmans, Wilson, Cacciatore, & Flenady, 2013). Some of the most common reactions present in perinatal grief, specifically, are deep sadness, depression, irritability, worry, anxiety, and alterations in eating and in sleeping patterns. The symptoms of acute grief usually diminish over time, but it has been reported that the normalization of the psychosocial effects of perinatal death takes between 5 and 18 years (Cacciatore, 2010; Flenady et al., 2014; Koopmans et al., 2013; Purandare et al., 2012).

Maternal bereavement is the experience of a mother that begins after the loss of a fetus due to miscarriage or stillbirth. It is a global and multifaceted phenomenon that is a concern for health-care providers (Fenstermacher & Hupcey, 2013; Purandare et al., 2012; Razeq & Al-Gamal, 2018).

Perinatal mortality has been reduced thanks to scientific advances and the quality of health care for pregnant women and newborns (Dallay, 2013; Koopmans et al., 2013). Despite this, worldwide between 20% and 30% of pregnancies end in miscarriage (Meaney, Corcoran, Spillane, & O'Donoghue, 2017), and the rate of fetal death was 18.4 per 1,000 of total births, representing 2.6 million fetal deaths annually in the world in 2015 (Lawn et al., 2016). In Spain, according to the latest data from the National Institute of Statistics, the perinatal mortality rate is 4.37 per 1,000 of the total births, and the late fetal mortality rate is 3.11 per 1,000 of the total births (Instituto Nacional de Estadística, 2018). However, the literature establishes the possibility that these ratios are underestimated (Flenady et al., 2014). This underreporting in Spain may be due to the fact that the data used are collected from the local civil registers, which are based on the voluntary declaration of the parents, and not on the data available to the hospitals (Suárez, López, Martínez, & Sánchez, 2008).

Globally, knowledge about this type of loss and care provided have evolved from nonrecognition to the provision of more humane care (Dallay, 2013). Despite this, pregnancy losses are still considered taboo losses and made invisible by the social and health environment, and parents perceive a lack of social and health support (Heazell,

2016). Consequently, these losses do not reach the relevance to influence political agendas. Invisibility of pregnancy loss is exacerbated in low-income countries, where poverty can contribute to complex situations for women in after pregnancy loss, while in high-income countries, the invisibility of pregnancy loss is not homogeneous and varies from one country to another (Frøen et al., 2011). In Spain, in the health providers' protocols of action, there is great variability in terms of interventions, and these are primarily aimed at clinical aspects (Pastor-Montero et al., 2011).

There is a lack of literature referring to the experiences of Spanish European women after pregnancy loss. One study reflected that women assertively sought individualized professional support to obtain assistance with managing their emotions and to talk about their loss experiences (Pastor-Montero, Vacas-Jaén, Rodríguez-Tirado, Marcías-Bezoya, & Pozo-Pérez, 2007).

In the literature (Cacciatore, Erlandsson, & Rådestad, 2013; Ryninks, Roberts-Collins, McKenzie-McHarg, & Horsch, 2014; Van, 2012; Van & Meleis, 2003; Yamazaki, 2010), strategies and coping behaviors in perinatal losses are described. But these belong to other cultures, which is a problem when it comes to transferring results to Spanish European women, because culture influences the construction of grief (Dallay, 2013; Fenstermacher & Hupcey, 2013; Van & Meleis, 2003). There are articles (Fenstermacher & Hupcey, 2013; Mander, 2014) that affirm that qualitative research is necessary to discover and describe the variations in the experience of perinatal grief through age groups, races, and cultures so that the concept of perinatal grief can be advanced and offer appropriate support.

Previous studies have shown that talking to loved ones about death contributes to the process of overcoming grief, while a lack of social support can prolong and worsen the grief response (Maguire et al., 2015). When grief is repressed or hidden behind a façade of strength or under patterns of work addiction, the sensations of pain, suffering, and emptiness due to the loss of the loved one would be numbed in this way (Hutti, Armstrong, Myers, & Hall, 2015; Yoffe, 2003). In the short or long term, this usually generates physical symptoms, psychosomatic illnesses, behavioral disorders, depression, or chronic grief, giving rise to pathological grief. The cultural factor influences the coping mechanisms used by individuals. While in North American cultures, there is a marked

tendency to self-control and silent coping, in Spain, cultural frameworks allow for the expression of emotions (Yoffe, 2003).

This report expands the theoretical model "Multicultural Model of Coping after Pregnancy Loss" (Van, 2012, p.77). The model establishes connectedness as a facilitator of coping, while disconnectedness is the central concept that inhibits coping. This model consists of three dimensions of connectedness: personal (self), interpersonal (others), and religious/spiritual. Specifically, the interpersonal dimension (others) is widened because our data answer the questions of why and who. For all this, the aim of this study was to identify the coping strategies of Spanish European women following their pregnancy loss experiences. The results of this report are a component of a larger study in which coping after pregnancy loss was explored among women and their partners.

Implementation of the Study

This study was approved by the Ethics Committee (registration code 2015/232) and was developed within the current regulatory framework (Council of Europe, 1997; General Council of Nursing, 1999; Law 14/2007, of July 3, on biomedical research; Law 41/2002, of November 14, basic regulatory of the autonomy of the patient and rights and obligations in matters of information and clinical documentation; Organic Law 15/1999, of December 13, Protection of Personal Data; World Medical Association, 2013). The study participants were recruited by the collaboration of midwives and gynecologists of the Gynecology and Obstetrics Service of a major medical center located in northern Spain. They delivered an informational flyer to the parents after the loss, with which women gave their consent for the researcher to contact them by phone. During the first contact, the researcher and the women established appointments at times and locations convenient to the women. Eligibility criteria for the study included women who reported a recent experience of pregnancy loss (e.g., miscarriage, eugenics abortion, or fetal death) and assigned to a specific health-care area of northern Spain.

Informed consent was obtained from each participant before data collection. Before signing the consent, an additional information sheet was provided with content related to the study and their rights in the study. Participants were assured that they could stop the interview at any time and could skip any questions they did not want to answer. If interviewers perceived that a professional approach was necessary, they could contact the

team of health professionals or recommend that the women request an appointment with a health professional to be seen. In all cases, the interviews were conducted at the first contact with the parents, at the request of the parents. Of the 16 interviews, 12 interviews were conducted with couples (male and female) and 4 with only women, although the results presented here are from the women, only. There was only one interview per participant. The average time between the loss and the interview was 1 month.

The individual interviews were conducted at the time and place chosen by the participants, usually their homes. The qualitative method used to collect data was grounded theory (Charmaz, 2006).

Using a semistructured interview format, the participants were asked about their experience of pregnancy loss. From their initial story, questions about the specific aspects, such as strategies and coping mechanisms, were explored. Some examples are as follows:

1. Have you used any coping mechanisms or strategies in this situation? Which ones?
2. What role did your family play at that time? What was the influence of your social environment?

The interviews were audio-recorded. After the completion of the interviews, the researcher wrote field notes. The interviews were transcribed by the researcher. The audio-recordings were destroyed using acceptable industry procedures.

Demographics

The mean age of the 16 participants was 35.18 years. The nationality of all the women was Spanish European, although one was from South America. The level of study of the participants was basic education ($n = 2$), medium professional training ($n = 3$), higher professional training ($n = 3$), and university studies ($n = 8$). Except one, all participants were married or partnered. Most (80%) were working at the time of their participation in the study. Their loss occurred as follows: first trimester ($n = 12$), second trimester ($n = 3$), or third trimester ($n = 1$). Regarding their reproductive history, $n = 8$ had previous children, $n = 3$ had previous losses, and $n = 3$ were included in a fertility program.

Data Analysis

The interviews were coded in individual and group sessions among the authors. Construction and confirmation of the categories and related themes were derived from the data and the field notes. Verbatim quotes were selected to illustrate the themes and the participants' perspectives. Preliminary results were presented to a group of registered nurses, who represented a variety of specialties, but predominately perinatal nursing. A group of practicing registered nurses, employed in mostly perinatal units in the United States, provided feedback to confirm our interpretation of the data and extend our understanding of the implications for education, research, and practice.

Results

The women of this study were open to participate and talk about their experiences. During the interview, they appeared comfortable, and, in many cases, they said the interview was therapeutic, and they expressed gratitude for having the opportunity to participate in the study. Some women cried when remembering their experiences; they were given the opportunity to stop the interview but declined and continued. Due to the short time since their loss (1 month), they described clinical aspects about their experience, perhaps in an effort to redirect from discussing more painful emotional issues.

From the analysis, two major themes were identified: talking and avoiding.

Talking

This theme focused on why and with whom the women used conversation as a coping strategy.These conversants were connected with the women on a personal level.

Participants talked most frequently with their husbands/partners, mothers, sisters, and other family members. They talked with these people because they wanted to be open and transparent with someone they could trust.

> Let's say, that we [my husband and I] spoke for 2 weeks about this topic, it was the only topic. (DP15, Involuntary Pregnancy Loss [IPL] 15 weeks, 38 years old)
>
> I say everything, he [my husband] listens to me. We have been together for 10 years, so we know each other very well […] We support each other. (DP1, IPL 30 weeks, 31 years old)
>
> Yes, we [my husband and I] have discussed this many times, but without drama. For sure, without drama for our health. (DP13, IPL 7 weeks, 39 years old)
>
> But my mother, who saw him [the baby], would say to me, "Don't dwell on that because L [the baby] … Remember him when he was in your womb and when you spoke to him and he responded, and when you had that bond." And then, that helped me and consoled me […] "While I had him in my womb, I know that he was conscious of the love and the desire we had to have him." (DP1, IPL 30 weeks, 31 years old)
>
> My mother is helping me a lot, because she understands death in a different way. And she said, "I already know that it is a horrible experience. And hopefully I could die, if necessary, so that you would not have to experience all of this." […] "Don't worry, because in the future you'll see this in a different [new] way." (DP1, IPL 30 weeks, 31 years old)
>
> I spoke much about this [the loss] with them [my sisters] […] And I explained everything to them. (DP15, IPL 15 weeks, 38 years old)

Another group that stood out were people who had similar experiences, such as family members or close friends who had a pregnancy or fetal loss. The women highlighted that talking to others who had the same experience was beneficial for them.

> Two days after [the loss], we were with friends who just had the same experience. […] So then, the first thing I told her was, "I thought of you, you know?" And we spoke [about our losses]. […] It helped me to see the person who had the same experience and to feel supported by them. (DP2, IPL 7 weeks, 34 years old)
>
> […] You see that they have gotten beyond it. They [women who experienced pregnancy loss] are coping by moving on and having children. (DP16, IPL 13 weeks, 31 years old)
>
> It's a relief to be able to talk with someone who had the same experience. (DP2, IPL 7 weeks, 34 years old)

Some would talk to coworkers, a more formal situation, because they did not want to pretend with their colleagues:

> I told coworkers because I was going to miss work and I wanted them to know […] I had the need to talk about what happened so they could understand that I was missing work for an important reason. (DP20, IPL 6 weeks, 41 years old)
>
> I had to tell a work friend … And it was a relief that someone knew about the loss. Because if not I would have to cover it up with excuses and lies. (DP13, IPL 7 weeks, 39 years old)

Avoiding

In the early stages of the loss, some women used avoidant coping regarding conversations, for various reasons. The most frequent reason for avoiding discussion of loss was due to their anticipation of negative and unsupportive responses from others.

> [I didn't talk about my loss because of things people would say to me such as …] You're fine, you know that with your age the miscarriage rate is very high, what did you expect? Why are you … Giving it so much [attention] … that is just how it is. (DP9, IPL 8 weeks, 43 years old)
>
> I don't have the will to explain [the loss]. […] It's not that not wanting to explain it is in the nature of my personality … It's not acceptable to discuss these things. (DP9, IPL 8 weeks, 43 years old)
>
> […] I made something up … I told them I had bleeding due to a polyp … It [the loss] would have been the talk of the funeral, "Look, 'Isabel' had a miscarriage." And then … it would have been unnecessary whispering. (DP20, IPL 6 weeks, 41 years old)
>
> I don't like talking about … I had a miscarriage … Because I know that people may say, see a single mother by choice and now look what happened to her. (DP19, IPL 9 weeks, 37 years old)

Other reasons included the desire to protect oneself, as can be seen in the following quotes:

> We went to a spa, to see if we could disconnect, to find peace, to be together … We did not even want to be with family [or talking family]. (DP15, IPL 15 weeks, 38 years old)
>
> The shock of meeting and them asking you how is your pregnancy going. Then, I felt my heart sank to my feet. I arrived home I just got in bed with my clothes on and did not want to talk, cook, or eat. (DP13, IPL 7 weeks, 39 years old)
>
> […] But, I, for example, have not told my mother. And I still don't know why, but it may be for self-protection. (DP9, IPL 8 weeks, 43 years old)

The last reason for the use of avoidant coping was that they avoided the discomfort of retelling the story of the loss.

> I did not even pick up the phone. I did not want to talk to anyone … It was remembering … Everything … with every person who called you … (DP22, IPL 11 weeks, 35 years old)
> But I think that, right now, after these months, and after having gone through work of getting beyond it and packing it away … It could reopen things that I think are already settled. (DP9, IPL 8 weeks, 43 years old)

Discussion

The analysis of this study with predominantly Spanish European women revealed that their coping strategies were guided by their preferences for communication. The women demonstrated divergent communication styles by either communicating or avoiding discussions.

The theoretical model "Multicultural Model of Coping after Pregnancy Loss," developed by studies with African American, Caucasian, and Asian American samples (Van, 2012), is expanded with our findings. The results of this study expanded and confirmed our understanding of the influence of connectedness or disconnected among interactions with self or others.

- *What* was discussed;
- With *whom* the communications occurred; and
- *Why* communication occurred or did not occur.

The time of data collection differs from one study to another. In this study, the mean time from the loss to the interview was 1 month, while in the study by Van (2012), the participants were interviewed in the final month of a subsequent pregnancy. Although evidence reflects the recency of the perinatal loss can influence women's responses related to talking or avoiding the loss (Flenady et al., 2014; Koopmans et al., 2013), the literature also reflects alternative perspectives. Specifically, talking and avoiding strategies have been used by women for more than a year in response to their perinatal losses (Carolan & Wright, 2017; Gopichandran, Subramaniam, & Kalsingh, 2018; Van,

2012). The capture of the sample at different moments of the experience of the phenomenon strengthens and expands the theoretical model.

On the other hand, our results revealed a cultural difference between both samples. The American samples used religion as a coping mechanism, while the Spanish group did not.

Talking

The benefit of informal support, provided by family, friends, and close people with similar experiences, is well documented in the research literature and coincides with our results (Gerber-Epstein, Leichtentritt, & Benyamini, 2009; Meaney et al., 2017), but we did find cultural differences. In investigations such as that of Allahdadian, Irajpour, Kazemi, and Kheirabadi (2015), cultural differences were visible in terms of the informal source of support. Their results, which were framed in the Arabic culture, highlighted that the role of the husband in this process was to be present, and the family and close friends were to perform daily activities and housekeeping and return to their normal lives. In our sample, women faced the loss of pregnancy, talking to their social environment, which included their husbands, family (mother and sisters), and close friends.

Our results do not coincide with those reported by Randolph, Hruby, and Sharif (2015). Their findings have shown that silence about losses is especially frequent in the workplace. This may be due to the idea that conversations about death are not normalized in the workplace and that the professional development of women can be affected by these conversations. In our results, women gave the news of the loss and talked about it with their coworkers. Being able to talk openly did not force them to pretend or try to distract from their experience.

The benefits of social support are widely reported in the literature as a healing element for women after pregnancy loss (Flenady et al., 2014; Koopmans et al., 2013; Sutan & Miskam, 2012). In addition, when the loss is recognized or publicly expressed, social support is usually greater (Randolph et al., 2015). In our results, we found that talking about loss is a relief for these women as they shared their experiences with others.

They felt accompanied in their loss, and this was especially visible in those who talked with other women about their experiences of pregnancy loss. Findings from this study support what has been reported by others. Talking to others who have gone through

similar losses is helpful to women. Sharing these experiences helps them to normalize their feelings (Cacciatore & Bushfield, 2007).

Talking also validates their loss, especially with losses early in the pregnancy. Early losses lack tangible proof of the baby's existence that are present in later losses, such as physical changes in a woman's body that are socially perceptible, or memories recorded through photographs, footprints, or ultrasounds (Fernandez, Harris, & Leschied, 2011; Garrod & Pascal, 2019).

Avoiding

The avoidance behaviors of women were strongly influenced by cultural components. For instance, in Taiwanese society, these losses are taboo and represent failure to fulfill the reproductive tasks of mother, wife, and daughter-in-law. For this reason, Taiwanese women are alone during the loss (Tseng, Chen, & Wang, 2014). In the study of Gopichandran et al. (2018), Indian women faced a baby loss through isolation, returning to work, caring for their family's children, and having wishes for a viable new pregnancy, the support of family and friends, and religion. Isolating behaviors were due to guilt, pain, and shame because the women perceived a sense of stigma of failed womanhood. Our study was similar with respect to these avoidance behaviors due to the pain of reliving the experience it when they talked about it. But it is also due to other causes such as the desire to protect oneself and avoiding negative or nonbeneficial responses from others.

Avoidance behaviors may be because these women are not prepared to talk about their loss. According to the research literature (Dyregrov, Dyregrov, & Kristensen, 2016; Nazaré, Fonseca, & Canavarro, 2013), avoidant coping is associated either with adaptive or maladaptive responses that may be helpful following a loss and trauma. In our results, the mean time between loss and the interview was a month, and this could suggest an adaptive response in the grieving process because the presence of avoidance behaviors by parents is in the early stages of the grieving process.

Implications for Practice, Education, and Research

In practice, it is important that health providers acknowledge the perinatal loss and the individuality of this grief on the woman and her partner. Individuals cope with and build on the loss according to their situational factors (existence of previous children, previous pregnancy losses, the upbringing of a twin that survives), internal (personality, gender), and external (culture, social support; Dallay, 2013; Fenstermacher & Hupcey, 2013; Van & Meleis, 2003). This gives rise to the concept that the grief is externalized in a certain way and with a different duration between each one.

On the other hand, follow-up interventions must be carried out, to find out how the women are coping with the loss after leaving the hospital, because avoidance behaviors are frequent in the early stages of loss.

When educating health-care providers, grief must be included. It is important that health-care professionals, especially nurses, know about the grieving process and its symptoms. With this knowledge, health-care providers can give women educational resources to cope with a loss, helping women to understand that grief is a normal and healing process that occurs after a loss. In addition, this education could be extended to the close social environment of the women because these are the main support people. In our results, the feeling of *normality* and support was acquired by talking with other women with similar experiences. Finally, with this knowledge, the detection of pathological grief could be identified if it occurs.

Further research on men may also extend the work of Van (2012) on the coping mechanisms after the loss of a pregnancy. In this research, the coping mechanisms of Spanish European women, belonging to the Mediterranean cultural framework, have been collected. Research in other cultures, in different age groups and in different types of pregnancy loss, will broaden the knowledge of grief and, therefore, its proper management by health-care providers.

Conclusion

Spanish European bereaved women cope with the loss of pregnancy with two antagonistic strategies. They talk with their social circle (family, friends, and others with similar experiences) and with coworkers. They use this strategy because it is a relief for them,

they normalize their feelings, others can empathize with them, they increase their social support system, they validate their loss, especially those early losses, and because they do not want to pretend. They use avoidant behaviors, mostly to anticipate negative responses and lacking support from others. They also use them as a mechanism of self-protection, avoiding the discomfort of retelling the story. This study guides health providers regarding interventions used in practice, which are based on recognizing the loss and the individuality of this processes of connecting with others and then structure and content of those connections.

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