Women's lived experiences of maternity care in pregnancy after loss: A Heideggerian perspective.

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

May 2021

Declaration of authorship

I, the undersigned, declare that the thesis entitled **Women's lived experiences of maternity care in pregnancy after loss: A Heideggerian perspective,** is solely my own work, and has not been used in any other submission for an academic award. All quotations and sources have been distinguished with quotation marks and sources have been specifically acknowledged.

Signed: Teresa Garrod

07th of May 2021

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Abstract

For some women, pregnancy loss is a traumatic event that can have far reaching effects. Whilst a new pregnancy may have external cause for celebration, the experience instead often re-ignites internal fear, guilt, anxiety, and grief. This paradox of emotions is carried through the current pregnancy, with long term consequences for these women's emotional and psychological health. Meeting these needs in this subsequent pregnancy should be an essential component of providing quality maternity care, yet there is a lack of evidence in the UK to suggest that these needs are recognised or being met.

This thesis aimed to explore pregnant women's experiences of maternity care in Lincolnshire following a previous pregnancy loss. Pregnancy loss in this thesis is defined as including miscarriage, abortion, stillbirth, and neonatal death. A hermeneutic phenomenological approach was used, underpinned by the philosophies of Heidegger. Thirteen in-depth interviews were conducted with seven women from Lincolnshire who were purposively recruited via social media and NHS hospital sites. Data analysis was undertaken using Moustakas's interpretative framework.

Three interpretative themes were identified. The first two were framed using Heideggerian concepts which illuminated the women's experiences of loss, despair, hope, fear, and adjustment through a temporal and attunement lens. The third theme highlighted the extremes of experiences of maternity care in the subsequent pregnancy in a maternity system that did not recognise their needs. As a whole, this thesis revealed that where awareness and understanding from maternity care professionals was perceived as lacking, then maternity care was experienced as suboptimal. As a result, implications for practice and research are significant. This thesis calls for providers of maternity care to broaden their package of care to recognise the distinct needs of women who are pregnant after loss, and to contribute to further research into how best these needs can be met.

Acknowledgements

Firstly, I am indebted to the seven women who so generously gave up their time to share their stories of loss so openly and courageously. Without them, this thesis would not have been possible.

I would like to thank all the members of my supervision team who have shared all, or part, of this journey with me, Dr Caroline Horton, Dr Sue Becker, Professor Jan Pascal, and in the earlier stages' Dr Graham Basten and Dr Gianina Postavaru. You have all inspired, encouraged and challenged me in different ways through the highs and lows of this process. Special thanks though must go to Jan Pascal, who has become a treasured friend and confidante. Your belief in me to complete this project has never faltered, and for that I am eternally grateful.

There are others, too numerous to mention, who have helped with the thinking of this thesis. The conversations had with fellow PhD students, leaders and candidates on courses and conferences attended, work colleagues and friends on the Health and Social Care team at Bishop Grosseteste University, your voices have all contributed in some way to bring this thesis to conclusion.

I want to say thank you to all my family and friends, who have been there on this journey, quietly encouraging me on. Thank you to the friends who have waited patiently, often neglected while I have been immersed in this process, not long now until we can resume where we left off. To my family, my brothers, sisters-in-law, nieces, and nephew, you may not understand why I would want to embark on such a project, but you have supported and encouraged me anyway. To my lovely mum, Sylvia, thank you for your love and guidance. I hope that I have made you proud.

Thank you to those who have kept me grounded throughout this journey, my sons, Adam and Lewis, and Adam's wife Rachel. Special thanks though, must go to my three

beautiful granddaughters, Kiarah, Lily and Rosie. You all have been a most welcome distraction and remind me daily of the important things in life.

Finally, my heartfelt thanks must go to my long-suffering husband Al. When I embarked on this project, we had no idea of the life changing events that would occur, leading to us both having to adapt to a new way of *Being-in-the-world.* Throughout it all though, you have been a pillar of strength and encouragement, as well as a constant provider of cups of tea and regular meals whilst I have been locked away writing. Thank you for your belief in me, and for always being there.

This work is dedicated to the lost babies, whose stories have been vicariously told by their courageous mums throughout these pages. You will never be forgotten.

There is a love that begins before birth. There is a love that is unmarked by death. There is a love that never ends. This is the love we have for our children. It is untouched by wind, rain and sun. Age has no impact on its ferocity, and life with all its beauty and pain cannot distract us from it. We have been privileged to know this love four times. But there has been a price to pay for this love. The price has been a broken heart.

(Dahlen, 2003)

Contents

Chapter 1 - Introduction

This research reports the findings of a hermeneutic phenomenological study that sought to explore the lived experiences of pregnant women accessing and receiving maternity care after a previous pregnancy loss. The setting for the study was the large, rural county of Lincolnshire, England. When seeking to explore pregnant women's experiences of maternity care in this context, it became apparent that these care experiences were shaped by the previous pregnancy loss and subsequent pregnancy. It was therefore imperative that the care experiences were researched with this knowledge in mind. To do this, research was undertaken into women's lived experiences of pregnancy loss, pregnancy after loss, and maternity care received during the pregnancy after loss. In-depth interviews were used to gain insight into this complex lived experience, and a Heideggerian hermeneutic phenomenological approach was utilised as a way to understand the phenomenon being studied.

1.1 Aims of the research and the research questions.

Given the scarcity of literature relevant to this research context, the aim of this study was to:

1. Explore the lived experiences of pregnant women's maternity care after a previous pregnancy loss, from the perspective of women who had experienced the phenomenon.

To do this, it was important to position these lived experiences in the context of the previous pregnancy loss, to honour those losses, as well as to acknowledge that the accounts of those experiences were told from the shadow of that loss. The intention was to reveal the phenomenon of care in a pregnancy after loss as it appears in the everyday Being-in-the-world, and to understand the meaning and significance that women placed on these experiences.

Pregnant women's lived experiences were explored through gaining an understanding of the previous pregnancy loss, the interpretation of the meanings they attached to those losses, into the subsequent pregnancy, and the maternity care they received during that subsequent pregnancy. As the study progressed, the aim was refined into the following research questions:

a. What are pregnant women's lived experiences of maternity care and support following a previous pregnancy loss?
b. How are these experiences meaningful?

1.2 Personal background to the research

According to Sarantakos (2013), one of the key features of qualitative research is that it values the reflexivity of the researcher. By this it is meant that the researcher should be reflexive about the implications of their values, beliefs, decisions, bias, and pre-understandings that they bring to the design, and their role as researcher in the construction of knowledge (Bryman, 2016). Unlike Husserlian phenomenology, which encourages the 'bracketing' of such experiences (Husserl, 1970), Heideggerian hermeneutic phenomenology does not seek to ignore the researcher's pre-understandings of the phenomena being studied, but instead encourages meaningful reflexivity throughout the process (Smythe, 2011). With this in mind, my personal and professional background which has influenced the design and process of this study is outlined below. Here, and in other parts of the thesis where appropriate, the use of the pronoun 'I' and 'my' will denote when I am speaking.

My interest in this subject can be located within my own lived experience on both a personal and professional level. Significantly, I have had personal experience of multiple losses, of a potential sibling, child, and grandchild. These losses, and those of friends and family, exposed me to just how prevalent pregnancy loss was (and is). Until this point, although perhaps known about, these stories were hidden and never spoken about in such intimate ways. Through my lived experiences I have been a part of and witnessed the complex emotional and social effects of pregnancy loss on individuals, families, and relationships.

For as long as I can remember, pregnancy and birth have always intrigued me. After the birth of my own children, I trained as a midwife and worked for the next 20 years in a variety of midwifery settings, but predominantly as a community midwife. Throughout my professional career I have been privileged to share in parents' experiences of incredible joy at the birth of a new baby, and conversely, the intense sadness of pregnancy loss. As a result, I became interested specifically in the provision of maternity care in a pregnancy after loss, in part because of my own loss experiences, but also because of my professional work as a provider of that care.

In my own quest to provide appropriate and relevant care that addressed both clinical and emotional needs to this group of women, alongside midwifery, I trained as a Gestalt counsellor, specialising in counselling women who had experienced a pregnancy loss. My professional observations from these encounters have been that women's experiences are a complex web of feelings and emotions that are faced and managed on a daily basis. The stories of the challenges they face, and the difficulty they have with Being-in-the-world (Heidegger, 1927/1962) of pregnancy after loss are emotional and challenging to hear.

I acknowledge that although this study is not about me, or my lived experiences, these experiences have informed how I have designed the study, from the research question through to the choice of methodology and influenced my interpretations of the data. In addition, the awareness of these experiences has provided the motivation needed to investigate this research topic.

1.3 Significance of the research

Contemporary literature relating to pregnancy loss and a subsequent pregnancy appears to be concerned with risk aversion, safety, and the medicalisation of the pregnancy and birth process (Chojenta et al., 2014; Geyser & Siebert, 2015), or with the role of healthcare professionals caring for these women (Gergett & Gilllett, 2014). In comparison, a relatively small number of studies consider the experiences of women in a pregnancy after a pregnancy loss (Andersson et al., 2012; Cote-Arsenault, 2007;

DeBackere et al., 2008). Very few of these studies question the meaning of the experiences of care in the subsequent pregnancy, and there is little consideration of the influence that the previous loss will have on meaning making in the current pregnancy. There is the assumption that the subsequent pregnancy will be emotionally unproblematic, bringing ‘healing’ and ‘closure’ (Meaney et al, 2016). This in-depth, qualitative study is important because it will assist in understanding the phenomenon of care in a pregnancy after a previous loss in the context of the women’s lived experiences, and through the lens of a Heideggerian interpretive framework. An extensive literature review demonstrates that there are currently few published studies that focus on this subject or consider how these women’s lived experiences are meaningful and significant across time, space, and relationships.

The emerging interpretations from this research could inform maternity care practice, with significance for all maternity care providers who work with women who have experienced loss. In the study, women were interviewed twice (once in the antenatal period and once in the early postnatal period). This was because I wanted to try to capture the nature and temporality of their experiences in the present (and when the outcome of the pregnancy was still unknown) but also retrospectively (after the birth of their baby). I was concerned that we might otherwise have missed aspects of their lived experiences that may have been obscured by maternity care that is characterised by the western medicalisation of childbirth. The findings may have important implications for the providers and commissioners of maternity services not only in Lincolnshire, but also nationally and internationally. Within Lincolnshire, it is hoped that as a result of this study, a dialogue will be opened up with local maternity services on the provision of care for this group of service users.

1.4 The context of the research

Globally, pregnancy loss continues to be a neglected issue (World Health Organisation WHO, 2016a). Millions of women experience pregnancy loss daily. Official figures suggest that globally there are 2.6 million stillbirths annually, 2.7 million babies die in the first 28 days of life, and that between 10 – 25% of all known pregnancies end in miscarriage. In 2016 in the United Kingdom (UK), it was estimated that 1 in 4 pregnancies ended in miscarriage (which equates to 684 miscarriages per day), with 1 in 80-90 of those being diagnosed as ectopic pregnancies (12,000 per year) (Tommy's, 2018). In the same year there were 3065 stillbirths (9 per day), and 1337 neonatal deaths (MBRRACE, 2018). In 2017 there were 189,859 reported abortions in the UK, with 3158 of that number being abortions for a diagnosed fetal abnormality (Department of Health and Social Care, 2018).

However, the true magnitude of these losses is unlikely ever to be known, as not all losses are recorded and are therefore unreported, and many miscarriages occur before a pregnancy is suspected or confirmed (WHO, 2016b; Tommy's 2018). The enormity of these statistics in the 21st century should not be underestimated. Behind these statistics is a woman, her partner, family, a lost dream. The effect of pregnancy loss does not just touch the woman, but has a ripple effect on those around her, "like a stone cast into the stillness of a quiet pool; the concentric ripples of despair sweep out in all directions, affecting many, many people" (De Frain et al., 1991, p.165).

Historically, in Western culture, pregnancy loss was a taboo subject. Stillborn infants were whisked away from their mothers before they could see them, and any talk of the loss was discouraged (Cassidy, 2007). From the mid twentieth century onwards, medical understanding and attitudes towards pregnancy loss began to change, partly due to the development of medical technologies such as the ultrasound scan, where the visualisation of the fetus was instrumental in changing medical and societal attitudes towards the unborn child. The establishment of the National Health Service in the United Kingdom, and the provision of a health system that promised a healthier population, saw the acceleration of these changing attitudes, to the current understanding we have of pregnancy loss today in the early twenty-first century (Duchemin-Pelletier, 2017).

There is now a much broader understanding of the clinical and medical implications of pregnancy loss for women, however, less is known of the psychological and psychosocial consequences of such losses. Pregnancy loss can be a devastating life event. Although acknowledging that the experiences and long-term effect of pregnancy loss will be different for each woman, for some who are affected, their lives are changed forever in the shadow of the loss (Lalor, 2018; Ockhuijsen et al., 2013). Those who have lived with the experience may learn to adapt to a future life, and even consider having another child. However, often the psychological and psychosocial repercussions linger, and are re-ignited in a future pregnancy (O'Leary, 2014). As a woman enters the world of maternity care in this subsequent pregnancy, this myriad of emotions accompanies her.

1.5 Defining pregnancy loss in this research.

It is acknowledged that there are many different types of pregnancy loss, however, in this study it is defined as a loss of a pregnancy from conception right through to the loss of a baby born alive, but who dies in the neonatal period (up to 28 completed days after birth). The term pregnancy loss was chosen above perinatal loss, as this could include biological pregnancy losses from conception onwards and not only the ones from 22 weeks gestation (which is the definition of perinatal loss). The classification of losses considered therefore include miscarriage (early and late), ectopic pregnancy, elective abortion, medical abortion (where there is a diagnosed fetal abnormality, or a danger to the mothers' life or mental wellbeing), stillbirth and neonatal death. Although possibly a controversial decision (given society's view of the 'choice' women have to undergo this procedure), the decision was taken to include women who have had an elective abortion in the study. The rationale for this decision was that for many women, the 'choice' to end the pregnancy is taken precisely because some women feel that they don't have a choice to continue (Coleman et al., 2005). Table 1 outlines the definitions used for each classification of loss in this study.

Table 1

UK classifications of pregnancy loss used in this study.

Key terms	**Definition**
Pregnancy loss	A pregnancy loss due to miscarriage, abortion, medical termination, stillbirth, and neonatal death that occurs within 28 days of a live birth. A generic term to incorporate all types of biological pregnancy loss.
Miscarriage	A spontaneous loss of a pregnancy before 24 weeks gestation (Nice, 2013). Miscarriages can further be classified as early (up to 13 weeks gestation) or late (from 13 weeks gestation to 23 weeks and 6 days gestation).
Ectopic pregnancy	When a fertilized egg implants itself outside the womb, usually in the fallopian tube. Can be fatal for the mother if not diagnosed early and treated (NHS, 2018).
Abortion	The elective, legal termination of pregnancy, usually in the first trimester but occasionally in the second trimester. This can take place in the UK up to 28 weeks gestation in special circumstances.
Medical termination	A termination of pregnancy due to medical reasons such as fetal anomaly or severe health risks to the mother.
Stillbirth	A baby born without any signs of life from 24 weeks gestation (Bevan, 2015).
Neonatal death	A baby that is born at any gestation who lives (even briefly) but dies within 28 days of birth (Bevan, 2015).

1.6 Structure of the thesis

This thesis consists of ten chapters.

Chapter 1 (Introduction) sets the scene, by revealing the aims of the research and the research questions. Following on, my personal and professional motivations for undertaking this research are outlined. Next, the significance of this research, as well as the context of the research are considered before an explanation of the definitions of pregnancy loss used within the study. The chapter concludes by outlining the organisation and structure of the thesis.

Chapter 2 (Background) begins by reviewing national policy and reviews for maternity care in England, considering these from both a national and local context. The focus then moves to examine the provision of maternity services for women in Lincolnshire, the setting for this study. The second part of this chapter considers the concepts of loss and grief, examining key debates in this area, and the possible implications for women who lose a pregnancy and then embark on another pregnancy in the future.

Chapter 3 (Literature review) reviews the literature of the phenomenon of the experience of pregnancy loss, being pregnant again after such a loss, and the experience of maternity care in that subsequent pregnancy. This takes the form of a narrative review and draws on a broad range of literature.

Chapter 4 (Theoretical perspectives and methodology) introduces hermeneutic phenomenology as the theoretical framework that underpins the research design and approach. The chapter considers the rationale for this choice, and an outline of the ontological and epistemological perspectives specific to this study. An explanation of phenomenology and hermeneutics, as related to the work of Heidegger, leads to the introduction of key Heideggerian concepts that are used to inform the findings from the data. This chapter provides the theoretical foundation for chapter 5.

Chapter 5 (Research design and methods) outlines the research design and methods used in the study. The sampling and data collection processes are discussed, including the use of in-depth phenomenological interviews. The ethical issues considered in the study are outlined, in addition to the analytical framework used to produce the interpretations. Issues of credibility are introduced. Finally, a reflexive account is provided to demonstrate the methodological and procedural rigour in the study.

Chapter 6 (Preview to the findings) introduces the participants. As this is a study of lived experience, this introduction is vital to provide context to the women and the accounts they provide. The chapter also introduces an overview of the key themes presented in the finding’s chapters.

Chapters 7 to 9 (Findings) present the findings of the women's experiences of pregnancy loss, pregnancy after loss, and their experiences of maternity care in that subsequent pregnancy. Chapter 7 presents the women's lived experiences in the context of their past experiences, future dreams, and present realities. Chapter 8 considers their lived experiences under the all-pervading mood of pregnancy loss, that permeates every aspect of their Being-in-the-world. Chapter 9 focuses on the women's lived experiences of maternity care in the pregnancy following loss, with a particular focus on the relationships of care and the systems of care.

Chapter 10 (Discussion and Conclusion) presents the central interpretations from the data and explores the key themes in relation to the literature presented in the literature review. Following on, these interpretations are considered in the context of Heideggerian perspectives, seeking to understand the phenomenon of the women's experiences through this hermeneutic lens. The chapter continues by outlining the perceived strengths and weaknesses of the study. The unique contributions to knowledge of the understanding of the experience of pregnancy loss, pregnancy after loss, and maternity care in a subsequent pregnancy are outlined. Following on, the implications for practice from this research are highlighted, along with recommendations for further research. The chapter concludes with a reflexive account of the impact of conducting this research and the PhD journey.

Chapter 2 - Background context

This chapter is presented in two parts and provides relevant background information to the phenomenon being researched. In the first part, national policy, and reviews for the provision of maternity care in England are considered. The rationale for this is because women who receive maternity care in England do so in the context of a maternity system shaped by national and local policy. As this study focuses on women's maternity care experiences in Lincolnshire, the focus then changes to explore how these policies translate into the provision of maternity services locally in Lincolnshire. This information is important because it provides the political and organisational context in which women's experiences of maternity care occur. The second part of the chapter moves to define and explore the concepts of loss and grief, considering key debates in this area, and providing important information related to possible emotional and psychological disturbances for women as they embark on a further pregnancy following loss.

2.1 National government policy and review, and local provision of NHS maternity services

NHS services in England are undergoing a period of profound change as they adapt to the changing needs of patients in the 21st century. Plans are currently being implemented at both a national and local level to provide cost effective, appropriate services that meet the needs of a diverse population (NHS England, 2019).

As part of these changes, a major review of maternity services was announced in 2015 by NHS England. This was part of the NHS Five Year Forward View agreement (NHS England, 2014). The review published its findings in February 2016.

2.1.1 National maternity review

The report from the review, entitled "Better Births: Improving outcomes of maternity services in England, a five-year forward view for maternity care" (NHS England, 2016) identified seven key priorities that would drive improvement of care for women and their babies. These included personalised care; continuity of carer; better postnatal and perinatal mental health care; a payment system; safer care; multi-professional working; and working across boundaries. These key priorities were designed to provide safer care for women and give them greater control and more choices (NHS England, 2016). The review found that although care and outcomes had improved drastically over the last decade, there was still much to be done, with meaningful differences in care provision identified throughout the country. Improvements in the safety of care could be made that would be instrumental in reducing the number of stillbirths across the country and be beneficial for all women receiving maternity care (NHS England, 2016).

2.1.2 Specialist Bereavement Midwives

High quality bereavement care for parents who have experienced the loss of a baby is vital. It is what makes the difference between making a devastating experience more manageable, as opposed to poor or insensitively managed care exacerbating the emotional pain suffered. An audit by the stillbirth and neonatal death charity (known as Sands) (2017), of bereavement care provision in the UK in 2016 found that the quality of bereavement care provision for women who had lost babies varied widely between trusts but also within trusts (dependent on the staff member delivering the care). The audit found that although there had been an increase in the number of bereavement support midwives employed by trusts since 2010, there were still one third of units that did not have regular access to one. They stated that:

> It is clear that bereavement support midwives play a significant role in both providing and improving bereavement care within maternity units and are a necessity to ensure that all women can receive appropriate care following the death of a baby.
>
> (Sands, 2017, p. 28)

Specialist bereavement midwives have specialist knowledge and training in working with parents whose baby has died (Sands, 2017). There is no nationally recognised job description for the bereavement support midwife role, so the role and resources allocated to that role have been found to vary widely between trusts. However, there is consensus that as a minimum the role should include working with both parents and families of those who have been bereaved, as well as providing training and support for staff who encounter bereaved families. The role is wide ranging and varied and requires the midwife to have specialist knowledge around bereavement and childbirth, as well as in-depth knowledge about local resources and procedures for when a baby dies (Sands, 2015). Therefore, appropriate bereavement care training is crucial in ensuring that the workforce working with bereaved families have all the up-to-date knowledge and skills they need to confidently provide a standard of care that meets the needs of these families (Downe et al, 2013; NHS Improving Quality, 2014; Redshaw et al., 2014). To address some of the variations in training and service provision of bereavement care in the maternity services, a National Bereavement Care Pathway (NBCP) was designed, with the national release of its pathways, resources, and standards for care from October 2018 (NBCP, 2018).

2.1.3 National bereavement care pathway

The national bereavement care pathway for pregnancy and baby loss is a care pathway designed to improve the bereavement care that parents in England receive after a pregnancy or baby loss (NBCP, 2018). Developed in partnership with national government, baby loss charities and local NHS bodies, the pathway provides:

- the provision of documentation for professionals (in the form of flowcharts, templates, and guidance notes)
- a training programme for professionals
- an independent evaluation

(NBCP, 2018, p.1)

Within this pathway, nine care standards are identified that, if implemented fully by maternity units, will act as a guide for staff for what good care for bereaved families should look like. These standards include the appropriate training of all staff; the development of a parent-led bereavement care plan for every woman that will provide “continuity between settings and into any subsequent pregnancies” (NBCP, 2018, p. 2); the provision and accessibility of bereavement care rooms in all hospitals; information about, and access for bereaved parents to emotional support and mental health services if needed; a dedicated named bereavement lead in every healthcare setting where a loss may occur; parents to be offered clear information and support by staff to enable them to make informed decisions in relation to the care of themselves and their babies; all parents are offered the opportunity to make memories; a system is in place to ensure that all professionals who may care for bereaved families are fully aware of the loss that has occurred; and that staff have access to resources and support that will in turn enable them to provide high quality care. This care pathway is the first of its kind in the country, providing guidance for professionals who care for bereaved parents. It is flexible enough to be able to be adapted to the individual needs of each woman, whilst still providing a framework to work to.

2.1.4 Local maternity bereavement care provision in Lincolnshire

Lincolnshire is the second largest county in England. It is a rural county, with pockets of urbanisation, and a poorly developed road system (Better Births, Lincolnshire, 2017). With a population of approximately 751,200, it is served by two NHS hospital trusts. One of the trusts is one of the biggest acute hospital trusts in England, serving a total population of 720,000. There are four hospitals covered by this trust (NHS, 2019). The other trust is much smaller, covering a population of 350,000 over three hospital sites across two different counties (NHS, 2019). Across the two trusts there were approximately 11,119 births in 2016 (Lincolnshire Research Observatory, 2019).

The maternity services in these trusts provide both consultant led, and midwifery led care. The maternity care pathway a woman follows will be dependent on several factors, such as pre-existing medical conditions (for example, diabetes, epilepsy, or a treated mental health condition), and their previous obstetric history (for example, a previous emergency caesarean section or a previous stillbirth). If there are no adverse previous factors, a woman will follow the “low risk” care pathway and can be cared for solely by a team of midwives throughout her pregnancy, labour, and the postnatal period. If there are pre-existing factors, or complications that occur during her pregnancy a woman will follow a “high risk” consultant led care pathway where her care will be shared between a consultant team and a team of midwives.

2.1.5 Better births initiative in Lincolnshire

To implement the findings of the National Maternity Review in Lincolnshire, a maternity transformation team was formed. The team set out to devise a programme that would see the development of innovative new maternity services across the county. In consultation with local parents, providers and commissioners of services, the team work together to bring the services women want and need throughout their pregnancy journey, so that they have access to high quality care and a choice of services most suited to their own individual needs (NHS, 2019).

One of the ways that the team have approached this is through the development of six community hubs across the county. Developed in partnership with the local authority, the hospital trust and voluntary agencies, the hubs offer a range of services, from antenatal and postnatal care, early years development, health visitor input, smoking cessation, general health, and social services. Meeting together in these hubs provides a valuable source of support and friendships for parents who might otherwise not have the opportunity to meet with other parents. Initial feedback from the hubs has been overwhelmingly positive, with increased family engagement at these sites. There are plans to increase the number of hubs across the county in the coming years, as at present access is not available to every pregnant woman in the county. It is dependent on the catchment area that they live in (Better Births, Lincolnshire, 2019).

2.1.6 Specialist bereavement midwives in Lincolnshire

Since the end of 2017, both trusts have employed a specialist bereavement midwife to provide bereavement care and support to women. In addition, these midwives work with midwifery staff and other members of the multidisciplinary team to provide training and advice about bereavement care and support. With no national job description of the role (Sands, 2017), both midwives continue to work to develop their role, dependent on their trusts remit and the needs of women in their care. They both face the challenges of working across multiple sites (different hospitals) in a rural location.

Describing how the service provision offered to bereaved parents before her appointment was totally inadequate, one of these bereavement midwives spoke to me of the changes she made since her appointment in 2017. These have encompassed all aspects of care offered to women, from the development of bespoke information and keepsake packs for parents, to working together with parents and charities to raise money for a bereavement suite at one of the hospitals, to liaising with the mortuary manager and staff at the local crematorium to enable the individual cremation of babies born before 24 weeks gestation, to the setting up of rainbow clinics for women pregnant after a previous pregnancy loss. In addition, she has worked to change the attitudes of staff towards bereavement by providing bespoke training and, in partnership with local baby loss charities hosted the first bereavement conference in the area. Her compassion and enthusiasm for her role has led to her being invited to Westminster to present her work to the All-Party Parliamentary Group on Baby Loss and be involved in the development of the National Bereavement Care Pathway discussed earlier (N. Kerry, personal communication, 12 October 2018).

The Sands audit of bereavement care provision in maternity units in the UK (2017) highlighted the value that is placed by parents on the care provided by specialist bereavement support midwives, “They (bereavement support midwives) are a vital part of the care of bereaved parents, we as a group see the difference in parents that have access to a specialist bereavement midwife to those who don’t” (Hunter et al., 2016, p. 6). Whilst it is early days (at the time of writing) to audit the work of the bereavement midwives at the trusts in Lincolnshire, early indications demonstrate that the work that they have undertaken since their appointment has been a positive step in providing high quality, compassionate care to women and their families who have experienced pregnancy loss.

When thinking about pregnancy loss, it is first useful to consider what is meant by loss, and the effect that is has on us as individuals, as well as the social context in which the loss is experienced.

2.2 What is loss and grief?

In its simplest, everyday form, loss refers to having had something, and then no longer having it, for example, the loss of a job, a home, an item of clothing. Loss, however, becomes much more complex when we have an emotional attachment to the something or someone we have lost. The emotional investment or connection we have in the thing or person we have lost is significant. When this connection is strong, loss can evoke a deeply painful response, utter devastation, emptiness, and a sense of insecurity (Thompson, 2012).

When a person close to us dies, we mourn a past as well as a hoped-for future. We mourn that person, their personality, voice, presence, touch. We have memories of that person and perhaps photos to help us remember. A loss in pregnancy, or shortly after birth is very different. Here we are mourning an individual we have never known, a future, not a past. We are mourning the hopes and dreams we had for that baby, or the possibility of a baby. We are left with what could have been, an imagined future, and not what has been. There are regrets, and a deep, deep sadness (Dahlen, 2017).

It is acknowledged that there are many different kinds of losses relating to reproduction that can have an equally devastating effect on those experiencing them. Earle et al. (2012) use the term ‘Reproductive loss’ to encompass losses not only relating to the ending of a pregnancy/life, such as miscarriage, termination of pregnancy, perinatal and infant death, but also maternal death, infertility, assisted reproduction, high-risk pregnancies, the medicalisation of pregnancies, and the curtailment of reproductive futures and desires. They suggest that to categorise one type of loss as more traumatic or serious than another risks minimising the diversity of experiences and responses that women have to these losses. Experiences of pregnancy loss vary widely, and it is unhelpful therefore to place pregnancy loss in any type of hierarchy.

The picture is further complicated when we consider the multitude of terms used to describe the different types of pregnancy loss. Some of these refer directly to a specific type of loss, for instance, miscarriage or stillbirth, others use a term to group together several different pregnancy losses, for example, reproductive loss and perinatal loss. WHO (2018) define the perinatal period as from 22 completed weeks of pregnancy to seven completed days post-delivery. In addition, the legal terms for classifications of pregnancy loss varies from country to country. For example, in America and Australia the definition of a miscarriage is the ending of a pregnancy before the 20th week (Dahlen, 2017), whereas in the UK the definition is any time before 23 weeks and 6 days (Miscarriage Association, 2018). A stillbirth in America and Australia is a baby born after 20 completed weeks of pregnancy that shows no signs of life at birth, in the UK it is a baby born from 24 weeks onwards showing no signs of life. Although awareness of these distinctions is important in this study, focusing on them too closely detracts from the ontological aims of the work, namely women's lived experiences of pregnancy loss. These pregnancy losses often evoke a grief response.

Grief can be described as an emotional response to loss, yet it is much more than this. It is a response that is multifaceted, encompassing all aspects of our being. When we grieve our whole being is involved. Thompson (2012) highlights these holistic responses by grouping them into four broad categories, a physical response, for example, loss of appetite, nausea; a psychological response such as difficulty in concentrating, remembering, or thinking clearly; a social response, dependent on the social context in which the loss is experienced, and cultural influences; and a spiritual response. This may or may not be a religious response, but it is shaped by the meaning we place on experiences, our view of our place in the world, and our sense of being.

When the loss we are grieving involves a death, the response from the bereaved has been described as the most painful of all human experiences (Stroebe, et al., 2001). Death is the integral final stage of living, the only certain event after birth for all humans (Work, 2013). Yet pregnancy, birth and death are rarely thought about in the same space, so when death occurs before birth, or very shortly after birth, we have no frame of reference to base our experience upon (Dahlen, 2017). This gives rise to questions of existence. How do we grieve in these circumstances? What is natural and expected of us? Is there a right or a wrong way to grieve? These are just a few of the many questions that are raised in these circumstances.

There have been various theoretical frameworks that have attempted to explain how people respond to, and work through grief. Perhaps the most well-known and influential of these frameworks is the stages approach (Kubler-Ross, 1969), where reactions to grief are presented as stages to work through, namely denial, anger, bargaining, depression, and acceptance. Although influential over many years, this approach has been challenged as not being representative of the diversity of people who mourn, and too simplistic in suggesting that people grieve in a linear, stage-by-stage way (Neimeyer, 2000). For this reason, it is misleading to speak of the 'stages' of grieving, as if all mourners follow the same path in their journey from painful separation to personal restoration. In addition, it can be misleading to assume that all people who grieve go through a stage of depression. This risks pathologizing the griever and confusing a natural grief response with a confirmed mental health condition (Schneider, 2006).

Worden's (2009) approach was to develop of a set of tasks to work through when grieving. This approach, like the stages approach, suggests that there is a process to be worked through, by accepting the reality of the loss, working through the pain and grief, adjusting to all aspects of life without the deceased, and emotionally relocating the deceased and moving on with life. It has been suggested that although this enables an understanding of the complexities of grieving, on its own it does not consider the differences in how individuals grieve or the social context in which grieving takes place. Nor does it consider the complexities associated with different types of bereavement, such as when grief becomes complicated or disenfranchised (Thompson, 2012). Disenfranchised grief has been described as "a loss that is not openly acknowledged, socially validated, or publicly mourned" (St. Clair, 2013, p.402). With all pregnancy loss there is a risk that women will experience a grief that is disenfranchised, but this may be more prevalent with certain types of pregnancy loss, for example, abortion, where feelings of loss and grief are not recognised as valid by society (Hazen, 2006; Anunkor, 2016).

The theoretical frameworks discussed above are just two of several frameworks that are considered traditional approaches to understanding our reactions to grief and loss. In addition, there have been several contemporary frameworks devised that attempt to increase our understanding on the same issue but consider it from a very different perspective, moving away from the stage-by-stage, task orientated process. One significant development was by Neimeyer (2001) who developed Meaning Reconstruction Theory as a way of explaining the process of grieving. This theory suggests that when we lose something or someone, we also lose what they or it meant to us. We then have to reconstruct new meaning of a life without that person or thing. Narrative, or storytelling is a key concept with this theory because in effect we are re-writing the next chapters of our life, developing new meaning whilst still retaining a relationship, through memories and rituals, with the person or thing we have lost. Schneider's (2006) theory of transformational grief is a further development in trying to explain the grief process. This theory proposes that although grieving is a difficult and extremely painful process, it does not have to be a purely negative process and often something positive will be borne out a person's grief. For example, the resolution to make the most of every opportunity in life following the death of a loved one in tragic circumstances, or at a young age. These contemporary theories are useful because they recognise the complexities and the dynamic nature of the grief process, as well as the diversity of the grief experience, including when grief does not follow a natural process and instead becomes complicated or disenfranchised.

All grief is complex but can become further complicated when additional factors are involved. These could include when losses are cumulative, when several losses are experienced in quick succession; multiple, with a number of deaths occurring at the same time, such as in a road traffic accident; unexpected, as in a murder, suicide, pregnancy loss; or stigmatized, where there is no social recognition or validation of the loss experienced, such as in a miscarriage, voluntary termination of pregnancy or ectopic pregnancy. In addition, issues such as the nature of the loss, for example, where trauma is involved; the reaction to the loss, where the loss is not socially recognised and the bereaved struggle to make meaning of their grief due to the nature of the loss; the characteristics of the griever due to previous experiences of loss, mental health issues or learning disabilities, and the strength and reliability of their social support networks should all be taken into account when distinguishing between ordinary grief and complicated grief (Thompson, 2012). Recognising that the phenomenon of loss and grief is far broader than death and bereavement is important if we are to avoid oversimplifying the devastating impact it can have on us as individuals and society. Grief reactions to a pregnancy loss can therefore be far more complex than individuals or society realise. This complexity, especially when the validity of the loss is not acknowledged or recognised can have long-term consequences for women and their families.

This chapter has provided an overview of national and local policy in relation to maternity care provision in Lincolnshire. This knowledge provides a brief outline of the context into which women within the county who are pregnant after loss enter the maternity system, and the support that may be available to them. Following on, the focus of the chapter shifted to consider the concepts of loss and grief, and how women after a pregnancy loss may experience these concepts that will affect every aspect of their day-to-day life.

The following chapter is the literature review that was carried out to establish what is currently known about women's experiences of pregnancy loss, pregnancy after loss, and experiences of maternity care in that pregnancy after the loss.

Chapter 3 - A narrative literature review of women's experiences of pregnancy loss, pregnancy after loss, and maternity care in a subsequent pregnancy after loss.

3.1 Aims of the review.

Based on the aims of this current research (see Chapter 1, section 1.1 above), this narrative literature review seeks to explore the phenomenon of women's lived experiences of maternity care in a pregnancy after a previous pregnancy loss. The rationale for the selection of this topic was that whilst there appears to be an abundance of literature that focuses on the medical and clinical causes of pregnancy loss (see for example, Heazell et al., 2015; Chojenta et al., 2014) there is a scarcity of literature that explores the phenomenon of women's experiences of maternity care in a pregnancy after loss. In reviewing the literature on this topic, the review will also include women's experiences of pregnancy loss, and pregnancy after loss. The rationale for doing this is that experiences of maternity care in a pregnancy after loss cannot be understood in isolation but can only be understood in the context of the woman's experience of pregnancy loss, and the experience of being pregnant in a following pregnancy. In other words, as these experiences are intrinsically linked, they cannot be considered as separate from each other.

The aim of this review then, was to identify, collate and evaluate the scope of evidence available. Specific objectives were to:

- Identify the extent, range and nature of the studies identified on the subject.
- Explore the reported impact that the care received by these women had on their health and well-being.
- Identify any gaps in the evidence identified for review.

A narrative approach to this review was chosen as being the most appropriate for this study. Bryman (2016) suggests that the intent of a narrative review is to provide a broad overview of literature in the field of study through a comprehensive assessment and critical interpretation of the literature identified. Such a review in this study has two purposes. Firstly, to provide an account of what is already known on the topic, and secondly, to provide justification for the undertaking of this research. Although a narrative approach was deemed the most appropriate in this review, it was felt that there was still the need to be focused and systematic in the way that the review was undertaken, to demonstrate a clear and comprehensive process. Thus, some procedures associated with systematic literature reviews were incorporated in this review. These included transparency about the literature search, and the process for the selection of literature included (see section 3.2 below). However, no formal framework (such as that proposed by Bryman (2016, p. 104) or Booth et al, (2016, p.147)) for the assessment of the quality of the selected literature was adopted. Initially this was because of the scarcity of literature available on women's experiences of maternity care in pregnancy after loss. Assessing for quality in this instance risked further diminishing an already scant field of research. Then, to achieve consistency, the decision was taken to extend this across the whole of the review.

The literature review is organised into three sections. The first section considers the experience of pregnancy loss, and the unique type of loss and grief that is experienced because of that loss. The theme of disenfranchised grief is introduced in the literature, with several studies exploring the effect of this grief on women's everyday life. Consideration is given to the effect of the pregnancy loss on the women's significant others, such as partners, siblings of the lost baby, and parents. This effect will, by association, be influential in how the women view their present reality. The final part of this section reviews literature that considers societal attitudes around these types of losses, and the support mechanisms that are available for women. The second section turns to the experience of pregnancy after loss from two different loss perspectives, that of miscarriage and stillbirth. The psychosocial impact of pregnancy after miscarriage is examined, with a focus on changes to women's psychological and emotional health, and the strategies employed to enable women to navigate the current pregnancy. For women pregnant after a previous stillbirth, consideration is given to the potential benefits of being labelled high-risk in the current pregnancy, the factors affecting couples' decisions of when to try for a subsequent pregnancy, and women's concerns and expectations for the current pregnancy. In the final section of the review, attention turns firstly to consider women's experiences of maternity care in a pregnancy following a stillbirth, from a UK perspective and then an international perspective. The research reviewed here reveals an assortment of experiences of care, with a disturbing number of women reporting dissatisfaction with the care that they received in these subsequent pregnancies. Following on, we focus on specific interventions that are offered to some women who are pregnant after loss, firstly from a classified 'high-risk' pregnancy perspective, and then from a perspective where no classification of risk is given. The review concludes with a drawing together of the pertinent points raised, and a justification for why this present study is needed to add to and expand the small amount of research that is available on women's experiences of maternity care in a pregnancy after loss.

3.2 The literature review process

The literature review was an iterative process that occurred across the main stages of the study. At the beginning of the research, an informal, broad review was undertaken to find literature of women's experiences of maternity care after a previous pregnancy loss to examine what was available on the topic. For this search I used the databases that were available to me at the time, namely Worldcat and Proquest. Those early, informal searches were unsuccessful in uncovering any literature that was specifically on the topic, although there was a large body of research about women's experiences of pregnancy loss, and pregnancy after loss, some of which has been included in this review. When reviewing these articles and academic books, some of them were found to include sections that outlined the women's experiences of maternity care in a pregnancy loss even though that was not the main focus of the article.

As the design of the research became more focused, the search for literature for this review commenced. The information gained from the initial search mentioned above had helped in the refining of the topic and the objective of the proposed review, which was broadened to include women's experiences of pregnancy loss and pregnancy after loss, as well as the maternity care received in that pregnancy. The main part of the search and review was conducted between June 2017 and April 2018, which was when data collection commenced. The review was then revisited later in the study to ensure that no relevant literature had been missed.

Booth et al. (2016, p.308) define a literature search as "the process of identifying published or non-published items for inclusion within a review output using either database subject-based techniques or supplementary techniques such as hand searching, follow up of references and citation searches". The emphasis is on using a range of resources and techniques to enable the search to be as comprehensive as possible whilst still focusing on the central research question. With this in mind, a search strategy was devised that included a search of electronic databases; reference lists; an author search; handsearching of key journals; and use of existing networks, relevant organisations, and conferences.

The first stage of this search was a classic bibliographic and abstract search across several key databases. These were chosen based on their accessibility, relevance to the discipline, recommendations from colleagues familiar with the type of search being undertaken, and those that were assumed would yield relevant results. A total of eleven databases were initially chosen, namely, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Maternity and Infant Care Database (Midirs), PsychInfo, Medline, PubMed, Allied and Complementary Medicine Database (AMED), Social Sciences Citation Index, Scopus, Applied Social Sciences Index and Abstracts (ASSIA), Science Direct, and Worldcat.

A comprehensive approach to the searches began by identifying keywords, concepts, and synonyms relevant to the central research question. These were then further developed by consulting a thesaurus, considering variations in spelling and in consultation with colleagues and peers who were familiar with the subject area. The keywords used in the searches reflected the variety of terminology used to describe different types of pregnancy loss, for example, 'pregnancy loss', 'perinatal loss', reproductive loss', 'abortion', 'elective abortion', 'medical termination' (see table 2 below). The "Boolean operator" OR was used at each stage of the process to broaden the search, whilst AND was used to narrow the search down when needed. A total of 20 searches were conducted on each of the identified databases.

Table 2

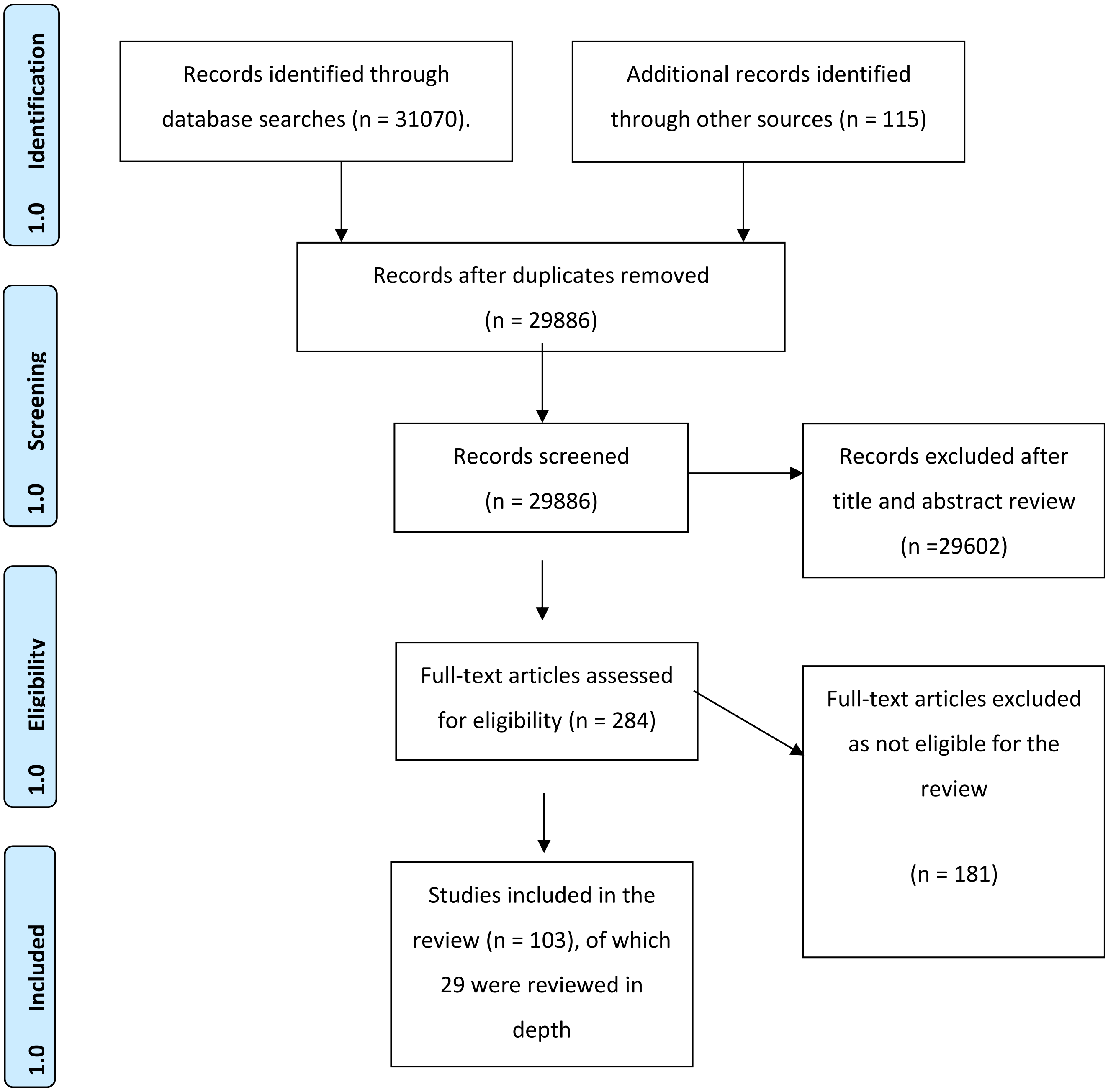
Identifying key terms and synonyms using PICO (Qualitative version)

	Population	**Issue**	**Context**	**Outcome**
PICO Term	Pregnancy	Pregnancy loss	Maternity care	Experience
Alternative terms **(Synonyms)**	Pregnant women Pregnant mothers' Pregnant mums Pregnant teenagers	Reproductive loss Perinatal loss Miscarriage Stillbirth Ectopic pregnancy Elective abortion Elective termination Medical abortion Medical termination Neonatal death	Midwifery care Care Maternity services Midwifery services	Feelings Thoughts Perceptions Needs Expectations

The initial database searches generated a vast amount of literature, in part, due to the search terms not being specific enough, for example, there were a significant number of studies identified that related to pregnancy loss in various species of animals. In addition, there were many studies that related to the physical/medical aspects of pregnancy loss, not the lived experiences of the women. All these studies were able to be excluded either by the title alone, or by reviewing the abstract. The remaining studies from each database were selected for a full text review. These papers' citations and reference lists were then scrutinized, to uncover any additional publications with any new studies being added for full text review. Finally, a search of the websites of relevant organisations was also undertaken with the aim to generate further information and enhance existing knowledge on the topic area. These organisations included the King's fund, SANDS (Stillbirth and Neonatal Death Charity), Tommy's, Bliss, and The Miscarriage Association. An excel spreadsheet was utilised to record the results of the different searches. Figure 1 provides an overview of the search and selection process.

Figure 1

Flowchart of the search and selection process, (adapted from "Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA statement", by Moher et al., 2009, Plos Medicine, 6, p. e1000097).



3.3 The lived experience of pregnancy loss

When a woman loses a baby, the ripples of that loss are felt far and wide, impacting significantly on her, her partner, family, friends, community, and society as a whole (Dahlen, 2017). There is a physical, psychological, social, and financial impact that affects many people. For the woman there are many challenges to face as she navigates life in the face of the unimagined. The loss of a baby is an unexpected and devastating life event, that changes life forever as they know it (Lalor, 2018; Ockhuijsen et al., 2013; Brier, 2008; Ellis et al., 2016). In the aftermath, women describe a myriad of emotions that encompass them, from an overwhelming shock, numbness, and disbelief (Peel, 2010), to indescribable anguish and grief (Brier, 2008), guilt and blame (Adolfsson, 2010; Deas, 2017), despair, irrational thoughts, depression (Gaudet, 2010; Robson et al., 2010), and, in some cases, symptoms of post-traumatic stress disorder (Daugirdaite et al., 2015).

There exist many comprehensive reviews of psychological and psychosocial factors in relation to the pregnancy loss experience (Brier, 2008; Kersting, & Wagner, 2012; Jones et al., 2015; Daugirdaite et al., 2015; Burden et al., 2016; Deas, 2017). Overwhelmingly the psychological and psychosocial literature from both empirical studies and reviews acknowledge that the experience of pregnancy loss is a traumatic event that poses a threat to life, health, and emotional well-being (Krosch & Shakespeare-Finch, 2017; Mulvihill & Walsh, 2014; Fenech & Thomson, 2014), with the first threat being engulfed by a unique type of grief.

3.3.1 A unique type of loss and grief

A pregnancy loss has distinct differences to other types of loss. A pregnancy loss signifies the loss of an imagined future, of hopes and dreams, loss of a role, of memories to be made (Ockhuijsen et al., 2013; Adolffson, 2010). It is a unique type of loss that is difficult to understand, to articulate, to make meaning from, possibly since whilst for the mother there is an interdependence between her and the baby, the same is not true for others, with an incongruence between their experience and that of the mother (Cacciatore, 2010). As a result, much is left unspoken, leading to a social awkwardness around this type of loss. For some, this is because they have never been exposed to this type of loss before and therefore struggle to know what to say or how to behave. Others may have a very different view of the type of loss from the one who has experienced it. Whatever the reason, the result is that no-one speaks openly (with family, friends, acquaintances) about the loss (Brier, 2008; Adolfsson,2010), with it becoming 'the elephant in the room' that everyone sees but nobody talks about. These social taboos, stigma and silences are significant sources of distress and contribute to experiences of isolation for women who have experienced a pregnancy loss (Armstrong et al., 2009).

Whilst the literature points to the fact that experiences of stigmatization are present with pregnancy loss of any gestation (Burden et al., 2016), it is often in early gestational losses where this is most prevalent (Brier, 2008; Peel, 2010; Adolfsson, 2010). For women who have an early miscarriage, ectopic pregnancy, or elective termination this is especially true. Often the focus with these losses is on the social validity of the loss (Peel, 2010), the viability of the pregnancy, the life-threatening situation the woman has just experienced (Gergett & Gillen, 2014), the perceived "choice" a woman has made to terminate her pregnancy, and not the loss of a baby and a future with that baby (Daugirdaite et al. 2015). Women who have an early miscarriage may not have announced the pregnancy to family and friends and are then faced with the dilemma of whether to speak of their pregnancy and loss or remain silent. Whichever decision is taken, it is likely that they will experience feelings of isolation and exclusion, "the emotional suppression, the unacceptability of grief for the loss" (Peel & Cain, 2012, p.87). Unlike women who have a later loss (stillbirth, neonatal death), women with early losses are rarely afforded the outward expression of grief – a funeral, photos, footprints, that provide some comfort and have been shown to have a beneficial effect on the grieving process (Bremborg, 2012; Earle et al., 2008; Layne, 2012; Woodthorpe, 2012). For these women, guilt is often the over-riding emotion. They do not feel that they are entitled to grieve, that their loss does not afford them the right. This feeling is often perpetuated by family, friends, and health professionals. Thus, an early loss is not afforded the same level of social or medical recognition as a stillbirth or neonatal death. There is an incongruence between the grieving mother’s experience and the social responses she receives. Her grief is not acknowledged, and as a result may become disenfranchised, forcing her to rely on her own resources to navigate that grief.

Lang et al. (2011) suggest that the experience of disenfranchised grief was noted to be linked to experiential and relational factors, namely relationships with spouses, health professionals, family, and the extended community. Differences in the grieving processes of individuals within the couple relationship, coupled with a confusion of how to grieve such an ambiguous loss were highlighted as a significant factor in increasing tension in the relationships and thus limiting the amount of support they could offer each other. In addition, Lang et al. (2011) found that the couples perceived that there was little or no support available from the health professionals caring for them, with the health professionals being experienced as minimizing the significance of the loss and de-personalizing them and their lost baby. Insensitive words and behaviours added to the couple’s experiences of disenfranchisement and the feeling that their loss was of little importance. Significantly, Lang et al found that this experience was extended to the couple’s family and wider social network, who were perceived as lacking understanding of the enormity of the loss, through a failure to acknowledge the loss for what it was, or mark important dates such as the baby’s birthday, expected due date or date of the pregnancy loss. The findings from Lang et als. (2011) study illustrate how issues of ambiguity and disenfranchisement contributed to the suffering and the mourning experience of couples bereaved by perinatal loss. It also, in part, demonstrates the link between the quality and amount of social support available and the level and intensity of the grief experience.

Whilst there is agreement in the literature that many women’s lives are directly impacted by grief following a miscarriage, there is no clear consensus on the intensity and duration of grief. Reports of the duration of grief following miscarriage in the literature have varied widely from between six months (Swanson et al., 2007) to up to

12 months or even years (Tseng et al., 2017; Rosenberg, 2012; Bennett et al., 2012). Brier's (2008) literature review argues that this was due to a lack of a clear definition of grief, in addition to varying time intervals, formats, and measures used in the studies reviewed. Collectively this contributed to a wide variation of the grief reactions reported.

There is some suggestion that for certain types of pregnancy loss, or in distinct populations, the grief response is heightened and the stigmatization experienced is much greater than in others (Peel & Cain, 2012; Kersting et al., 2012). For example, in the literature reviewed thus far, it has not been possible to discern the sexuality of the women in the studies. Peel (2010) suggests that for women who identify as lesbians, the phenomenon of grief after miscarriage becomes much more complex. Lesbian couples' attempts to conceive are very different to heterosexual couples, and have been classed as 'artificial', even if medical intervention is not sought (Peel & Cain, 2012). As the route to conception is often a long process that is meticulously planned for by lesbian couples, Peel suggests that much more is invested in a pregnancy, and that experiences of miscarriages are intertwined with the journey taken to achieve conception. As a result, Peel argues that an experience of pregnancy loss is amplified in this community, with grief responses reported in 81% of participants. Comparisons could be drawn between the experiences of non-heterosexual couples' challenges when trying to conceive and those of heterosexual couples with fertility issues, a point which Peel acknowledges in her research, recommending that further comparative research is undertaken to examine the pregnancy loss experiences of these two groups. Considering the examples of literature reviewed, it is highly probable that most women will experience some sort of grief reaction after a pregnancy loss, and that when that grief is not acknowledged as present or valid this can lead to complications due to the disenfranchisement of the experience.

It is now recognised that for some women, a pregnancy loss will elicit a pathological response in the form meeting the diagnostic thresholds for post-traumatic stress disorder (PTSD), anxiety and depression (Koopmans et al., 2013). Childbirth has been listed in the Diagnostic and Statistical Manual of mental disorders as a recognised cause of PTSD since 1994 (American Psychiatric Association, 1994). PTSD is defined as comprising of four clusters of symptoms that occur as a result of an exposure to trauma that poses a significant threat to the physical, emotional, or psychological safety not only of the victim, but also to loved ones, family, and friends. The clusters of symptoms include intrusive and recurrent memories of the trauma, avoidance of anything that may trigger a further trauma, numbing or negative changes in moods or thoughts involved in the trauma, and changes in reactivity and arousal (APA, 2013). These symptoms vary in intensity and are expected to diminish (although there are times when this is not the case) over time (NICE, 2018). In relation to pregnancy loss and PTSD, factors identified that influenced development and duration of symptoms included the gestation of the loss (Daugirdaite et al., 2015), the type of loss (Kersting & Wagner, 2012), and sociodemographic variables such as age, poverty, educational attainment, poor housing, and race (Daugirdaite et al., 2015). Whilst acknowledging that all types of pregnancy loss could lead to a diagnosis of PTSD, a study by Kersting et al. (2007) suggested that PTSD symptoms may be more prevalent in a subset of parents, who had a termination of pregnancy for fetal abnormalities (TOPFA). They found that at 14 months post loss 17% of women in the study had been diagnosed with a psychiatric disorder. It is, however, problematic to ascertain the exact prevalence of women who report or are diagnosed with PTSD symptoms, in part due to different combinations of pregnancy loss used in the studies which makes extraction of relevant data difficult. Krosch & Shakespeare-Finch's study (2017) into grief, traumatic stress and posttraumatic growth in women who had experienced pregnancy loss (defined in the study as miscarriage and stillbirth) found that high to moderate levels of posttraumatic stress symptoms (indicating higher than the recognised clinical cut-offs) in nearly 50% of their participants were reported. This figure was noted as significant due to the time lapse between the loss and participation in the study, which was just over 4 years. As mentioned, although a clear comparison of figures from these studies is not possible, what these results do is alert us to the fact that an appreciable number of women who have experienced pregnancy loss will also suffer symptoms of PTSD, anxiety and depression that can be long lasting. Of significance is the fact that, as up to 50% of women will conceive again within a year of their loss (Franche, 2001), these symptoms will therefore often still be present when a further pregnancy is embarked upon. Psychological distress in pregnancy is known to have an adverse effect on both the woman and the unborn baby, with outcomes such as preterm birth and low birthweight infants (Mills et al., 2016).

The literature has shown, thus far, how the experience of a pregnancy loss can have an adverse and long-lasting effect on every aspect of a woman's life. The sudden and unexpected loss and subsequent grief reactions highlight the emotional and psychological severity of this all too frequent event. Yet, considering what we now know about the impact of a pregnancy loss for women, the fact remains that these types of losses are frequently ignored and stigmatised, resulting in women becoming increasingly isolated in their grief, left to manage their emotions alone. For some women, living with grief that is ignored and disenfranchised, can result in a pathologizing that leads to a PTSD diagnosis, the symptoms of which can continue into any subsequent pregnancy and beyond.

Whilst it is the woman who suffers the physical loss of the pregnancy, and subsequent experiences described above, the ripple effects of a pregnancy loss reverberate through and across relationships with those close to her.

3.3.2 The ripple effect of pregnancy loss on relationships

The devastating effects of pregnancy loss are not only present for the individual mother, but also have a significant impact on those around her. There can be tensions and challenges within the intimate partner relationship as couples struggle with the enormity of their loss. The loss of the parental role is also experienced by the intimate partner but is minimalised by societal expectations that the intimate partner should be there to support the mother. This can leave them feeling marginalised and excluded (Rinehart & Kiselica, 2010; Kersting & Wagner, 2012). Male partners may feel a need to appear strong and supportive, and often use keeping busy as a way of combatting the grief that may overwhelm them. As a result, grieving styles can appear incongruent between a man and a woman, with men being reported as being less open in their grief and appearing to ‘move on’ much quicker than their partners (Kelley & Trinidad, 2012). These differences can increase tension and conflict in a relationship, with up to 40% of relationships being reported as breaking down after a stillbirth, compared to relationships where no loss had occurred (Gold et al., 2010).

When considering the help and support available to men following a miscarriage, it was found that the responses noted in men in relation to miscarriage were the same as those noted in other types of pregnancy loss, for example, stillbirth, sudden infant death syndrome (SIDS), and neonatal death, with most men expecting that their partners pregnancy would be straightforward with no complications (Rinehart & Kiselica, 2010). There was no anticipation that a loss may occur, so that when it did men reported being shocked and surprised. The sense of loss felt was found to be heightened if the couple had announced the pregnancy to their family and friends, and if an ultrasound scan had been performed as this has been shown to begin the bonding process with the unborn for both the mother and the father (McCreight, 2004; Renner et al., 2000; Rich, 2000; Serrano & Lima, 2006). In their review of the literature, Rinehart and Kiselica (2010) found that men grieve as intensely as women following a pregnancy loss but less openly, with some men resorting to harmful avoidance measures in an attempt to keep busy and distracted. Men were often overlooked and marginalised by family, friend and health professionals as the focus was on the mother. They concluded that it was imperative that health professionals included fathers, and not dismiss them when caring for women who have experienced a pregnancy loss to negate the risk of prolonged disenfranchised grief for the men and potential conflict for the couple. The findings from this review raise an important point, that is often overlooked in western society, where it is expected that men will be the ‘strong’ one in the relationship, there to provide both practical and emotional support for their partner. For some men, the pressure to conform to this expectation, can have unforeseen consequences for their own emotional health, which, by association, can also have repercussions for the woman.

As well as having a devasting effect on the couple, there is a substantial body of literature that explores the implications that pregnancy loss has on the extended family including grandparents, siblings, and unborn siblings. Such research is relevant to the present study because it adds to the awareness of the lived experience of pregnancy loss for women, and the changed relationships with extended family and friends. The literature shows that the ripple effects of pregnancy loss on the extended family can have direct consequences for the bereaved parents (Roose & Blanford, 2011). For example, if the relationship between the bereaved couple and their parents is strong, the prospective grandparents can be a source of strength and understanding for their adult children. However, where there is conflict, or perceived distance, the bereaved parents can experience tension and a lack of support. O'Leary et als. (2011) empirical study considered bereaved parents' perceptions of grandparents' reactions both when there was the pregnancy loss and during a subsequent pregnancy. Using secondary data from two phenomenological studies that investigated bereaved parents' experiences during their loss and subsequent pregnancy, they found that some families were able to share their grief and support each other in a constructive manner, whilst for others, where there was already pre-existing tension, the intergenerational relationship was fractured and, in some cases, irretrievably broken. They suggested that differing approaches to acknowledging the significance of the loss and being non-judgemental in allowing the bereaved parents space to grieve in their own way can be instrumental in changed intergenerational relationships that can be strengthened or weakened as a result (Murphy, 2012; O'Leary et al., 2011). Other literature that focused on grandparents' grief following the loss of a grandchild suggests that grandparents' experience a 'double pain', where they not only grieve the loss of their grandchild, but at the same time also experience pain associated with their own child's grief (Reed, 2000; Nehari et al., 2007). The challenges for the grandparents managing this 'double pain' could have a potential negative impact on the woman, by leading to increased feelings of isolation in her grieving due to the emotional unavailability of those around her who she would look to for support.

Gilrane-McGarry and O'Grady (2011) in an earlier study also reported on the grandparent's experiences of 'double pain' but proposed that the pain was better understood as 'cumulative pain'. Their research sought to explore the grief experiences of bereaved grandparents. The components of the cumulative pain identified in the study include pain from previous bereavements; pain from the loss of the grandchild; the pain of witnessing their child's grief; the pain of witnessing any subsequent negative changes (loss of confidence, withdrawal) in their adult child, and pain that is common to all grief. Although the findings from this study do not focus specifically on grandparents bereaved by pregnancy loss, they do present evidence to suggest that grandparents' grief experiences following the loss of a grandchild are far more intense and significant than is recognised by society (Gilrane-McGarry & O'Grady, 2011). This has notable implications for both the bereaved parents and grandparents, in that for all parties their experiences of the loss may negatively affect their resilience and coping ability, which in turn may compromise their ability to offer reciprocal support.

For surviving siblings, and siblings born after a pregnancy loss, the literature reveals that there are both similar and different challenges to face (Warland et al., 2011; Ustundag-Budak et al., 2015; Kempson & Murdock, 2010). Similar to the findings by Gilrane- McGarry & O'Grady (2011), Reed (2000), and Nehari et al. (2007) on the cumulative, or double loss experienced by grandparents, Malkinson & Bar-Tur (2005) suggest that there is a double loss for siblings, who have not only to deal with the loss of a longed for brother or sister, but also have to navigate a grieving parent who may have reduced parenting capacity for the surviving children following the loss. Significant themes identified from the literature on sibling responses to a pregnancy loss include the psychological implications of upholding and guarding the continuing bond to the lost baby, initiated by parents originally, but expected to be carried forward in family life (Kempson & Murdock, 2010; Grout & Romanoff, 2000); the challenges of being parented by parents who are grieving and may be absent both physically and/or emotionally (Warland et al., 2011; Ustundag-Budak et al., 2015); and the controversy of whether parenting styles after pregnancy loss contribute to increased psychopathology and disorganised attachment styles in the surviving siblings (Hughes et al., 2001; Reid, 2007; O'Leary & Thorwick, 2008).

What is evident from the research reviewed in this section, is that the ripples of a pregnancy loss are felt deeply, not only by the woman, but by significant family members surrounding her. This has important implications, not only for all health professionals, but also for all those within society who have contact with women and their families after a pregnancy loss.

3.3.3 Societal attitudes and support mechanisms

Historically, in the western world, pregnancy loss was considered neither a significant loss nor a sad part of a family's history (O'Leary et al., 2006). As a result, it became a silent loss, not to be spoken about and shrouded in secrecy (Hazen, 2006). Societal expectations were that parents should move on, forget about it, and have another baby to replace the one that was lost. Women who had delivered babies who were stillborn were not allowed to see or touch them, with the babies being removed straight away by the hospital staff. Although much has changed in the last 50 years, from the accounts in the relevant literature it can be argued that some of the taboos and stigma that surround pregnancy loss remain (Murphy, 2012; Caccciatore, 2010; O'Leary et al., 2006; Bellhouse et al., 2018; Gold et al., 2011).

The literature shows that although these taboos remain to a certain extent for all pregnancy losses, they are particularly apparent after a miscarriage or early pregnancy loss such as ectopic pregnancy or elective early abortion. Support for the women who experience these types of losses has been reported as being sporadic. Bellhouse et als. (2018) research found that women in their study experienced a combination of both positive and negative social support from both their immediate families and their wider social network. The positive interactions were deemed to be beneficial when both practical and emotional support was offered, such as friends helping through providing meals or childcare for older siblings. Emotional support from women who had experienced miscarriage themselves was found to be particularly understanding and supportive, a shared allegiance in their loss that enabled sharing not always possible with others in their support network. In contrast, a significant number of women in the study perceived some of the support they received as negative. Often this was due to untimely, insensitive comments made by family, friends, or the wider social circle such as work colleagues and health professionals. This could be anything from a dismissal for the validity of the pregnancy, insensitive comments to try again, or that it was meant to be, to blame for lifestyle choices and awkwardness around communication because of not knowing what to say or how to approach the subject. Collectively, these instances were seen to contribute to women's feeling of isolation in their loss.

Similar findings were found in an earlier study by Rowlands & Lee (2010), suggesting that these are long standing societal attitudes that can contribute to the occurrence of disenfranchisement and isolation for women after an early pregnancy loss. In addition, Rowlands & Lee's (2010) study found that whilst some aspects of maternity care following these types of losses was supportive and sensitive, the women in the study felt that the medical management of the miscarriage was unsatisfactory, with instances of a lack of information, insensitive comments, and a lack of empathy from the care providers being cited as contributing to their distress at the time of their loss. The findings of these two studies demonstrate that women's interactions with other people at the time and after their miscarriage were pivotal to their miscarriage journey. Acknowledgement of the significance of the loss has been identified as an important aspect for coping with miscarriage. For some women, this acknowledgment included formal and informal memorialization rituals to allow them to grieve and receive public recognition for their loss (Rowlands & Lee, 2010; Bremborg, 2012).

In early pregnancy loss these rituals include finding comfort in naming the lost baby, lighting a candle, planting a tree or shrub in their garden as a memorial to their lost child (Woodthorpe, 2012). In later pregnancy losses these rituals include having photos taken of the baby as well as hand and footprints (Bremborg, 2012). With the development of cold cuddle cots (these are refrigerated cots that allow stillborn babies to stay with their parents instead of being taken straight to the morgue), some families even take the baby home for a few days before the funeral to spend time making memories together (Layne, 2012; Earle et al., 2008). Whilst these rituals afford some comfort to women, western cultural expectations are that they are time limited. Women are only expected to grieve for a certain amount of time before they are expected to move on, return to normal, and seek closure. The reality is that whilst those around them move on with their own lives, the women are unable to do so. They are no longer dwelling in the same temporal space as those around them. This is often the time when alternative support is sought (Bremborg, 2012; Gold et al., 2016; Gold et al., 2012).

In the UK, this alternative support often was, and is provided by several non-profit organisations and charities, for example, Stillbirth and Neonatal Death charity (SANDS), The Miscarriage Association, Tommy's. There is literature that shows that support groups such as these were, and are, a valuable lifeline for women bereaved by such losses, providing a structured and safe environment where their experiences of loss can be acknowledged and shared (Cacciatore, 2007), although Koopmans et al (2013) cautions that more research is needed into the potential benefits of these groups, and they may not be suitable for all grieving mothers. Women traditionally heard about the work of these organisations through word of mouth from health professionals, families, and friends, or through advertisements in newspapers and magazines. Developed to address concerns about the prevalence of different types of pregnancy loss, and to bring women together who had been touched by these losses these organisations provide (and continue to provide) a supportive arena for women and their families. Through face-to-face support groups in different geographical locations, these organisations offer valuable sources of support. Access to these groups was, and is, dependent on living in the geographical area where they met, which meant that for some women who did not live in these locations were excluded from these groups. The development of the internet meant that these organisations, and other groups that offer a similar type of service, were now able to reach many more women.

In contemporary society, internet usage for many people is a way of life (Bremborg, 2012). It has revolutionised the way that we communicate and has opened up the possibility of instant access to likeminded people from all over the world (Hill, 2015). One aspect of internet usage has been the evolution of online communities for a whole host of different groups. These groups have one thing in common, in that they are virtual online communities that share a similar interest. People in these groups can share information, experiences, offer support, guidance, and advice virtually wherever they are. These online groups are highly valued and regularly used, especially by groups where losses are highly stigmatized, such as stillbirth and suicide (Gold et al., 2016: Chinn, 2015).

To ascertain how beneficial the use of internet groups were to women who had experienced a miscarriage and/or stillbirth, Gold et al. (2012) conducted an international study to examine the usage and benefits of belonging to such groups. Their findings suggest that women overwhelmingly experienced comfort and solidarity through belonging to a group with other women who were united in their grief and loss. A sense of community was strongly felt through engagement with others with similar stories, which led to the development of supportive relationships both within and outside the group. In addition, membership of the group enabled grief and speaking of the lost baby to be normalized and encouraged as part of the healing process. In other words, membership brought a sense of safety and validation of their experiences. Ease of access and convenience were frequently cited benefits of group membership, as was the choice to remain anonymous (or not). The cathartic effect of writing down their stories, making it easier to communicate deep emotions, was perceived as being especially beneficial as it enabled open communication without the risk of being seen to break down in public. Finally, sharing stories afforded the women hope that they would survive their grief and in time be able to have another baby.

On the surface, these findings suggest that there are many benefits that belonging to an internet community can provide. However, it is worth considering that women who access these groups are not necessarily representative of the population in question.

Gold et al. (2012) themselves noted that large sections of the perinatal loss community were notably missing from the groups, for example, African American women were noted to be underrepresented in the online communities, despite them being at a higher risk of stillbirth. It also needs to be acknowledged that not all bereaved parents find the internet to be beneficial in expressing their grief with some, particularly from different cultural backgrounds, finding comfort through more traditional ways of grieving, for example, through religious rituals or seeking support through religious organisations. However, notwithstanding the limitations to the study, these results suggest that some women do find solitude and support following a loss that they are not able to access in traditional ways. Positive social support, whichever way it is accessed, is pivotal to improving psychological and emotional health before a subsequent pregnancy is considered.

3.4 The lived experience of pregnancy after a pregnancy loss

3.4.1 Emotional anxiety and maternal vulnerability

One of the largest areas of research into women who have become pregnant after loss has described how women experience a myriad of intense conflicting and competing emotions (DeBackere et al., 2008; Hunter et al., 2016; Andersson et al., 2012). Some of these women will be still grieving their previous loss and feel conflicted between celebrating the new pregnancy whilst mourning and maintaining their continuing bonds to the lost one. The literature demonstrates that these intense, conflicting emotions, are revealed in different ways. For this group of women, the joy of a new pregnancy is often overshadowed by the anxiety and fear of loss happening again (O'Leary, 2014). The difficulties these women face include delaying bonding to the unborn child (Gaudet, 2010); delaying seeking care and announcing the pregnancy (Lamb, 2002; Ockhuijsen et al., 2014); an internal 'denying' of the pregnancy until it is impossible to do so (O'Leary, 2009) and showing no interest in preparing for the birth by avoiding purchasing equipment and clothing (Cote-Arsenault & Donato, 2011). These strategies are seen as a way to cope with the anxiety, uncertainty, and sense of vulnerability that the subsequent pregnancy brings. Whilst being helpful to the mother, these strategies can have an adverse effect on the unborn fetus and new-born, including preterm birth, low birth weight, adverse attachment issues (Bowlby, 1989), deficits in cognitive-linguistic functioning of the child, and an increase in negative behaviour (Kinsey et al., 2015; Meredith et al., 2017).

In a subsequent pregnancy, the innocence of which the previous pregnancy was embarked upon is now gone. Women now know that a pregnancy does not always equal a live baby (Moore & Cote-Arsenault, 2018). There is a distrust in their bodies to nurture and maintain a pregnancy, with the resultant fear that there will be a recurrence and a further pregnancy loss (Meredith et al., 2017; Meaney et al., 2016). Attempting to manage their emotions, some women try to emotionally distance themselves from their pregnancy, whilst at the same time focusing intently on their pregnancy symptoms (morning sickness, breast tenderness) as an indicator that the pregnancy is viable and continuing. In addition, they will continually seek confirmation from health professionals that all is well through seeking reliable advice and accessing additional screening. Yet this too can have a psychological cost, as for some women it was through the screening process that their previous loss was discovered (O' Leary, 2005). Heavy reliance on social support from family and friends is common, as is seeking support from health professionals (although this is not often perceived as satisfactory). The conflicting feelings experienced in the subsequent pregnancy are often heightened at significant milestones, for example, in the days and weeks leading up to the gestation of the previous loss, the anniversary of the loss, and during labour and the early postnatal period (Andersson et al., 2012).

For women who experienced a previous miscarriage, they may still be struggling with the enormity of their loss when they become pregnant again. There may have been few physical markers to indicate that a pregnancy and a loss had occurred, especially if it was a first trimester miscarriage (Hunter et al., 2016; Gergett & Gillen, 2014). A lack of social recognition and validation for their loss can mean that they have had no outlet where they feel they could safely express or voice their grief and anxiety, leading to isolation and a need to withdraw as a means of self-protection (Peel & Cain, 2012). With a miscarriage there is often little opportunity for an outward expression of grief that is afforded women who have had a later loss such as a stillbirth or neonatal death. Some women may not have even announced their pregnancy to the outside world, thus leaving them with the dilemma of disclosing the news of the pregnancy and subsequent loss or remaining silent. Outward rituals, such as a funeral, memorial service, hand, and footprints of the baby, which have been shown to have a beneficial effect on the grieving process (Layne, 2012; Woodthorpe, 2012; Earle et al., 2008) are rare with miscarriages, especially early ones.

When another pregnancy, which may be seen as a cause for celebration, and a huge relief for those known to the women, is embarked upon, the reality is often very different (Ockhuijsen et al., 2014; Cote-Arsenault et al., 2006; Meredith et al., 2017). It may appear that the problem is ‘fixed’, and the woman is ‘moving on’, but this new pregnancy is embarked upon in the shadow of the previous loss. Women may experience fear, dread, guilt, feelings of disloyalty, and a reignition of grief (Hunter et al. 2016; Earle et al. 2008; Mills et al., 2014). The new pregnancy does not and cannot ever replace the lost one. However, there is the expectation that the focus will shift to the new pregnancy and negate the previous one. For some women, this expectation is difficult to reconcile with their experience (Campbell-Jackson et al., 2014). Whilst the accumulation of the conflicting feelings described above will fluctuate throughout the pregnancy, they often do not dissipate until after the delivery of a live and healthy baby (Moore & Cote-Arsenault, 2018).

The literature relating to miscarriage and a subsequent pregnancy report changes to a woman’s psychological and emotional health (Cote-Arsenault, 2007; Shapiro et al., 2017; Bergner et al., 2009); sleep disturbances (Van et al., 2004); restrained and changed expectations in the subsequent pregnancy (Cote-Arsenault & Donato, 2007; Cote-Arsenault & Morrison-Beedy, 2001); fear and anxiety of the birth experience (Kinsey et al., 2013); heightened tensions in the intimate partner relationship (Hutti et al., 2015); and variables that are significant predictors of prenatal attachment difficulties (Gaudet, 2010; Armstrong, 2002).

3.4.2 Coping strategies

The focus of some of the literature was on investigating the coping strategies that some women employed to manage these conflicting emotions when they became pregnant again. One study by Andersson et al (2012) found that women who had experienced a previous miscarriage employed coping strategies which included emotionally distancing themselves from the pregnancy; intently focusing on pregnancy symptoms; requesting ultrasound scans to assess viability; searching for confirming information; and seeking both professional and social support.

The findings of Andersson et al (2012) were supported by later empirical work by Ockhuijsen et al. (2014). Their qualitative study was concerned with how women experience miscarriage, conception, and the early waiting period, and the types of coping strategies used during this period. As in the Andersson et al. (2012) study, Ockhuijsen et al. (2014) found that once a subsequent pregnancy was confirmed women employed several coping strategies in an attempt to retain control in a situation when in reality, they had little control. For example, like Andersson et al. (2012), they found that there was an intense focus on monitoring of pregnancy symptoms as an indicator of the viability of the pregnancy. Any reduction of these symptoms was a cause of great concern and anguish, with many women doing repeat pregnancy tests in the early part of the pregnancy as a way to monitor that the pregnancy was continuing**.** The provision of regular ultrasound scans and the passing of the gestation when the previous loss occurred were all found to contribute to an increase in confidence that all was progressing well. In an attempt at a self-protective strategy, Ockhuijsen et al. (2014) used the term 'Bracing' to reflect the women's attempts to remain in control and protect their emotions. Bracing strategies employed included living in the here and now and avoiding envisaging a future with a baby, withholding commitment and bonding to the unborn baby, whilst also distancing themselves from the social environment and support by restricting the amount of people they spoke to about the pregnancy. In other research, this strategy has been labelled as "Emotional cushioning" (Cote-Arsenault & Donato, 2011), and illustrates the confliction experienced by women at this time. Of note in the literature that investigates coping strategies in a pregnancy after loss, especially a pregnancy after a miscarriage, was the observation that women in this category often need additional support because this type of loss is generally not acknowledged in all areas of society, and that as a result, there is a lack of recognition that women in this category would need any additional support to that already offered in the course of routine antenatal, intrapartum and postnatal care.

The literature has shown the link between previous miscarriage and the myriad of conflicting emotions reported by women in a subsequent pregnancy. Psychological morbidities, such as stress, anxiety, and depression, have been reported in some women who miscarry both following the loss and in a pregnancy that follows (Campillo et al., 2017; Bergner et al., 2009; Blackmore et al., 2011; Kinsey et al., 2015). There are, however, important limitations to consider when reviewing this literature. There is often an overlap of depression and anxiety symptoms and disorders, making it difficult to distinguish which symptoms belonged to which mental health condition.

Thus far, the focus in the literature reviewed has pointed to an array of conflicting emotions that characterise a woman’s subsequent pregnancy. There have been several studies that have investigated how long term these emotions persisted following a successful subsequent pregnancy. Blackmore et als. (2011) study examined the degree to which symptoms of anxiety and depression associated with a previous miscarriage or stillbirth persisted. The study found no evidence that affective symptoms of anxiety and depression associated with a previous miscarriage or stillbirth resolve following the birth of a healthy baby. Instead, these symptoms persisted throughout the subsequent pregnancy and long after the postnatal period had passed. In contrast, however, other studies did not support such a long continuation of symptoms postnatally (See for example, Hughes et al., 1999). A later study by Kinsey et al. (2015) concurs with some of the findings from the Blackmore et al study, although a direct comparison is difficult because Kinsey et als study focused purely on depressive symptoms in women who had experienced a previous miscarriage. Their study, which compared data from women who had a history of miscarriage with those who didn’t, found that there was no observable difference in odds of probable depression between the women who had a history of previous miscarriage and those who didn't. They did, however, find that those with a history of miscarriage were more likely to have probable depression at one month postpartum, although when adjustment was made for all potential confounders, the researchers reported that these results did not maintain significance. What is worthy of note from these studies, however, is the awareness that for some women who are pregnant again, symptoms of anxiety and depression may be persistent and long lasting.

Pregnancy after stillbirth is associated with similar psychological and emotional factors as pregnancy after miscarriage, for example, increased emotional anxiety and maternal vulnerability, with the same clinical concerns for both the mother and the unborn child (Mills et al. 2014). Providing emotional and psychological support for these women has been found to drastically improve their experiences of the subsequent pregnancy (Campbell-Jackson et al., 2014; Heazell et al., 2015).

Women who have had a previous stillbirth are known to be at a higher risk of recurrence, and therefore are often moved onto a high-risk care pathway in their subsequent pregnancy (Heazell et al., 2015). For some, this will be a comfort, as they feel that the enhanced care that they will receive will afford them the best chance of having a successful pregnancy outcome (O'Brien et al., 2010). Far from being a negative experience, being classified as 'high-risk' can be seen as bringing many benefits to some women, including closer monitoring from the maternity professionals and thus a closer relationship with the multi-disciplinary maternity team (Simmons & Goldberg, 2011).

Many women in this subsequent pregnancy report that they want to be treated differently, to reflect the experience of their stillbirth and the fact that they are not just another normal mum experiencing pregnancy for the first time (Meredith et al., 2017). Other women find that being labelled as 'different' is a risk that can trigger fear both they and their unborn child are at risk. Extra surveillance, whilst welcomed initially, offers little comfort, instead provoking further distress (O'Leary, 2005; Mills et al., 2016).

3.4.3 Concerns and expectations

One of the considerations women face after a pregnancy loss is if and when to try for another pregnancy. The literature that investigated this aspect of pregnancy loss and a further pregnancy after loss reported that there was no specified time for a recommended interval between stillbirth and a subsequent pregnancy (Fockler et al., 2017). Instead, couples were encouraged to pursue a subsequent pregnancy if and when the time felt right (Radestad et al., 2010). This is supported by Lee et als. (2013) study investigating women's decision making about subsequent pregnancy following stillbirth, as well as reporting on women's thoughts and feelings about the experience of a subsequent pregnancy. Their research found that a number of factors contributed to the decision-making process about whether to try for another pregnancy. These included the strength of the women's aspirations to be a mother and have a family; their evaluation of whether they had the emotional capacity to cope with another pregnancy and the possibility of another potential loss; and the honouring of the stillborn baby's memory. These factors translated into a range of decisions of wanting to pursue a further pregnancy immediately and trying to conceive as quickly as possible (often displaying feelings of desperation or obsession in their quest to conceive quickly); those who knew that they wanted another pregnancy but decided to wait to conceive until they felt physically and emotionally strong enough to do so; and those who had immediate thoughts of not wanting to have another pregnancy and risk losing another baby. The findings demonstrate the individuality of each woman's decision, and the array of background influences on the making of that decision.

Given the knowledge we have about the psychosocial effects of a pregnancy loss, it is understandable that some women will be cautious about embarking on another pregnancy. Considering these issues from a different perspective, there have been several studies that have investigated women's concerns and expectations of a future pregnancy following a loss. In their work, Robson et al. (2009;2010) investigated women's expectations of management of care in their next pregnancy after an unexplained stillbirth (2009), and whether women's perceptions of care at the time of the unexplained stillbirth influenced their wishes for management of care in the subsequent pregnancy (2010). The results from these studies showed overwhelmingly that most women expected to be offered extra screening such as ultrasound scans and cardiotocographs (CTG's) in any subsequent pregnancy as a minimum requirement. This was in addition to having the option of an early delivery, although only a small group wanted the option of an elective caesarean section. It is worthy of note that for the participants in these studies, expectations and wishes for management in any subsequent pregnancy focused specifically on requesting additional clinical testing and interventions, without any mention of attending to their emotional and psychological needs. Whilst this is representative of a western biomedical approach, where the focus is purely on the biological and clinical aspects of health care (Martel, 2014), it is often at the expense of a woman's emotional and psychological needs when they are feeling vulnerable. Indeed, there are a number of studies that suggest that increased fetal surveillance by ultrasound or CTG's has the opposite effect of reducing anxiety, instead increasing it (O'Leary, 2005; Meredith et al, 2017). It is paradoxical that, for many women, this extra surveillance is offered by maternity professionals as a way to alleviate the anxiety, when the reality for some women is that extra surveillance provides little long-lasting comfort, with often a build-up of stress and anxiety in the lead up to the appointment (Cote-Arsenault & Marshall, 2000).

Robson et als (2010) second study investigated whether women's perceptions of the care that they had at the time of the unexplained stillbirth influenced their wishes for the management of care in any subsequent pregnancy. Specific comments about aspects of the care were invited, including about who broke the news and how was it handled; how were the arrangements for delivery handled; and whether a perinatal autopsy was offered and undertaken. Whilst the results showed that there were aspects of the care that were not deemed to have been handled sensitively or thoughtfully, it was deemed that there was no clear relationship between women's perceptions of care at the time of the unexplained stillbirth and their care wishes for future pregnancies.

In a later empirical study, Meaney et al. (2017) highlighted the importance of both clinical and emotional care after a stillbirth and its influence on subsequent pregnancies. Their qualitative study aimed to investigate the consideration and planning of a subsequent pregnancy by parents in the weeks following a stillbirth. Ten couples who had stillborn babies were contacted to take part, with 5 men declining. In total 10 female and 5 male participants were recruited. Data was collected using semi-structured interviews conducted at 4 months and 16 months after the stillbirth and analysed using Interpretative Phenomenological Analysis. Two superordinate themes were identified – aspirations for a future pregnancy and expectations of future care. Meaney et als. (2017) findings indicated that parents considered the possibility of another pregnancy as early as in the days following the stillbirth. This consideration was clouded though by fear of recurrent loss. In keeping with findings from other studies (see for example, Campbell-Jackson et al., 2014; Heazell et al., 2016; Meredith et al., 2017; Mills et al., 2016), the parents reported being on the receiving end of unhelpful and insensitive comments from family and friends. In addition, there was a reported disparity between parents and their aspirations for a future pregnancy, with mothers planning and aspiring to future pregnancies much quicker than their male partners.

Although it is not possible to draw comparisons between the Meaney et al. (2017) study, and those by Robson et al. (2009;2010) due to the different methodologies and sample population utilised, there are some similarities in the findings relating to expectations of future care. For example, participants in both studies indicated that they would want additional surveillance and additional appointments as a means of reassurance. Meaney's study further identified that parents valued being given clear and consistent guidance from staff about the frequency of hospital appointments, and any preventative measures to be considered. This was often in the form of a plan of care for any future pregnancy, given in a follow up appointment with a consultant after the stillbirth, where any questions about the stillbirth could also be addressed. For some participants, this individualised plan for consistent specialized care enabled them to consider a future pregnancy.

3.5 The lived experience of maternity care in a pregnancy following loss.

The previous two sections have identified some of the psychological and psychosocial challenges that women and their families face following a pregnancy loss, and in a subsequent pregnancy. We now turn to the small amount of research that considers women's experiences of maternity care in this subsequent pregnancy. The small number of empirical studies identified is significant, as it demonstrates that there is a dearth of literature on the experience of care in subsequent pregnancies following loss. In total, nine empirical studies were identified. Two considered women's care in a pregnancy following a previous stillbirth (Wojcieszek et al., 2016), and stillbirth and neonatal death (Mills et al., 2016). One study focused on women's experiences of one aspect of care, an ultrasound scan in a pregnancy after loss (O'Leary, 2005). Four studies researched women's experiences in these pregnancies when additional support was offered in the form of specialist pregnancy after loss antenatal clinics (Meredith et al, 2017); midwife-managed interventions in both low (Caelli et al., 2002) and high-risk pregnancies (Rajan & Oakley, 1993); and specialist support groups for women pregnant after loss (Cote-Arsenault & Freije, 2004). Two further empirical studies are included in this section because of their focus on high-risk pregnancy (Simmons & Goldberg, 2011; O'Brien et al., 2010), as many of the women pregnant after loss will be placed on this care pathway in a subsequent pregnancy due to the risk of recurrence, preterm birth, and low birthweight (Mulder et al., 2002). Finally, one literature review (Mills et al, 2014) and a meeting abstract (Mills, 2014) were identified.

3.5.1 Provision of, and experiences of maternity care in a pregnancy after perinatal loss

Mills et als. (2014) metasynthesis of parents' experiences and expectations of maternity care in pregnancy following a stillbirth or neonatal death reveals a variety of factors that are associated with navigating pregnancy and care in that pregnancy following a loss. Their findings concurred with findings from previous work recognising that for women pregnant after loss there is profound ongoing grief and anxiety in the subsequent pregnancy and beyond (for example, see DeBackere et al., 2008; Hunter et al., 2016; Andersson et al., 2012; O'Leary, 2014), which was compounded by isolation from family, friends, and others. Mills et als. (2014) review draws associations between parents' coping activities (both helpful and unhelpful) as a means to attempt to retain some control over the current pregnancy and better psychological adaptation to the current pregnancy. Parents were shown to be more assertive with health professionals over the maternity care that they sought, by changing obstetrician, or hospital in an attempt to differentiate the current pregnancy from the previous one and avoid distressing memories associated with the previous pregnancy. Planning for the birth early was highlighted as a way that parents tried to retain control. Interactions with maternity care providers were viewed as a central source of support for most parents. However, the studies reviewed consistently demonstrated that for many parents their experiences did not meet their expectations, with insensitivity, dismissive attitudes, and lack of preparation before a consultation being cited as some of the common problems. In contrast, parents valued interactions with maternity care professionals when they were empathic, supportive, validating and collaborative. Of particular concern for parents was the lack of appropriate antenatal education and birth preparation for them, with the expectation that they would attend the routine antenatal groups along with other parents-to -be who would have a very different expectation about the course of pregnancy. The review highlighted that interventions designed and implemented specifically for this group of parents were viewed positively and provided regular and sustained psychological support that appeared to improve experiences for parents.   Whilst recognising the limitations of this review (the studies reviewed related predominantly to maternity care in the USA, where birth is viewed as potentially pathological and there is an over-reliance of technological medicalisation of all pregnancies), Mills et als. (2014) work does recognise that the unique care needs of these parents are only just beginning to be recognised by professionals, and that in view of this, urgent attention is needed to examine maternity care provision both within the UK and internationally if psychological morbidities and other adverse outcomes in this group of parents are to be reduced.

In a different study, Mills et al. (2016) investigated both the UK's maternity care provision and practice in pregnancies after stillbirth and neonatal death, and women's experiences of that care. This study is of extreme importance as, to date, it is the only UK study identified that does this. Significantly, their results identified a discernible variation between maternity units in the provision of care for this group of women. 40% of units reported having some written guidelines to support this care, but this guidance tended to focus on clinical interventions rather than emotional and psychological support, which has been identified in earlier studies as vital in reducing the risk of long-term morbidities for these women (Campbell-Jackson et al., 2014; Heazell et al., 2015). Very few units included specialist bereavement midwife input, access to counselling, or specialist antenatal education. Of those units that had a bereavement midwife in post, it was found that the role varied widely, with only a minority of units reporting that the role included caring for women in a pregnancy after loss. This concurs with research by Sands (2015) into the role of the bereavement midwife. Other units reported that the bereavement midwife's engagement with this group of women was sporadic, and in 13% of units not at all.

When researching women's experiences of maternity care in pregnancies after loss, Mills et als. (2016) work revealed that whilst most participants reported positive experiences, a substantial number reported the opposite. The standard of communication and staff conduct was highlighted as a significant factor of the participant's satisfaction with their care. Frequent complaints about poor care included perceived insensitivity by some staff to their situation through words poorly chosen lack of knowledge of the woman's history before contact leading to women having to constantly re-tell their story, and a lack of knowledge and understanding amongst maternity care professionals of the long-term, continuing impact of perinatal bereavement on women. Other complaints included inflexible maternity systems, multiple caregivers throughout the pregnancy and perceptions of not receiving specialised care in view of their previous obstetric history.

The results from this study highlight the lack of equity in the provision of emotional and psychological support for this group of women across the UK (Mills et al., 2016). This study reveals the gap between what women need and expect in these pregnancies, and what is being provided by maternity services, which could further exacerbate the experiences of women highlighted in other studies considered in this review (see for example, Cote-Arsenault & Donato, 2011; Rowlands & Lee, 2010; Bellhouse et al., 2018). This reveals a gap in the literature and suggests that further research is needed in this area, both in the provision of care and evaluation of interventions developed for this group of women to enable a holistic approach to care that encompasses not only clinical care in the form of extra monitoring and surveillance, but also addresses these women's psychological and emotional needs. Without this holistic approach, it is likely that these women's needs and expectations of maternity care in a pregnancy after loss will continue to be unmet.

Wojcieszek et al. (2016) published results of an international survey of parents' experiences of care in a pregnancy after a stillbirth. Although it should be noted that the responses in this study were from parents, and not only the pregnant woman, the results are consistent with the findings in the Mills et al. (2016) study. Wojcieszek et al. (2016) found that the majority of women pregnant after stillbirth received increased antenatal surveillance and monitoring, yet far fewer received specific care that addressed their emotional and psychological needs. Satisfaction with care was dependent on whether women perceived that they had received quality, respectful care from their providers. In addition, it was found that women whose stillbirth occurred at a later gestation were more likely to receive additional care to those whose loss occurred at an earlier gestation.

Although these are only a small number of studies, collectively they do point to a systemic failure in the provision of maternity care for these women, in that women's holistic needs are continually being unmet in systems of care that fail to identify and acknowledge the complex life changing event that these women have experienced, and their role in alleviating some of the long-term consequences of these events.

One of the ways in which women are offered extra clinical surveillance and monitoring in a pregnancy after loss is through having additional ultrasound scans. These provide important diagnostic information to maternity care professionals about fetal wellbeing, but also, it is thought, reassurance that all is well in the pregnancy for the women and their partners. However, O'Leary's study (2005) cautions against assuming that this is always the case, and warns that instead of reassurance, for some women, grief and symptoms of PTSD are re-triggered during these clinical procedures. O'Leary's research found that for some parents in the study, it was having scans that evoked memories of the previous loss, and caused fear, anxiety, and distress that they would see a further loss on the scan. For these parents, the past was relived in the present, in the lead up to, in the clinical rooms where the scan was undertaken, and continued into the future with reports that the anxiety did not ease until after the birth of a live baby. O'Leary's (2005) study suggests that vigilance is needed when offering these types of screening tests to women above what is medically required. Other studies have agreed that, far from providing reassurance, extra scans, indeed any scans during pregnancy, can be a source of anxiety, with the experience, if all is found to be well with the baby, bringing only short-term relief (Mills et al., 2016; Meaney et al., 2017; Fockler et al., 2017). It is suggested that further research in this area would be beneficial in identifying further the benefits and challenges of offering routine extra scans to women where no clinical need has been identified.

3.5.2 Women's perceptions of the benefits of additional clinical appointments and support in pregnancy after loss

3.5.2.1 High-risk pregnancies

NICE (2019, p.97) state that "A pregnancy is 'high risk' when the likelihood of an adverse outcome for the woman or the baby is greater than that of the 'normal population'". The classification of which pregnancies should be defined as being 'high-risk' pregnancy differs from country to country, but in general terms means that the obstetric management of the pregnancy will involve extra care above the standard routine maternity care offered to other pregnant women who do not have any underlying complications that could jeopardise their health or the health of the unborn baby. Women who fall into this category will experience the benefits of receiving additional maternity care from a team of highly qualified specialists, but at the same time may also be at risk of increased stress and anxiety, which have been associated with adverse obstetric outcomes (O'Brien et al., 2010; Enkin et al., 2000).

Recognising that women who are pregnant after loss require additional support is not a new phenomenon. Rajan & Oakley's (1993) study revealed the difference that additional social support made to a woman's emotional health, demonstrating that additional social support in a pregnancy after loss improved both the physiological and psychological health of women compared to those who received routine antenatal care. The data was collected as part of a larger trial of social support for women whose pregnancies were identified as 'high-risk'. The additional support offered to the support group included the provision of three home visits and two telephone calls between the visits by the research midwife, plus having telephone access to the midwife at any time of the day or night. Rajan and Oakley found that there were significant differences in the emotional well-being of women between the support group and the control group at six weeks and one year after delivery. Key to the improvement in emotional well-being was the affirmation and understanding they received from the research midwives. The development of a trusting, non-judgemental relationship with a professional who was consistent throughout their care enabled the grieving process and in time restored some of the women's emotional health, self-confidence and empowered them to take back some control of their lives. The findings from this study suggests that continuity of care/carer is a vital factor in facilitating the improvement of women's emotional health, and that to be effective needs to continue long after delivery. NICE (2015) outline postnatal care as care up to six to eight weeks post-delivery, delivered by a multidisciplinary team. Yet, the structure of UK maternity services is such that maternity care for women ceases by one month post-delivery, and in reality, is much sooner than that, often within the first two weeks post-delivery, suggesting that continuity of carer to be carried on long after delivery may be difficult to achieve under the current maternity care provision in the UK.

Although vastly different methodologies, the findings from Rajan & Oakley's (1993) study were consistent with the findings of Caelli et al. (2002) in their phenomenological study. Caelli et al also found that the provision of extra clinical and psychological support to women pregnant after loss made a significant difference to their psychological and emotional well-being. The structure of the additional support offered in the two studies was vastly different, yet there were also some striking similarities. Notably, women were empowered to ask questions and take an active involvement in their care through the development of trusting, empathic relationships built with the midwives on the Special Delivery Service intervention. This extra service normalized many of their anxieties in a sensitive and non-judgmental way, in contrast to their experiences of dismissal and insensitivity encountered in routine antenatal care (Caelli et al., 2002). It was the development of a trusting relationship with a midwife who was present and truly listened to their concerns in an understanding and empathic way that was seen as making the difference, as opposed to being attended to, in a detached, clinical way with no awareness or understanding of the woman's needs at such a crucial time.

Examining 'high-risk' pregnancy from a different perspective, Simmons & Goldberg (2011) used a feminist phenomenological approach, with the aim of revealing a deeper understanding of the phenomenon of 'high-risk' pregnancy following perinatal loss. Seven women's experiences were sought through conversational interviews and writings in reflective journals. Although four themes were identified, the focus of the article included in this review was solely on the first theme, women's understanding in the meaning of the label of 'high-risk' pregnancy. Simmons & Goldberg found that, in contrast to the belief that women find 'high-risk' pregnancies stressful (Stahl & Hundley, 2003), the women in their study viewed being allocated the label 'high-risk' as a positive experience. Several factors were identified as influencing this perception. Firstly, being allocated this label ensured that the women had access to specialised maternity care that may previously have been denied to them. Secondly, access to this care ensured that the current pregnancy was, in the view of the participants, afforded improved care with increased vigilance of maternal and fetal well-being. This enabled the women to experience a sense of control and power, in as much as they were doing all that was in their power to ensure that they took a baby home at the end of the pregnancy. Finally, having access to the same team of specialists enabled positive interpersonal relationships to be built that provided support to the women when they were feeling vulnerable. These findings complement findings from other research (see for example, Cote-Arsenault & Donato, 2007; Meredith et al., 2017; Caelli et al., 2002) that show that increased monitoring and surveillance in the subsequent pregnancy at least afford some sense of reassurance to women, although it has also been reported in other research that this reassurance can be short lived (O'Leary, 2005; Meaney et al., 2017).

O'Brien et al (2010) utilised an interpretative qualitative approach to enable them to gain an understanding of the experiences of pregnant women at risk of having a preterm birth. Focus groups and face-to-face interviews were conducted with women who were pregnant, classified as 'high-risk', with a history of preterm birth in a previous pregnancy and who were receiving antenatal care for the current pregnancy in a specialist preterm clinic at the study hospital. Preterm birth is a risk factor for increased perinatal morbidity and mortality (Goldenberg et al., 2008). This study has been included in this review because, although not specifically about women after perinatal loss, 15 of the 17 participants reported a previous perinatal loss. It was therefore considered relevant to this review. In the study, all the women were having observations and treatment to try to prevent preterm birth in their current pregnancies. The women described their current pregnancy as a feat of "emotional and physical endurance" (p.79) as they endeavoured to balance the risks associated with their condition and preterm birth and getting through the pregnancy. For these women, their experience was a dichotomy of emotions associated with being labelled as ‘high-risk’. On the one hand they were fearful, scared, terrified, yet at the same time they felt reassured and relief that being given the label meant that they would have access to specialist carers who would try to ensure that they had a healthy baby at the end of their pregnancy. Women reported that they would do almost anything, only briefly considering the risks of some of the treatment offered, in the hope of having a live baby. To that end, they devised coping strategies to get them through the pregnancy, from one milestone to the next. In keeping with other studies, these included distancing themselves from the pregnancy and not preparing for the birth, living week by week and appointment to appointment, focusing on getting past the milestone of the gestation of the previous preterm birth/loss, and seeking regular reassurance from known professionals (Simmons & Goldberg, 2011; Mills et al., 2016; Fockler et al., 2017; Campbell-Jackson et al., 2014).

The studies reviewed in this section have revealed how women’s perceptions of the maternity care that they receive in a pregnancy after loss can have a direct impact on both maternal and infant morbidity and mortality (O’Brien, 2010; Simmons et al., 2011). Women, in these subsequent pregnancies, need to feel that their previous loss is acknowledged, that their experience is valued, and that they are treated with respect by maternity care professionals (Rajan & Oakley, 1993; Caelli et al., 2002). For this to be achieved, women need to feel that the care that they are receiving is reflective of their experiences and warrant extra support and care above ‘normal’ antenatal care. Their satisfaction with the care they receive is flawed if they do not perceive that they are receiving this extra, quality care. The findings from these studies on ‘high-risk’ pregnancies demonstrate that additional clinical, psychological, and emotional support from maternity care professionals for this group of women can have a positive effect on their emotional well-being and provide them with valuable resources to navigate the pregnancy journey. Yet not all women who are pregnant after loss are offered this extra care, especially if the previous loss was an early miscarriage, ectopic, or termination, where these losses have traditionally been allocated a lesser status by maternity care professionals (Gergett & Gillon, 2014). Perhaps, collectively the research in this review points to the viewpoint that all women who are pregnant after loss, regardless of the type of loss or the risk status of their current pregnancy, should be offered an alternative care pathway that provides not only extra clinical care, but also emotional and psychological care. For the final part of this review, we turn to consider the research from two different interventions that offered this type of holistic care to women who were not classified as having ‘high-risk’ pregnancies (Meredith et al., 2017; Cote-Arsenault & Freije, 2004).

3.5.2.2 The importance of additional, specialist maternity care for all women in a pregnancy after loss

The previous section of this review revealed some of the benefits associated with receiving specialist high-risk maternity care. Two studies are now examined that explore the benefits of additional interventions for all women who are pregnant after loss, not just those who are afforded the ‘high-risk’ label.

The literature reviewed thus far has shown that a significant proportion of pregnancies after loss are characterised with high levels of anxiety and maternal stress that in turn can lead to negative outcomes for both the mother and the unborn child (Mills et al., 2016; Meredith et al., 2017; Moore & Cote-Arsenault, 2018). This is true for all pregnancies after loss, whether it be long term or relatively short term. In these subsequent pregnancies, there is a gulf, a paradoxical conflict between cultural expectations and a woman’s perceptions of her pregnancy (Cote-Arsenalt & Freije, 2004). In their focused ethnographical study, Cote-Arsenalt & Freije (2004) studied two pregnancy after loss support groups through observation of group meetings, individual interviews, questionnaires, and artefacts. The groups provided support to couples who were pregnant again after miscarriage, elective termination for a genetic defect, selective termination in high-tech multiple pregnancies, stillbirth, and neonatal death. Consistent with findings from other studies (Mills et al., 2016; Gaudet, 2010; Wojcieszek et al., 2016), it was found that whilst women felt that their physical needs were being met by their care providers, their emotional needs were not. The support group, therefore, was seen as a lifeline that provided the extra support needed to get through the stresses of the current pregnancy. It was found that the support group provided a safe space where the participants gained new knowledge, strategies for coping and help in reconciling the discrepancies between cultural expectations of pregnancy and their previous experiences of pregnancy loss. The supporting relationships and shared commonalities in the group led to women feeling validated and able to reciprocally help others in the group as their confidence and self-esteem grew. The group structure put their experiences into perspective, affording them a shared normality as they focused on getting through the pregnancy. In agreement with the other literature, this study is pointing to the importance of strong interpersonal relationships in helping these women through difficult times.

These findings were echoed in a study by Meredith et al. (2017) which looked at women's experiences in a Pregnancy After Loss Clinic (PALC) set up in a hospital in Brisbane, Australia. Meredith et al reported that women found the additional services offered a much-needed lifeline at a potentially difficult time. In particular, women valued continuity of care with a known multidisciplinary team which enabled the building of strong, emotionally supportive relationships. The specialist clinic enabled women to be open about their concerns and the space to talk about their lost babies without fear of being misunderstood or judged. Women in the study appreciated the fact that the staff recognised the uniqueness of the circumstances of a pregnancy after loss, and that they were "not just a normal mum" (2017, p.9) accessing maternity services. From the overwhelmingly positive experiences of the PALC, Meredith et als (2017) findings suggest that women's experiences of other maternity services were less than satisfactory, with problems ranging from a lack of continuity of carer, to carers appearing blasé about the women's circumstances and failing to familiarise themselves with the women's history before undertaking a consultation. Collectively, these led to some women perceiving that the care they were receiving could possibly miss vital signs of possible complications or prescribe treatment that was not appropriate to the circumstances. However, overall, the women felt that the care received from other maternity services went some way to meeting their clinical needs, but it was the care received from PALC that met their emotional needs.

Together, the findings from the studies considering pregnancies with high-risk factors, and those not considered high-risk suggest that it is the authentic human element of care that makes the all the difference to women's experiences of, and the meaning they make of the maternity care they receive in a subsequent pregnancy after loss. These studies researched maternity care where additional support to the standard normal care was offered, in the form of separate support groups or clinics specifically designed for their additional needs. This extra support helped to focus the women in the here and now of their current pregnancies, resulting in a reduction of, or at least the ability to manage the increased stresses reported. The realistic reassurances experienced through participation in these additional interventions were significant in the women making sense of the uncertainties associated with their current pregnancies.

In summary, this review has revealed an extensive range of research into women's experiences of pregnancy loss, and pregnancy after loss. A smaller, yet significant body of literature was identified that considered women's experiences of maternity care in that subsequent pregnancy. The review reveals consistent gaps in the current literature that has notable implications for this present study. Firstly, this review reveals that women's experiences of maternity care in a pregnancy after loss are under-represented in the current literature. Secondly, only one study was identified that examined that experience from a UK, NHS context (Mills et al., 2016). Thirdly, very few studies were identified that explored women's experiences from a phenomenological perspective, and of those that were identified, none of the studies focused on these experiences from a hermeneutic phenomenological framework.

As such, this present study seeks to contribute to further understanding of the phenomena of experiences of maternity care in pregnancy after loss, through a focus on the lived experience of, and the Being-in-the-world of women navigating this journey. Further, the results from this study will seek to address the identified gaps in the literature and contribute to the emerging discourses of this phenomena.

The following chapter presents the theoretical framework and methodology for the study. The philosophical and methodological foundations of the study will be discussed. Included is an overview of phenomenology, with the emphasis on the Hermeneutic Phenomenology of Martin Heidegger.

Chapter 4 - Theoretical perspectives and methodology

The previous chapter placed the study in the context of the available literature. This chapter now turns the focus to exploring and justifying the decisions made in relation to the theoretical perspectives and methodology.

This chapter will start by considering the theoretical position in relation to the present research study's aims, and the rationale for the decision to design an interpretivist study, as well as considering the ontological and epistemological perspectives. Following on, an explanation of phenomenology and hermeneutics, as related to the work of Heidegger (2004), leads to the consideration of a number of Heideggerian concepts. These concepts provided a framework for the conception and the analysis of the data collected for this thesis. Next, there is a discussion of the hermeneutic circle and how the use of the circle facilitated the understanding of the connection between theory, data, and experience. The chapter concludes with a consideration of the fore-structures of understanding, my reflexive positioning and how these relate to the approach adopted in this thesis.

4.1 Determining the theoretical position.

4.1.1 The beginnings

At the outset it was always the goal of this research to use an approach that would allow the voices of women to be heard. The rationale behind this decision was that most literature read on the subject of pregnancy loss and pregnancy after loss appeared to be written from a biomedical perspective, with only a small number of studies available that related the women's experiences from their own perspective. A qualitative methodology was therefore deemed the most suited approach for this present study, in order to capture women's voices of experience. Unlike quantitative approaches that are known for seeking to measure, codify or quantify phenomena, a qualitative approach acknowledges the cultural complexities of life, of relationships and understandings, and seeks to incorporate them into the research process (Flick, 2014). In addition, the position of the researcher is also acknowledged and incorporated into the process as a way to highlight how background, culture and experiences may shape the interpretations reached and the direction that the study takes. Collaboration with participants is also encouraged, often in the interpretation and data analysis stages, as a way to check the accuracy, credibility and reliability of the data following analysis (Creswell, 2014). It may be argued that this collaboration may bias the findings, however, there is the counter argument that suggests the opposite is in fact true, and that interpretations and findings are enriched by this process (Ezzy, 2002; Creswell, 2014). The nature of the collaboration in this study involved checking with the participants as to the authenticity of my interpretations by returning the stories of their lived experiences to them for approval. Although the decision to use a qualitative methodology was taken very early in the design of this study, there were other design questions to consider.

4.1.2 Ontological and epistemological perspective

Within qualitative research Creswell (2013) highlights what are known as 'Philosophical Assumptions', the guiding philosophy informing qualitative research. These are assumptions referred to as ontology and epistemology. Ontology is concerned with the nature of reality and its characteristics, the study of being. It encompasses our notion of the world and the things in it. Epistemology is more concerned with the theory of knowledge, and the way we understand and explain how we know what we know, and what is known (Crotty, 1998; Ritchie et al., 2014). In any study, the ontological and epistemological questions asked are shaped the researchers' view of the world, and beliefs about the nature of reality and knowledge. Thus, as Denzin and Lincoln (2013) suggest, each researcher *"who speaks from a particular class, gendered, racial, cultural, and ethnic community perspective"* (p.23) will approach a research study in a different way, framing their ideas and questions in such a way as to reflect these views and beliefs. To ensure transparency and credibility, in qualitative research these are revealed through the researcher making them known through personal reflexivity, thereby the reader is then able to make a judgement about the rigour of the study and its findings. With this in mind, Bondas

(2011) cautions that the ontological and epistemological starting points of the study need to be full explored if the credibility of the study is not to be compromised.

4.1.2.1 Adopting Social Constructionism as an ontological approach.

A constructionist perspective holds the firm belief that reality is constructed, and as such there is neither objective reality nor objective truth (Sarantakos, 2013). Rather, constructionism is about perceived realities and relationships. Objects and entities may exist outside people's consciousness, but they have no real meaning until they are experienced and addressed. Thus, meaning is made from interaction with objects and experiences and their place in the world. For example, as adults, we can be aware that not all pregnancies result in a live baby being born, but it is not until this event becomes a personal, lived experience, that meaning is constructed. In contrast to objectivists, who believe that meaning is fixed and ready to be discovered, constructionists believe that meaning emerges through relationships and interactions with the world (Sarantakos, 2013).

The realities of the everydayness of individual lives are constructed realities and are an active process that are based on an individual's interpretation of events. The meanings that are formed from these interpretations can be as varied and multiple as the individuals themselves (Creswell, 2014). The meanings attached to these multiple realities are formed through interaction with others as well as an individual's historical and cultural norms that all interplay in a person's life (Sarantakos, 2013).

The Social Constructionist ontological positioning is compatible with Heidegger's Hermeneutic Phenomenology. According to Heidegger, the world is "always already there" (Heidegger, 2004), and it is through engagement as *Dasein* that meaning is constructed. The focal point of Heidegger's work was on answering the question of "Being" and is the focus of his famous work *Being and Time (Sein und Zeit)* (Heidegger, 1927/1962). The literal English translation of *Dasein* is "there being" and refers to the uniqueness of human beings (as opposed to animals, or objects such as trees, buildings) in that we exist as an individual but also within a socio-cultural context.

Heidegger maintains that the two cannot be separated. This connectedness and inseparability from the world are known as Being-in-the-world*,* the interconnectedness of the two being emphasised using hyphens (Pascal, 2010; Horrigan-Kelly et al., 2016). Crotty (1998) suggests that we are born into a world that is already full of meaning, which we view through the lens of our culture. As such, we make sense of the world around us in different ways, always coloured by our cultural roots. Thus, the research participants in this study will have constructed their own individual meanings of the phenomena, that is, their experiences of being pregnant and receiving maternity care after a previous pregnancy loss. A researcher's task in such a study is to stay as close as possible to the participants' lived experiences of the phenomena being studied, to reveal the meaning constructed to enable an understanding of those experiences. At the same time, the researcher has the role of re-telling and reconstructing the stories of those experiences, producing their interpretation of the participant's interpretation of those rich lived experiences.

To do this, a researcher might refer to the participants' accounts of their lived experiences as stories (as in this study), a term that has been shown to be problematic to some. Like all methodological approaches, hermeneutic phenomenology has its limitations. Of note, is the work of John Paley, who has spent over two decades offering multiple critiques of qualitative research and its methods, and in particular the methodological approach of phenomenology. Some of this work relates to the credibility of the use of stories and narrative as a means to portray the lived experiences of participants in research (Paley & Eva, 2005).

Paley and Eva's (2005) argument against the use of stories in portraying the lived experiences of participants focuses on what they describe as the confusion that exists in the research between the term's 'stories' and 'narrative'. They recommend what they describe as 'narrative vigilance', as they propose that there is a "tendency to romanticize 'narrative', especially in health care literature" (p.94). They suggest that narrative is objective, in that it relates to a sequence of events that have a causal element to them, whilst stories are subjective, and contrived in a certain way as to elicit a response. Their argument is that the narrative objective position is a more accurate account of events as this can be tested (whether that account be true or false), than the subjective position of the story which will be "subjectively persuasive" (p.93). They propose that "stories are not naïve descriptions lacking all artifice. They are contrived" (p.94). Contrived suggests that stories of experiences are deliberately created and arranged in such a way as to seem artificial or unrealistic. This is problematic in relation to stories of lived experiences, as the implication is that there is some kind of dubious motive in the telling of these stories. It is true that stories are told for a purpose (and maybe in that way they are contrived), yet it seems that Paley and Eva are dismissive of these accounts if they are labelled as 'stories of lived experience'. Yet it is argued that in this research these stories of lived experiences have much to offer the world of maternity care practice, as they turn the attention from the clinical, task centred environment (much loved by empirical research and funding bodies alike, as objective, and measurable) to what it is to be a service user in such an environment.

Thus, in this research, it is envisaged that the crafting of the participant's stories will reveal their ways of being, thinking and acting in the Being-in-the-world of pregnancy loss, pregnancy after loss, and receiving maternity care in that pregnancy after loss, to illuminate what has been forgotten (Crowther et al., 2016). Van Manen (2014) suggest that stories are a way to elicit shared pathic responses. A full account of how the data collected in this study was transformed into stories can be found in section 5.1.5.6.

As well as being influenced by a constructionist ontology, the present study design adopted an interpretivist epistemology (Sarantakos, 2013).

4.1.2.2 Adopting interpretivism as an epistemological approach

The interpretivist perspective suggests that social reality is subjective. It is constructed, reconstructed, and interpreted by people, meaning it is difficult to measure or observe (Denscombe, 2017). According to Crotty (1998, p.67) interpretivism "looks for the culturally derived and historically situated interpretations of the social life-world”. To a qualitative researcher, the value within this approach is that it is able to generate meaning that is rooted in human experience, and still provide rich and meaningful interpretations of the phenomena being studied (Thomson, 2007).

Approaching a research project from an interpretivist perspective does have its challenges. An interpretivist researcher does not measure or use scientific methods to gain that knowledge, instead using methods that consider the social context, or lifeworld, lived experiences and concerns of the participants and the influence that has on the meaning they make of their experiences. As Denscombe (2017) acknowledged, it can be difficult to measure or observe due to the fact that individual, personal inputs are responsible for the construction, reconstruction, and interpretation of reality. Denzin and Lincoln (2018, p.13) suggest that qualitative research is “a set of complex interpretive practices”. These complexities become apparent when navigating differing terms and definitions in the vast body of research methodologies literature. Furthermore, there has been criticism that the accounts of the researcher and the participant may in fact vary, which suggests that there cannot be any surety that the researcher has provided a true account of the participants meanings (Sarantakos, 2013). This criticism has been addressed to a certain extent through some researchers’ ‘member-checking’ techniques (Creswell, 2014). The aim of this approach, therefore, is not in seeking surety, but rather complexity in the shared (intersubjective) nature of the research.

Two further considerations, in the design stage of the study, were contemplated, which justified the use of these epistemological and ontological approaches. Firstly, through undertaking this research there was the potential to uncover, understand, and disseminate through the findings and discussion with the local hospital trusts the ways in which these women’s lived experiences of using the maternity services after a pregnancy loss met their individual needs. This could facilitate an adaptation of or change in these services. As outlined in Chapter 2, some consideration in these trusts had been given to providing an additional service for women who had been bereaved by pregnancy losses in later pregnancy and early in the neonatal period. However, through discussion with the service providers at the time of this study it became apparent that this service was not available for women who had undergone pregnancy losses in the early stages of pregnancy (categorised as miscarriages, or ectopic pregnancies). Giving ‘voice’ to these women, perhaps for the first time and regardless of the gestation of their loss, will perhaps lead to further dialogue in collaboration with the women and hospital trusts to design a service that wholly meets their needs.

Secondly, although there has been an abundance of empirical literature exploring pregnancy loss from the perspective of long-term clinical implications and health risks for the mother and the baby, to date, nonetheless, there has been a dearth of interpretive research into women’s lived experiences of accessing maternity care at such a sensitive time. The reason for this is understandable, as gathering evidence of experiences of care following bereavement can be difficult due to the vulnerability of the participants. This, however, leaves a gap where women’s feedback of their experiences is not heard, with the result that some women’s needs and expectations may be continually unmet. The contribution of this present study will not only add to existing knowledge available but will also fill an insufficiently explored gap in the literature on this subject through a hermeneutic phenomenological lens. To understand how this approach was applied to this research study, there must first be an exposition of both phenomenology and hermeneutics.

4.2 Phenomenology

The term ‘phenomenology’ is derived from the Greek words of ‘phainomenon’ (appearance) and ‘logos’ (reason) (Gearing, 2004). Braun & Clarke (2013, p.334) define phenomenology as being “concerned with understanding people’s subjective experiences”, whereas Ormston et al. (2014, p.13) suggest that phenomenology is about “describing the meaning people attach to a particular phenomenon, concept or idea”. Phenomenology calls for us to notice, be curious and answer the question ‘How do we know?’ by turning back to the phenomenon that is often obscured by the things of this world. Todres et al. (2007) explain that this obscuring is prevalent because, as humans, we take for granted the world and our way of Being-in-the-world, so much so that we fail to notice the nature of the world around us.

Phenomenology was founded in the late nineteenth century by Edmund Husserl (1859 – 1938). Originally a mathematician, Husserl was concerned about the dominant positivist view of philosophy and psychology. Husserl was influenced by the work of Franz Brentano (1838 – 1917), especially his work on 'intentionality', where consciousness is always seen as consciousness of *something.* In other words, every mental act is related to an object, suggesting an active relationship between the "conscious subject and the object of the subject's consciousness" (Crotty, 1998, p.44). Husserlian phenomenology did not seek to separate reality from consciousness (Crotty, 1996). Instead, it sought to explore the conscious, lived experience of phenomena, and the way these are discerned in everyday life (Crotty, 1998; Pascal, 2010). This became the pivotal concept of Husserl's philosophy (Crotty, 1998).

Husserl's search for understanding of human experience led him to declare that we need to return "back to the things themselves" (Husserl, 1970, p.252), by which he meant back to the experiences of everyday life. Importantly, he suggested that to do that it is possible to '*bracket'* our own subjectivity, to enable us to look only at the phenomena without our own personal knowledge and prejudices influencing our understanding of the phenomena (Crotty, 1996, Crotty, 1998, Moran, 2000). This suggested that knowledge could be separated from experience, a view that became a major criticism of Husserl's work and that was challenged by his student Heidegger (1889 – 1976), who claimed that as a human Being-in-the-world, it was impossible to be separate from the world (Heidegger, 2004). This inevitably led to Husserl and Heidegger developing two very different phenomenological positions, and therefore the development of two very distinct phenomenological approaches, descriptive phenomenology as developed by Husserl and Giorgi, and hermeneutic (interpretive) phenomenology as developed by Heidegger, and advanced by Gadamer (2012) and Merleau-Ponty (2013).

4.2.1 Hermeneutics

The term ‘hermeneutic*s’* was first used in the 17th century, where it was introduced as the science of biblical interpretation. Over time, hermeneutics extended into philosophy, and was further developed by the German philosophers Friedrich Schleiermacher (1768 – 1834) and William Dilthey (1833 – 1911) into hermeneutics as we understand it today. Kearney, (1991, p.277) defines hermeneutics “as a method for deciphering indirect meaning, a reflective practice of unmasking hidden meanings beneath apparent ones*”.* For Heidegger, hermeneutics is an unveiling of ‘*Being*’ (human existential ‘*Being*’) (Crotty, 1998), as opposed to ‘*being*’ (the study of material or inanimate objects).

The central focus of hermeneutics is understanding (*Verstehen),* about how to understand, not what to understand (Sarantakos, 2013). It is about understanding how we as individuals understand the world and how that understanding is passed through the generations through socialisation. Crotty (1998, pp.95-96) suggests that Heidegger’s phenomenological hermeneutics “can be seen as hermeneutical phenomenology……. (with) hermeneutics as the revelatory aspect of ‘phenomenological seeing’ whereby existential structures and the Being itself come into view”. It is in the combination of hermeneutics and phenomenology that the phenomena can be revealed.

Designing this study, as understanding of hermeneutic phenomenology developed, along with an increased awareness of different interpretivist methodologies, it became apparent that different interpretivist methodologies were not suitable for this research study. The methodology of choice, hermeneutic phenomenology, was chosen because the approach incorporates the perspective of the individual (their lived experience of the phenomena), while not ignoring the significance of the socio-cultural context on how those experiences are interpreted. Furthermore, this approach acknowledges that the researcher’s pre-understandings of the phenomena cannot be successfully separated out from the research process. As such, values, past experiences, role, culture, vested interest will shape the way the world is experienced and understood.

Meaningful reflexivity on these pre-understandings allows the researcher to use them consciously throughout the research process instead of denying or minimising their existence (Smythe, 2011).

4.2.2 Heidegger's ontological difference

Working initially with Husserl as his student, Heidegger later rejected some of Husserl's philosophical ideas, instead basing his theories on the ontological position on what it means 'to be' a person, a Being-in-the-world. He challenged Husserl's assumption that the researcher can, and should separate knowledge from experience, instead maintaining that the two could not be separated. Heidegger saw meaning as being co-created between our shared humanness and life experiences, and that through reflection we could become aware of our assumptions. This concept is regarded as Heidegger's ontological difference and is a significant turning point in the development of hermeneutic phenomenology (Guignon, 2006).

4.3 Heideggerian concepts

We now turn to Heideggerian concepts and consider how their use provides a perspective for understanding the phenomenon being studied. Through the analysis of the study of *Being* in the work 'Being and Time' (1927/1962), Heidegger's concepts provide a lens through which to see and interpret the data. An understanding of these concepts in this study is therefore pivotal to understanding the nature of these womens' experiences, and the meaning that they ascribe to them. From this perspective, this study thus provides a unique and original contribution to the generation of knowledge of the phenomena being researched.

4.3.1 *Dasein* and *Being-in-the-world.*

Heidegger describes *Dasein* as Being-in-the-world. What he means by this is more than just living in the world (Blattner, 2006). He means that *Dasein* and the world are an indivisible entity and uses hyphens to illustrate this (Heidegger, 2004). Being-in-the-world means that *Dasein* "is immersed in the world, involved with it, permanently intertwined and occupied with it even when it feels alienated or lonely" (Harman, 2007, p.61). Being-in-the-world for *Dasein* is an involuntary part of our existence, and we are born into a world that is already organised in a distinct pattern (Heidegger, 2004). Heidegger calls this thrownness, in that the relationships we form, the languages and practices that we live by are all determined by being born into a particular place and time (Heidegger, 2004). This thrownness illuminates the very randomness of our being, and shapes our existence including our past, present, and future. Watts (2001, p.34) explains it like this:

> So, I can never create myself anew, as I have to work with what I have been and what I am now, in order to become what I want to be in the future. Consequently, there is a continual struggle between the drive to actualise my potentials and the influences or constraints of my thrownness.

Meaningful and significant encounters in the world can be revealed through the activities and events that we encounter in everyday life. However, the meaning of these encounters can often remain hidden in the background or taken for granted (Crowther, 2014). For example, the relief and happiness that is present when a healthy baby is born following a previous pregnancy loss may be apparent, but the meaning behind those feelings may be hidden or go unnoticed.

There are vast differences in the way that *Dasein* experiences different worlds that (for example, the world a woman pregnant for the first-time lives in will be very different to the world of a new mother), however, there is a basic, underlying everyday world that we all share. This everyday world is made meaningful to us through our involvement and relationship to the things around us and how we use them to accomplish our goals. Heidegger states that *"Dasein is 'in' the world in the sense that it deals with entities encountered within-the-world and does so concernfully and with familiarity"* (Heidegger, 1927/1962, p.138). The practical everyday world is where we spend most of our time, and it is through our Being-in-the-world that we truly begin to understand it (Heidegger, 2004).

Heidegger says that it is not just *Dasein's* encounter with the entities in this world which are important, but it is how *Dasein* actually deals with these encounters in the ordinary everydayness of life. He calls these encounters with entities present-at-hand and ready-to-hand (Heidegger, 1927/1962). If an entity is regarded as having a useful function to *Dasein* it is regarded as ready-to-hand. We use these items, and often take them for granted in that we don't think about them. For example, the chair we sit on, the air we breathe. This all changes when the entity breaks or malfunctions, then it announces itself in our awareness and becomes unready-to-hand or present-at-hand. Heidegger describes present-at-hand as entities for which we have no interest or use, or their significance to us is as a detached observer. For example, a Pinard stethoscope may be experienced as present-at-hand by most of us, but to someone who makes use of them, for example, a midwife, they are experienced as ready-to-hand. It has been suggested that this tools analysis is perhaps the greatest moment of twentieth century philosophy (Harman, 2007). It relates to phenomena in that "what comes first are not phenomena that appear to the consciousness. Phenomena are only rare cases of visible things emerging from a dominant silent background of equipment" *(*Harman, 2007, p.63).

When women become pregnant, their experience of Being-in-the-world changes as they navigate the transition to their role as a mother within society. With the announcement of the pregnancy, this transition moves from the private to the public arena in their social and cultural context. For many, the announcement of a pregnancy is a celebration and signifies for the woman a new way of Being-in-the-world as a prospective parent. The announcement also signifies a growing social connection of the child within society, partly due to the assignment of personhood and visualisation of the child through ultrasound scans (Winson, 2017; Martel, 2014; Meaney et al., 2017). With a pregnancy loss, this connection is severed, with the world suddenly becoming strange and unfamiliar. The mood of *angst* that is experienced at this time refers to what Heidegger calls *unheimlichkeit.*

4.3.2 *Unheimlichkeit* (Uncanniness).

According to Heidegger, Being-in-the-world gives us *angst* about our potentiality for being (Heidegger, 2004). The mood of a*ngst* is uncanny and makes us feel not-at-home (*unheimlich; heim* = home). Dreyfus (1991) uses the word ‘unsettled’ or ‘unsettledness’ (*unheimlichkeit)* and uses the illustration of an instrument that has failed to do its job, leading to a feeling of unsettledness. He speaks of *angst* (anxiety) as a total breakdown, a revealing of “the whole world as if from the outside” (Dreyfus, 1991, p.179). For Heidegger (2004), this ‘revealing’ is key. *Angst* then, is not just a breakdown but also a revealing of how things really are, “a special mode of access to the ontological” (Withy, 2015, p.3). Yet, at the time *angst* takes away our understanding of ourselves and the world, so that we no longer feel ‘at home’ in the world. The world becomes unfamiliar, we become alienated from the world because the world can no longer offer us anything to make sense of our lives (Blattner, 2006). *Angst* then, reveals the nothingness at the centre of human existence (Heidegger, 2004). For many, this is the world of pregnancy loss, a world that is unfamiliar and alien. Suddenly, death in relation to birth becomes a reality, yet this is difficult to comprehend as *Dasein’s* focus is turned towards death.

4.3.3 *Being-toward-death.*

Death was a central theme of Heidegger’s thought. His focus was on human mortality, and the encounter with death that highlights the question of Being (Heidegger, 2004). As soon as we are born, or even before our birth (in the reality of pregnancy loss), we are old enough to die. Yet, being born sets *Dasein* on a journey from which there is no escape, Being-towards-death. This realization is with us at all times but may be concealed from us as we are distracted by the everyday entities of this world, and therefore choose to avoid or ignore the fact that we are all on a journey towards death, *“one of these days one will die too, in the end; but right now it has nothing to do with us”* (Heidegger, 1927/1963, p.297). Heidegger calls this distraction from death fallenness. Furthermore, he states that to remain unaware of this is to be inauthenti*c* (see section 4.4.4 below).

Heidegger speaks of an impersonal, inauthentic force, the ‘they’, that does our thinking and speaking for us. For example, *Dasein* may say that “they say that most first babies do not arrive on their due date”. The ‘they’ does not relate to anyone in particular and is distinguishable from the ‘owned self’. Heidegger (2004) suggests that it is something that we rarely break free from. This is especially true in Being-towards-death. The ‘they’ will offer words of comfort, by telling *Dasein* not to worry, that everything will be alright, all designed not to address the issue of death that may be approaching sooner than wanted. Harmen (2007, p.71) suggests that “death is not usually a shocking event”. I would contend that it is, especially in relation to pregnancy loss. In pregnancy, death is not a certainty. Indeed, a pregnancy is seen as a journey to potential life. So, pregnancy loss can be untimely, a juxtaposition of death and life, and can have long standing ramifications to those it touches.

4.3.4 Authenticity *and* inauthenticity

Heidegger outlines two fundamental different ways that human beings can understand and live their lives. He calls these authentic and inauthentic and they are related to *Dasein’s* way of being- in- the- world. He maintains that we mostly live inauthentic lives, by being concerned more with how others see us, and how we get on with aspects of everyday living. This is manifested through our absorption with the superficiality of the world, for example, gossip, trivia, and mass media, and by which, to some degree, we all live to make our lives meaningful. By doing this, *Dasein* loses sight of itself and ‘falls’ into a world of inauthenticity, “the more human beings interpret themselves on the basis of entities, the more inauthentic they are” (Harman, 2007, p.173). Heidegger (1962, pp. 69-70) suggests that inauthenticity is “fleeing in the face of my Being and forgetting that I can choose and win myself”. In this way, humanity has forgotten what being is, and a more authentic way of life has been neglected (Kay, 2016). In relation to death, specifically pregnancy loss in this study, Carel (2016) claims that by avoiding death, women deny themselves the opportunity to accept *Dasein’s* finite existence to the full, instead dismissing death as irrelevant to their current situation.

In contrast, Heidegger (1927/1962, p.264) suggests that to live authentically allows for a much deeper experience of the significance of existence, "the most primordial, and indeed the most authentic, disclosedness in which Dasein, as a potentiality-for-Being, can be, is the truth of existence". By living authentically, the meaning of existence is revealed to us, "existing according to one's essence" (Heidegger, 1962, p.247). Conversely, in inauthentic living it is concealed from us. To be *authentic* means to be aware of your own self, your own possibilities and to do your own thing, regardless of the opinion of others, the 'they'. However, to do this *Dasein* firstly needs to be aware of its own possibilities in light of its Being-towards-death*,* its own mortality. By being aware of and ultimately responsible for its own death, *Dasein* is responsible for its own life. This authenticity brings with it freedom and choice, no longer bound by the expectations of the 'they' and thus becoming *resolute,* which Heidegger regards as the essential and key feature of authenticity (Heidegger, 1927/1962).

Thus, *angst* in relation to pregnancy loss*,* although profoundly disturbing, can lead to an *authentic* way of being, as women are forced to face their own mortality, and the mortality of their unborn child. The innocence has gone, with life and Being-in-the-world being viewed through a very different lens. This forces a redefining of the world, a more *authentic* way of being through an appreciation of life and its fragility. There is no erasing this present reality, this is the reality of thrownness for these women, an aspect of what Heidegger (1927/1962) calls the threefold structure of life – the past, present, and future.

4.3.5 Temporality (*Zeitlichkeit*)

Heidegger speaks of temporality as the threefold structure of life, the past, present, and future, in which time is seen as the horizon of *Being*. He maintained that in order for *Dasein* to understand what it means to be, this understanding can only be reached if it is placed in the context of time (Heidegger, 2004). He wasn't speaking of clock time, or calendar time here. This is chronological time and is viewed by Heidegger as a distortion of the *facticity* (the total sum of *Dasein's* current situation, including future possibilities) of time, which is outside our awareness as *Dasein* is constantly obsessed with chronological time (Harman, 2007).

Harman (2007, p.2) suggests “the world is a constant passage back and forth between shadow and light – and this endless passage is called time”. What is meant by this is that *Dasein’*s history is not just a list of past experiences and events, because our history is what informs our present-day plans, actions, the what, why and how we do things in the present reality. Yet this is also true of the future, in that it informs our everyday actions and reasons for doing things in the present (Cerbone, 2008).

Thus, there can be a tension between the movement of life that is never static, and between what we have been given in life and how we respond to it (Harman, 2007). When a pregnancy is lost that can shake the foundations of a person’s most fundamental beliefs and values and may encourage reflection on life in the search for meaning, which may have been, albeit temporarily yet profoundly lost with the pregnancy (Carel, 2016). There is the implication here that loss may ultimately lead to growth, although this may not be viewed as such at the time and may not eventuate.

With pregnancy loss there is the disruption to everyday life and the concept of time. Carel (2016) suggests that there is a mismatch between the continuation of clock time and the experience of time ‘standing still’. There is the experience of time slowing down, and accelerating, whilst for the ‘they’, time continues as normal. The loss of meaning is what Heidegger calls anxiety, where any sense of purposeful activity is lost, and life becomes mundane with the slowing down of time (Carel, 2016).

Heidegger (1927/1962) claims that *Dasein* is temporal, existing within our own personal and historical social contexts. It is in these personal and social contexts that pregnancy loss occurs, and responses to the loss will be influenced by that context. In the search for meaning through the loss, personal values may change, as may the focus in everyday life. Priorities shift. Nothing is taken for granted anymore. Experiences are cherished and life is lived more in ‘the moment’. A more ‘*authentic*’ way of living may be grasped. Pascal (2010, p.4) proposes that “temporality illustrates being-in-time, as developmental and historical, as well as highlighting the impermanence of our existence”.

Thus, *Dasein’s* way of being spans the threefold structure of life, with the past and the future both meeting in unified present realities.

4.3.6 Attunement (*Befindlichkeit*)

Heidegger uses this notion to describe how *Dasein* is ‘tuned into life’ in a certain way that then influences our general attitude towards whatever we are tuned into, and therefore the nature of our understanding (Watts, 2001). *Befindlichkeit* is an uncommon German word, and in translation other words have been used to try to describe this notion, for example, moods, disposedness, affectedness, state-of-mind (Blattner, 2006; Dreyfus, 1991). In this present study, the words attunement and mood will be used to depict this concept.

According to Heidegger (1927/1962, p.173) moods are a permanent part of *Dasein*’s way of Being, “Dasein always has some mood. The pallid, evenly balanced lack of mood, which is often persistent, and which is not to be mistaken for a bad mood, is far from nothing at all”. Therefore, *Dasein* is never not in a mood, even when we appear to be moodless, as when we are indifferent, detached, or contemplative. This use of the word mood is not to be confused with the contemporary understanding of mood in Western cultures, where ‘being in a mood’ is often used to depict a state of grumpiness or angry state of mind. Instead, mood in this context is used to denote how our differing moods influence us to see and behave in the world in a particular way at a particular time. For example, if we are in the mood of boredom, we may see the world as dull, anxiety may depict senselessness and insignificance, whilst joy and love may conversely signify hope, beauty, and increased motivation (Watts, 2001).

Thus, a mood can be an indicator of how things are going. Sometimes *Dasein’s* moods can seem totally inappropriate for the situation we find ourselves in, and in these times, we may miss what is actually going on around us as our perceptions are restricted (Harman, 2007). Moods disclose *Dasein’s* thrownness, our place of Being-in-the-world and, dependent on the mood can reveal the bare nature of human existence as it is. Moods therefore are a vital source of insight to us and our Being-in-the-world and may bring us to a place of authenticity (Heidegger, 2004). This leads us to the next concept of *care*. For Heidegger (1927/1962), to live an *authentic*, autonomous existence, a life that is meaningful, *care* is the essential concept that links all the other concepts together, and embodies *Dasein* as an "integrated, organic whole" (Watts, 2001, p.46).

4.3.7 Care (*Sorge*)

The German word for *care* is '*Sorge*', which refers to the managing or looking after things, or to troubles and worries (Polt, 1999). For Heidegger, "the whole of *Dasein's* being is defined as *care"* (Harmen, 2007, p.69). By this he means to bring together all the aspects of *Dasein's* everyday existence, for example, its fallenness (absorption in the 'they' world), Being-with (the social context), thrownness (randomness of its being), its moods and understanding. These aspects of everyday existence are to Heidegger inseparable from one another. It is *care* of the things that matter to us (or perhaps not) that make human existence meaningful (Heidegger, 2004). When *Dasein* is neglectful, uncaring or dis-interested, care is still active, but in a "deficient mode" (Watts, 2001, p. 47).

At a basic level, there is an element of care in everything that we do. We care about our interests, our responsibilities, our imagined futures. For most pregnant women, this is demonstrated through a willingness to maintain a healthy lifestyle, attend antenatal appointments, and adequately prepare for the approaching birth, and their imagined future as a mother. Heidegger (2004) suggests that temporality enables us to make sense of the structure of *care*, in that *Dasein's care* embraces its past, present, and future by occupying all three phases of time – in its thrownness. *Dasein* is already in the world and dealing with the *facticity* of its past, and simultaneously focusing on the future and defining itself in terms of future possibilities, and existing in the world in the present, with the everyday practical concerns of the 'they-self'. Dependent on the situation they find themselves in*, Dasein's* manner of care can change, but our basic mode of *care* is that of worry and anxiety, through an apprehension for our own being and future possibilities (Heidegger, 2004).

When we care for others (Being-with-one-another = *mitsein*), *care* then takes on the form of ‘solicitude’, by taking care of and providing for the welfare of those in need. This can relate to any type of caring role for others and, Heidegger suggests, can take the form of two types of ‘solicitude’. ‘Authentic solicitude’ helps others to take care of themselves, to be independent and to take responsibility for their own lives; the other type, ‘dominating, inauthentic solicitude’ provides *care* that invites dependency (Heidegger, 2004). Thus, solicitude can be seen as harmful or helpful. For the women in this study this was their experience of solicitude from their family, friends, and care providers. Further discussion of this experience can be found in chapter 9.

4.4 The Hermeneutic circle

Heidegger, and later his student Gadamer are credited with the development of the hermeneutic circle. Heidegger (1962, p.195) tells us that “this circle of understanding is not an orbit in which any kind of knowledge may move; it is the expression of the existential fore-structure of *Dasein* itself*”.* In the quest for understanding of phenomena hermeneutics is not concerned with merely providing an explanation. The process of Heideggerian hermeneutics is circular and illustrates that the whole can be understood only in relation to the parts and in reference to each other. For example, when we read a book, we continually move back and forth between our understanding of the part of the book we are reading and our understanding of the book as a whole. Blattner (2006, p.22) suggests that the same is true when in relation to ontology “we move back and forth between articulating some specific mode of being and our vision of the whole field of being”.

The circular process of Heideggerian hermeneutics is a method of inquiry that highlights the relatedness of the researcher to the phenomena being investigated and its surrounding context (Healy, 2011). Thus, the hermeneutic circle can provide a way to understand the connection between theory, data, and experience.

Within this process, Heidegger (1962) devised a structure which he called the fore-structure of interpretation. This process is three-fold and includes fore-having, which is the background context. As researcher, it is the both their cultural and historical background that shapes their fore-having and is the context on which the research is undertaken. The second fore-structure is fore-sight, meaning we enter a situation from a specific viewpoint. It means seeing something *as* something. The hermeneutic *as* recognises that something is understood as something. In this research, this could mean seeing experiences of maternity care in a pregnancy after loss *as* potentially phenomenal or *as* potentially harrowing. Heidegger calls this our fore-conceptions, which is the anticipated sense of the interpretation. Heidegger suggests that engaging with and working out the fore-structures of interpretation is essential as a means of entering the hermeneutic circle.

4.5 Reflexivity and the acknowledgement of pre-understandings

Returning to the fore-structures of interpretation outlined above, my own pre-understandings required continual acknowledgement and identification throughout the design of the study and the data analysis. Creswell (2013) suggests that a researcher brings to any study various theories, paradigms and perspectives that guide how the study is approached. As such, my own background significantly influenced how I approached and structured the study. For example, my own lived experience as a bereaved mother and grandmother influenced my choice of topic. In addition, my extensive professional work with bereaved pregnant women as a midwife and counsellor further informed my thinking. In this study I knew that I wanted to hear women's voices about their experiences and the meaning they made of them, so it was important that an approach was chosen that was compatible with my thinking and values, as well as the existing empirical literature, practice, and theory. Choosing an interpretive phenomenological methodology enabled not only the individual and socio-cultural context to be considered, but also allowed "the perspective of the researcher to form part of the development of meaning" (Lee et al., 2011, p.308). This meant that my own beliefs and understanding, that form an integral part of who I am, did not have to be suspended from the study but instead influenced my approach to the collection, analysis, and interpretation of the research data. I concur here with Heidegger's notion of *Dasein* and Being-in-the-world. My life, and the lives of my fellow human Beings are lived out within a social context, intertwined, that shape who we all are. For me, my work in the midwifery context illuminated the paradox of the pregnancy and birth experience. On the one hand, there is joy and celebration, on the other there is intense pain and distress, with a host of differing experiences between these two extremes. I cherished my role as one woman being-with another, but I did question what I saw as the inflexibility of the maternity system which in my opinion, failed to recognise the complexities of caring for bereaved parents. In addition, my assumptions that most women (but not all) experience some sort of acute emotional and psychological long-term reaction to the loss of a baby were influential in the design stage of my study. Similarly, when previously working within the therapy context as a Gestalt counsellor, I journeyed alongside women who were still traumatised by their pregnancy loss and trying to navigate the conflicting emotions that arose as they embarked upon another pregnancy. These hosts of preconceptions, beliefs, values, morals, and viewpoints, some of which are mentioned above, would make it impossible for me to take a completely neutral objective stance in my approach to this research. Taken together, these influence and colour my understanding of the phenomena being investigated, as well as influencing the nature of the investigation, the identification of worthwhile evidence and pointing to the kinds of conclusions that can be drawn (Denscombe, 2017, Wahyuni, 2012).

By way of summary, this chapter has presented the theoretical positioning and philosophical foundation for this research, and how the choice of these were guided by the aims of this study. A rationale was provided for the choice of the chosen methodology, hermeneutic phenomenology. Key Heideggerian concepts have been introduced. These will be used and applied in the interpretation of the research data later in this work. Where applicable, illustration of how this approach can be used with the study has been provided.

In the next chapter an overview is presented of the design and methods chosen for the study, which are underpinned by the theoretical framework and methodology discussed in this chapter.

Chapter 5 - Research design and methods

The previous chapter provided an overview of the theoretical positioning and the philosophical foundation for this thesis. This present chapter presents the methods of data collection and the data analysis process of the research. Throughout, an in-depth account of the design and process of the research is provided, to ensure transparency of the developmental stages of the work. As a further means to ensure transparency, a reflexive account of my own pre-understandings, thoughts, feelings, assumptions, and values throughout the process will be provided in appendix A. Writing in this way ensures that the work is in keeping with the phenomenological approach of the research method, and highlights both the ontic and ontological aspects of the phenomena (Watts, 2001; Crotty, 1998; Smythe et al., 2008). Heidegger (1927/1962) maintains that interpretation is co-constructed, and that the interpreter can never "free themselves from their own pre-understandings which will always bias their thinking" (Smythe, 2011, p.37).

5.1 Research methods

5.1.1 Sampling and participants

It was important that the sampling criteria be as concise as possible to ensure that the research was open to a broad range of potential participants. However, to be eligible for inclusion women needed to have experience of the phenomena being investigated. Therefore, to be eligible for inclusion in the research all participants needed to be currently pregnant, and to have experienced a previous pregnancy loss (as defined by the key terms in chapter 1, table 1). This was self-reported by the participants; medical notes were not sought to confirm the pregnancy or the reported previous pregnancy loss(es).

Initially in the early design stage of the research the plan was to recruit women from England. Other countries in the United Kingdom were excluded because maternity systems in these countries differ from those in England, which could have added variability and confusion to findings. As the design developed, the decision was taken to narrow down the recruitment area to the county of Lincolnshire. The rationale for this change was firstly, it is an area I live in and have worked in professionally for many years. I am therefore very familiar with the area, and the challenges (such as a lack of good transport infrastructure, and the availability of services being centralised in the cities and towns) that are present living and working in a rural county. Secondly, it was intended that this research would be instrumental in enabling women's voices to be heard by the service providers and practitioners who work within maternity services in the county, and that this work will be influential in ensuring that women's needs and expectations are met when they are accessing maternity care after a pervious pregnancy loss. The findings of this research could also be applicable to maternity services around the UK, especially those services that are provided within a rural community.

Finally, Lincolnshire until recently has been a county with little cultural diversity in its population. However, the last twenty years have seen a small (in comparison to other regions in the UK) yet significant increase in the number of ethnic minority populations moving to the county, introducing the beginnings of a rich and diverse ethnic population (Lincolnshire Research Observatory, 2019). Aiming for a sample that reflected the cultural diversity of the county, the aim was to be able to recruit from a culturally diverse population as participants in this work. However, due to not having the resources available for translation services, women who could not speak, write, or read English to a reasonable standard could not participate. The final set of inclusion criteria was agreed as follows:

- The research participants must currently (at the time of data collection) be pregnant and assessing NHS maternity care.
- The participants will have experienced a previous pregnancy loss, or losses (as defined in the key terms in table 1).
- If English is a second language, participants will need to be able to speak, write, and read English (resources were unavailable for translation services).

- At the time of the research, participants must reside, and be accessing maternity services in the county of Lincolnshire, England.

5.1.2 Sampling techniques

A purposive sampling method (Sarantakos, 2013) was used to identify suitable participants for this research, as was snowballing by word of mouth. In practice this meant that the women who, during the marketing campaign of the research, showed an interest in taking part in the research, who met the inclusion criteria (see 5.2.1 above) and were interested in sharing their experiences of the identified phenomenon (Ritchie et al., 2014; Smythe, 2011) were invited by the researcher to be participants.

In considering sample size, there were several factors to contemplate. Practically, it was about ensuring that the sample size was substantial enough to reflect the level of a doctoral piece of research yet ensuring that it was not too large (for the methodological approach being used) and risk being overwhelmed with copious amounts of data (Smythe, 2011). The original plans were to recruit 15 participants. However, through extensive reading and discussion with colleagues about sample sizes in research using the hermeneutic approach the decision was taken to limit participant numbers to between eight and ten. With the plan to interview each participant twice, this would mean a total of between 16 and 20 interviews, which, according to Smythe (2011) is a suitable size for a doctoral study, and acceptable in in-depth studies, such as those using phenomenology, and other interpretive methods. In practice, due to difficulties with recruitment, seven participants were recruited. Initially concerned that this number would not be enough, these fears were unfounded when work with the interview material commenced, and it was recognised that the thirteen interviews undertaken had generated an immense amount of rich data for analysis. Preliminary analysis of the interviews revealed that there was a significant number of rich, meaningful accounts.

5.1.3 Participant recruitment

There were two different approaches to the recruitment process. Firstly, through contact with the Research Department at the two hospital trusts (unnamed in the study due to confidentiality issues), and then contact at a local level with departmental managers, arrangements were made for the distribution of posters and flyers advertising the research. These arrangements included attending a midwifery managers meeting at one trust where the research project was outlined, and questions invited. At the second trust, at the request of the designated midwife, the marketing materials were left with a receptionist who would pass them onto this designated midwife for distribution. A follow up call ensured that they had been received and that this midwife would arrange distribution as we had discussed. To maximise recruitment potential, arrangement was also made with the local county council for the marketing materials to be distributed to women who used the local children's centres.

The other approach to recruitment was through social media groups and Facebook pages. Initially the idea was to recruit via advertisements on social media websites such as Netmums (Netmums UK, 2021), Sands (Sands, 2021), Bliss (Bliss, 2021), and Bounty (Bounty, 2021). It was expected that from these advertisements some participants may also have been recruited via snowballing (word of mouth). However, this idea did not come to fruition, as requests to these national forums were declined, due to them not accepting marketing materials from researchers, or them advertising their own commissioned research into pregnancy loss topics. Instead, the administrators of local Facebook groups in Lincolnshire that were thought to have pregnant women as members, for example local parenting groups, mums' groups and county wide groups were contacted. Permission was sought to advertise the research project within these groups. An advertisement was devised that was compatible with social media platforms. In total twenty-three different groups were contacted, and all gave permission for the advertisement to be placed.

Potential participants who responded to the advertisements were contacted via telephone or email for an initial discussion about the research. Those who continued to express an interest were sent a letter thanking them for their interest in the project (see appendix B), an information sheet outlining the purpose of the research and the expectations of participation (appendix C), and a consent form to sign prior to any interview taking place (appendix D).

Participants who met the inclusion criteria were recruited via the following locations:

- Four participants responded after seeing advertisements on social media.
- Two participants were recruited after seeing the posters and flyers in one hospital trust.
- One participant was recruited after hearing about the research through a mutual acquaintance.

A further seventeen women made contact about the research, fourteen of whom did not meet the inclusion criteria. The remaining three did meet the criteria but after discussion, chose not to take part.

5.1.4 Participant profiles

The demographic characteristics of the participants are shown in table 3. Seven women participated; all were pregnant at the time of recruitment, meeting the inclusion criteria. Six of the women were born in England, one was born in Belgium. Five women had lived in Lincolnshire all their lives and one was born outside the county, moving to Lincolnshire with her family as a child. Four of the women in the research had children, one of whom had two adopted daughters. The total number of losses per participant ranged from one to four. Two women had fertility treatment to get pregnant in their previous pregnancies, that resulted in four losses in total (one for one participant and three for another). All except one were employed at the time of the interviews and intended to return to work following a period of maternity leave. They were all in heterosexual relationships at the time of the interviews. Participants reported a range of different types of pregnancy loss, including early and late miscarriage, ectopic pregnancy, and intrapartum stillbirth. The participants who reported more than one loss were given the opportunity to talk about all their losses in as much or as little depth as they wanted.

Six of the participants were interviewed on two separate occasions, whilst one participant was interviewed on one occasion only. This was because there was no response via email or telephone to my requests for a second interview. Thirteen interviews were completed in total. The interviews took place between April 2018 and August 2019. The duration between the first and second interview varied from three and a half weeks to five months. This was dependent on the woman's gestation at the first interview and the date of birth of the baby. The woman's gestation at the first interview ranged from twenty-two weeks to thirty-nine weeks. Each interview lasted between fifty minutes and one hundred and twenty minutes, were audio-recorded, and transcribed at a later date. All the interviews were confidential (with the exclusion of any safeguarding concerns, which did not arise during the duration of the data collection phase). There were a few interviews where others were present. I was the sole interviewer at each interview. A broader description of the participant profiles is provided in Chapter 6.

Table 3

Demographic characteristics of participants (N=7)

Age range	21 – 30	2
	31 – 39	5
Ethnic group	White/British	6
	White/Other	1
Type of pregnancy loss	Early miscarriage (up to 12 weeks)	8
	Late miscarriage (12 to 28 weeks)	2
	Ectopic pregnancy	1
	Stillbirth (intrapartum)	1
Number of previous pregnancy losses	One	4
	Two	2
	Three	0
	Four	1
Assisted conception	Yes	2
	No	5
Subsequent pregnancy planned	Yes	11
	No	1

5.1.5 Data collection

5.1.5.1 First contact with the participants

The initial contact with potential participants was via email or telephone and followed them responding to a recruitment advertisement. It was important that this first contact was as relaxed and as friendly as possible, regardless of the media used. After introductions and an explanation of both the professional and personal reasons for the research (to ensure transparency in the research process), potential participants who requested further information about the project were sent out the relevant paperwork (letter, information sheet, consent form), with the assurance that contact would be made after a few days to arrange a date for the first interview if they were still interested. There was a discussion at this point about where they would like the interviews to take place. It was important that the location was as familiar and as relaxing as possible for the participants to encourage open and free discussion of their experiences.

5.1.5.2 In-depth phenomenological interviews

In-depth interviews are used extensively as a method of data collection in qualitative research (King & Horrocks, 2010; Cresswell, 2016). Smythe (2011, p.42) suggests that a phenomenological interview “draws a participant into conversation to encourage them to bring words to shape, colour and texture the account of what happened. To stay close to the experience itself is to recount the story itself”. This is particularly relevant in hermeneutic phenomenology where the quest is to return as closely to the primordial (the beginning, original, instinctive) experience (Heidegger, 1927/1962), and was influential in the decision to interview the participants twice. Using two interviews, one in the antenatal period and one in the early postnatal period, enabled the voices of the participants to be heard when they were in the midst of the experiences and proved to be particularly poignant for them, as they were pregnant at the time of the first interview and had a baby at the second.

The nature of the interviews meant that it was likely that very sensitive experiences would be disclosed, and that participants could become distressed and vulnerable during the process. The sensitive nature of the subject data was an important factor in the decision to use dyadic face-to-face interactions as opposed to telephone interviews, interactive technology, or focus groups where participants may be reluctant to share such sensitive information in a group setting (Ritchie et al., 2014; Brinkmann & Kvale, 2015). Thus, the intention was to make the interviews as relaxed and conversational as possible to elicit the data needed. Brinkmann and Kvale (2015) suggest that the research interview is based upon the conversations of daily life, and that it is a professional conversation. The aim is to attempt to understand the participants’ world from their point of view and to uncover the meaning assigned to their experiences. Interviews, if conducted well, are therefore a valuable means to elucidate the subjective lived experiences and viewpoints of participants and the meaning constructed from these experiences (Tracy, 2013).

The decision to interview each participant on two separate occasions was made for several reasons. Firstly, as mentioned above, interviewing the participants in the antenatal period and the early postnatal period enabled access to their experiences of the phenomena whilst they were actually living it. Thus, the accounts provided were rich in detailed, current perspectives of their experiences. Secondly, there was methodological reasoning to my decision. Following the first interview, the audio-recordings were transcribed, and preliminary analysis commenced. This allowed feedback to be provided to the participants of the emerging themes at the second interview. In qualitative research, and especially in contemporary phenomenological research it is not uncommon for this to happen, as a means of checking that initial analytic interpretations are in keeping with the participants' lived experiences (Crowther et al., 2016; Sarantakos, 2013; Bryman, 2016). Finally, the second interview, after the successful arrival of the baby (thankfully) and the deepening rapport and trust built up between participant and me as researcher throughout the data collection process, enabled the full and frank disclosure of deeply personal insights and perspectives at such a poignant time in their lives.

The use of in-depth phenomenological interviews was therefore a combination of a method that complemented the chosen methodological framework, as well as enabling the incorporation of the professional interviewing skills that were gained as a midwife and therapist. In addition, personal experience as a mother and grandmother who had grieved the loss of her unborn child and grandchild, meant that the empathy felt for the participants was genuine. The participants were aware of my background from the beginning of communications when they enquired about the research and agreed to take part. Although it may be argued that objectivity cannot be maintained with such self-disclosure, using an approach that incorporates the subjectivity of both the researcher and the participants in the research design and process can achieve this (Flick, 2014). Moustakas (1990) suggests that far from being restrictive, self- disclosure can be seen as beneficial to the research process, as it often elicits further rich, fuller, and more comprehensive disclosure from the participants. As discussed earlier in section 4.5, a characteristic of the hermeneutic phenomenological process is that the researcher's own values, feelings, beliefs, and preconceptions are an integral part of the research process. It is through transparency of these pre-understandings, along with meaningful reflexivity, that accusations of researcher bias can be minimised (Ritchie et al., 2014).

The interviews were planned to take place in a mutually agreed location. Twelve of the interviews took place in the participants' own home, and one interview took place in a public café (chosen by the participant due to her living with other family members at the time of the first interview). In qualitative research, it is not unusual for face-to-face interviews to be conducted in such settings (see Thomson, 2011; Crowther & Smythe, 2016). However, as with all settings where face to face interviews are scheduled to take place, caution was needed to ensure the safety (physical and emotional) of both the participants and myself as researcher. In relation to researcher safety, Braun and Clarke (2013) suggest implementing a "buddy" system (with appropriate ethical clearance), where another identified person has details of the researcher movements around the data collection but only accesses these if a problem is encountered. The researcher contacts the "buddy" just before data collection is due to commence with a rough guideline of a finishing time. The researcher then checks in when the interview is finished via a brief telephone call. The "buddy" raises the alarm if the researcher fails to check in. Agreement was reached on using this system for the interviews.

5.1.5.3 The first interview

The first meeting with the participants commenced with a welcome into their homes or a greeting in the café. The participant interviewed in the café knew the area well and had chosen a café that would be quiet at the chosen time of the interview. We were able to find a quiet corner where we were not disturbed, and background noise was not a problem. Similarly, where possible, participants with small children chose a day and time for the interview when their children were at school or nursery. On the occasions when this was not possible, the interview was conducted with the children present playing in the room. At one interview, a participant's partner was present.

The purpose of the phenomenological interview is to gain information of how participants perceive and experience an identified phenomenon. The aim is to gather deep and rich information about the experience whilst remaining as close to the participant's stories as possible. A research conversation is encouraged to draw the participant into the telling of their story/experience. For this reason, it was important for the interviews to be participant led as far as possible. A semi-structured interview approach was chosen as this has been shown to give the participants the freedom to tell their story in depth (Smythe, 2011). However, the word 'interview' still portrays a formality to the task, so they were introduced to the participants as a conversation where they could speak of their experiences and would be asked to clarify anything if needed. Prior to the interviews a list was developed of possible questions and prompts that might be required. These were rarely needed, as the participant directed their interview. If the participant began to lose the focus, the prompts were used to encourage a return to the experience. To reflect the phenomenological approach, the interview questions were designed to be as broad as possible to give the participants the space to answer, free from the constraints of a structured interviewing process. In total, only three questions were devised for each research question. These focused on the experience of pregnancy loss, the current pregnancy, and experiences of maternity care in the current pregnancy. In the interview process it was crucial that the baby who had been lost was spoken of and acknowledged. It would have been disrespectful to that baby's memory and the participants to only focus on the experiences of maternity care in the current pregnancy. The review of the literature in chapter 3 had revealed that the experiences of pregnancy loss were present and influential in experiences of care in the subsequent pregnancy. Both experiences were equally relevant to my research, as experiences are often temporal, with previous experiences influencing present lived behaviour and future possibilities (Harman, 2007; Pascal, 2010).

Although genuine dialogue cannot be planned (Moustakas, 1990), several general questions were prepared in advance of both the first and the second interviews. To answer the research question "How do pregnant women experience maternity care and support following a previous pregnancy loss?" the types of questions considered included:

- Tell me about your previous pregnancy when you lost the baby/name.
- Can you tell me about this pregnancy?
- What have been your experiences of care in pregnancy/in labour/after the baby/name was born this time?

To answer, "How are these experiences meaningful", the questions considered included:

- Tell me about your needs and expectations of care in this pregnancy.
- Were these needs and expectations met?
- Does anything significant about your care in this pregnancy stand out for you?

Prompts such as "Tell me about what happened", "Tell me about a time that went well", "And what happened next" were used when appropriate to encourage the participant to stay close to the experience when recounting their story.

As expected, many of the participants became emotionally distressed and tearful at times during the interviews. Despite being given the opportunity to stop the interview, all the participants chose to continue, either without a break, or with a small break to compose themselves. Throughout the interviews and afterwards, attention was paid to the women's needs, with support and reassurance offered when necessary, including ensuring that the women knew how to access further specialist support if needed. In addition, as researcher and as an aid to self-support, immediately following the interviews time was spent recording and reflecting on the interviews, with accounts written up in field notes and a reflexive journal, and discussions held with supervisors and colleagues.

5.1.5.4 Transcribing, and preliminary analysis

All the interviews were audio-recorded and then transcribed. Braun and Clarke (2013) suggest that a transcription is a representation of an interview, the product of "an interaction between the recording and the transcriber, who listens to the recording, and makes choices about what to preserve, and how to represent what they hear" (p.162). This suggests that the transcription process can never be fully accurate. The aim in this research was to ensure that the transcription process was as thorough and meticulous as possible. In part, this was achieved through the devising of a notation system as a means to register in the transcript where, for example, there were silences, pauses, tears, laughter, and interruptions in the interviews. Although time consuming, it is recognised that the production of transcriptions is an integral part of the interpretive, data analysis process (Ezzy, 2002; Denscombe, 2017), and as such researchers are encouraged to personally undertake this process (Bryman, 2016). The process in this research enabled a reacquaintance with the data, with increasing familiarisation and immersion, thus beginning the data analysis process. Once both interviews had been completed and transcribed, the transcripts were used to later craft the data into stories (not to be confused with stories in the narrative approach, see section 5.1.5.6 for an outline of this procedure), which were then shared with the participants for confirmation and approval. To do this, each participant was emailed once the stories had been drafted and asked if they wanted to see them, with the caution that they were an emotional account, so self-care was advised when reading them. All the participants except for one (who didn't respond to the request for a second interview) requested to see the drafts and subsequently gave feedback. Returning the drafts in this way ensured that the data truly reflected the participants' recollections and allowed for any discrepancies to be identified. In addition, the inclusion of the participant in this process was an important aspect of ensuring the credibility of the data collected (Kumar, 2019). The transcription software Express Scribe (Version 9.10) was used to aid with the transcription process. The merits of using this software were in the time it saved transcribing each audio, through the use of the available tools in the software to aid the process. Each interview was transcribed as soon as possible after it had taken place. An example of a transcribed interview can be found in appendix E.

Through reading and dwelling with the data in the manuscripts of the first interviews, some basic insights were gleaned about how temporality, moods, and aspects of care featured in the participants accounts. I was led back to the work of Heidegger's Being and Time (1927/1962) in relation to these insights.

5.1.5.5 The second interview

Through mutual agreement at the first interview, it was decided how contact would be made by a specific date to arrange the second interview, after the due date of the new baby. Ethically, this contact could be challenging, due to not knowing if there had been any complications since the first meeting, or indeed if this subsequent baby had been born healthy and alive. The Health Research Authority (HRA), when giving consideration to awarding ethical approval for the study, had voiced concern about this very prospect, and it had been agreed that there would be a point of contact at each trust to find out if there had been any complications or adverse outcomes. Although two of the participants did indeed have complications having their babies prematurely, this safeguard was not used, as all the participants either contacted me directly to arrange the second interview or responded to email communication about arranging it. The one participant who did not have a second interview, did initially respond to my email requesting one, but wanted to delay the interview due to being out of the country for a long period of time. A timeframe was agreed for when contact would be made again, but she failed to respond to that correspondence. After a second attempt with no response (and several weeks being left between each attempt), with the timeframe for undertaking the project being tight, the decision was taken against any further attempts to contact her. An email was sent to thank her for her contribution to the research.

Returning to the participants' homes for the second interview, the dynamics had changed, in that there was now a new-born baby present that needed caring for and attending to. It was a huge relief that these babies had arrived and were thriving and healthy. Obviously, there was now the need to work around any interruptions from the baby, and any effect that may have on the flow of the interview. To put the women at ease and before the interview began, we spoke about any interruptions, and that the interview could be stopped and started as many times as was needed should the baby need attention.

The second interview was informed by the first one. Before the interview commenced, there was a discussion about initial thoughts of the findings from the first interview. The women also shared feedback of their thoughts and feelings from the first interview, often adding in information that they felt they had forgotten to include previously. The second interviews felt very relaxed, perhaps partially because their babies were here now and some of the anxieties around that process had been allayed. It was interesting to find out about their experiences of maternity care since the first interview, their birth experience, and their overall experiences of care now that they could look back with a healthy baby. At these interviews, the conversation flowed freely so that any input from myself was minimal. The draft questions for this interview, detailed below, were rarely needed as the participants covered all that was needed in this free-flowing conversation:

- Tell me about your experiences of maternity care since I last saw you.
- Tell me about your birth experience.
- Tell me what was good and not so good about your care experiences.
- Is there anything significant that stands out for you about your care?

Each interview at this stage lasted between fifty minutes and one hundred and twenty minutes, depending on the detail used in the discussion. The interviews ended with an explanation of the next stage of the research, the crafting of the stories from the data, and that if they wanted, they would receive these via email to verify that the stories were a credible representation of the interviews.

5.1.5.6 Crafting of stories

Smythe (2011) suggests that the interpretive journey begins when a story of an experience is told. Working with a story in this sense, is not to be confused with the working of stories in the narrative approach, although in both approaches the focus is on the lives of individuals, as told through their own stories. From a hermeneutic phenomenological perspective, interpretation is central to revealing knowledge and meaning, for both the participant and the researcher. In their stories of their experiences, the participant can never reveal the past 'as it actually was', only the truth of their experience from a certain perspective. For the researcher, particularly in the analysis stage, whose position can be neither neutral or objective, and being unable to access the personal experiences of the participants', is only able to report on what the participant relates (Larsson & Sjoblom, 2010). Thus, this process of data analysis is my interpretation of the participants interpretation of their experiences.

Following Caelli (2001), Smythe et al. (2008/2011) and Crowther et als. (2016) guidance in crafting the stories from the transcribed interviews provided a way of managing the raw data and engaging with the interpretive process. Caelli (2001, p.276) calls this "deriving narrative from transcripts". The process began with the re-reading of the transcripts alongside listening to the audio-recordings, listening for stories that captured the meaning of my research. Most of my dialogue and questions were deleted from the stories, as were details that were irrelevant to the research, for example, the exchange between the woman and her partner when he returned from the supermarket. During dialogical exchanges, the direction of the exchange was rarely linear. Instead, the tendency was to jump from one part of the story to another part, and back again, adding in new topics as the memory of them was triggered. This was the case with the participant's stories, so as well as the correction of grammar and syntax, using the participant's actual words, parts of the stories were re-arranged to present the experiences as they happened. The result was a clearer and more focused story (see appendix F for an example of a crafted story). There was some uncertainty at the start of this process whether to craft one separate story from each participant interview. Many different stories were emerging from within each story, and this led to a re-crafting the stories in the writing and re-writing phase of the data analysis. However, in this initial stage, the decision was taken to craft the two interviews together in one story. This provided a full account of the women's experiences, from the time of the previous loss through to the birth and early days with their new baby. It was this story that was sent to the participants for review, this stage undertaken to ensure that they remained close to the experiences as told in the interviews. Returning the stories to the participants in this way invited opportunities for clarification or editing, by adding or deleting parts as identified. There was only one request for an edit, where one participant, Becki, wished to add an addendum to her original story to reflect the fact that since more information had been released about the stillbirth of her daughter, she and her husband had started legal proceedings against the hospital involved. All the participants spoke of how emotional they were and moved by the re-reading of their stories. One said she had never had the opportunity to speak of her experiences in such a full and frank way. Another spoke of how it felt like she was reading somebody else's sad story and it was surreal to think that this was a story of part of her own life.

5.1.6 Data analysis

From a design perspective, it was essential that an approach to data analysis was consistent with the chosen methodology and philosophical approach. With this in mind, the choice was made to analyse the data in a hermeneutic/interpretive manner. Smythe et al. (2008) suggest that working with the data in this way opens up new possibilities that other research methods may miss. For example, working with the data in a hermeneutic manner requires the researcher to examine the phenomena in the rich textual background where it is lived. To remove a story from this context "is to remove meaning and thus the possibility of understanding the experience as it is lived, for we can only ever live in a context of time, place and situational influences" (p. 1392).

Working with the data in a hermeneutic manner involved a process of reading, dwelling with the data, thinking, writing, talking, re-reading, re-writing, thinking (linking to philosophical texts). The aim is through this process to make an ‘interpretive leap’ (Smythe, 2011) to reveal the meaning in the text. It is a cyclical process, outlined by Heidegger (1927/1962) that is illustrated by the hermeneutic circle. It is the moving back and forth between the self (as the researcher can never separate themselves from the process), the data and the literature, the whole (Ezzy, 2002).

There has been some debate about the use of the word ‘themes’ to report findings from research. Harmen (2007) suggests that to thematise is to objectify and to remove the experience from its context. Van Manen (1990, p. 79) states that “grasping and formulating a thematic understanding is not a rule-bound process but a free act of ‘seeing’ meaning. In the past, my personal thoughts of themes viewed them as commonalities in and across pieces of work, but, through this work, understanding has developed to now seeing them as something that stands out as significant in a piece of work that calls for further thinking and exploration. In this work, the word ‘themes’ will be used in this manner, to highlight something as significant, not necessarily something that is generalisable as being true for everyone.

Using Moustakas’ (1990) framework as a guide, data analysis started at the transcription stage, and in the repeated listening of the audio-recordings and reading of the transcripts. The process involved what Moustakas (1990) calls intuition, indwelling, focus, immersion, illumination, and explication. Each phase was worked through. This was never a linear process, but an iterative journey of moving back and forth between field notes, the data, Heideggerian theory, thinking, in keeping with the hermeneutic interpretive circle. Influences during this process included the writings of Caelli (2001), Smythe et al. (2008, 2011) and Crowther et al. (2016). Smythe (2011, p. 1392) maintains that “Working with the data is an experience of ‘thinking’. We are called by a particular story, just as one stops in front of a particular painting in an art gallery”. This explanation resonated, as immersion in the thinking of one story that captured attention would bring reminders of a conversation that had taken place, another transcript that had been read, or some aspect of the literature reviewed. And so, the process of interpretation commenced, although the interpretative journey began in the telling of the story.

5.1.6.1 The interpretive process

The interpretative process involved an intense process of indwelling in the data, working with the stories individually, collectively, moving between the parts and the whole, returning to the literature, re-thinking, re-writing, the cyclical process of the hermeneutic circle.

It was at this time that consideration was given to using the software programme NVIVO (2018) to assist with the task. However, due to concerns about whether the use of software would somehow introduce a distance between myself and the data, the decision was taken to continue to work with the data manually.

Ezzy (2002, p.25) likens the process of hermeneutic data analysis to a dance, where the interpretations of the participants and the researcher are “repeatedly interwoven until a sophisticated understanding is developed”. The search for meaning in the stories meant searching between the lines of what was said, to uncover the meaning behind (Smythe, 2011).

Using Moustakas’s (1990) process of data analysis, each story was worked with intensely, focusing, “indwelling”, to try to understand the participants Being-in-the-world of receiving maternity care after a previous pregnancy loss. Immersion in the data of each story brought an awareness of themes that emerged in and through the data. Moustakas (1990) advocates devoting time and energy to this stage as a way of comprehensively understanding the individual participants’ experiences through the data. Through this process, tentative themes were formed that influenced the emerging understandings of the participants’ experiences. For each part of the process, there were multiple sets of preliminary analysis notes, from journal entries completed after each interview that recorded any thoughts, feelings, observations, phrases, and emerging conceptualisations. Emotional responses to the interviews were recorded in a separate journal. In addition, notes were made on transcripts, and later the crafted stories. With the re-reading and listening of the audio recordings, the data analysis process became increasingly complex, as the process was repeated for each set of data. It is important to note that engaging with the hermeneutic circle in the process of data analysis is not a linear process, as interpretations and theories are developed and re-developed within the circle (Ezzy, 2002).

Engaging with the hermeneutic circle in this way enables an understanding of human life. It is exhausting and time consuming and ‘messy’. Moustakas (1990) recommends that a break away from the process, the period of incubation which enables the researcher to return with a fresh perspective. This break fell naturally after the initial immersion with the data and the timing of the second interview. This period was surprisingly productive, as the emerging themes, ideas and thoughts re-emerged through a process of pondering and intuition, often whilst out walking or playing with the grandchildren. Re-engaging with the data after this break brought forth new themes and perspectives, that were reinforced or refuted during and after the second interview. For example, one emerging theme was the prevalence of the participant’s relationship with time throughout the interviews, as their present realities were entwined with their past experiences and future dreams. In my interpretation, the present time was seen as a ‘waiting room’ for their future dreams of having a healthy baby. This emerging theme led back to Heideggerian theory, and Heidegger’s (1927/1962) notion of temporality. This is just one example of the way that the emerging themes in this research developed. The process was iterative, in that it involved a constant flow between the data, Heideggerian theory, academic literature, thinking, and a combination of my extensive notes and discussion. Smythe (2011) suggests that there is no end to hermeneutic interpretative phenomenology, instead there is a point in time, where present findings are reported on whilst knowing that there is much still to uncover. In this present research, this point in time was influenced by the constraints of undertaking a doctoral research project, where an end date was set at the beginning of the project with only a small amount of flexibility built into that. Thus, the interpretations and reported findings are a snapshot at this particular moment in time, offered to the reader as a basis to inform their own interpretations and judgements (Denscombe, 2017).

5.2 Methodological integrity

5.2.1 Ethics

The welfare of the participants throughout and beyond this research was of great importance. Phenomenology can draw out stories that people are not used to telling or are not used to telling in so much depth. It is common then for the subject matter in phenomenological interviews to elicit tears from the participants, as they reveal their experiences and render themselves emotionally vulnerable (Smythe, 2011). It was therefore vital that ethical procedures were put in place and adhered to. This included aspects of my safety as researcher as well. Ethical approval was obtained from the Health Research Authority (HRA), and Bishop Grosseteste University Ethics Committee prior to the commencement of any data collection or contact with potential participants.

When undertaking any research, there are ethical issues to consider. The ethical principle of beneficence requires that the researcher considers the welfare of the participants and is a fundamental requirement of all research. In this research, the welfare of the participants was at the forefront of the planning at the design stage. For example, it was known that there was a possibility that some participants may experience emotional distress as they recounted the experience of losing their baby. Included in the ethics application was a plan of action to take if this was to happen. Immediate support would be provided by myself as I would be present at the immediate time of the distress. In addition, the participants would be encouraged to speak to and reach out to family and friends or contact independent organisations and counselling agencies for support. Finally, a list of local support organisations was included on the information sheet provided to all participants prior to them agreeing to take part in the research. As researcher, if I became distressed during the process, I had access to Bishop Grosseteste University (BGU) student services, and private counselling if needed.

The information sheet (appendix C) was provided to all participants via email or post outlining the purposes of the research as well as addressing the ethical issue of informed consent and their right to withdraw from the research at any time up to the time of publication, with no negative repercussions. A consent form (appendix D) for each participant was provided for signing prior to commencement of any interviews (meeting the participants' respect for autonomy). The principle of non-maleficence was met by ensuring that all participant data was anonymised (e.g., consent forms, interview data, demographic information), with suitable pseudonyms being used where appropriate and other identifiers such as partners' names or place names, suitably amended to protect the anonymity of individual participants, and to ensure as far as possible that no harm came to the participants through their data being identified.

5.2.2 Addressing rigour in this study

There is debate about how to best determine the quality of phenomenological research (Langdridge, 2007; Morse, 2018), especially since the criteria for such determination has been described as "subjective, ever-changing, and sometimes problematic" (Tracy, 2013, p.228). It is not my intention to address this debate here, but there is a need to be able to demonstrate the credibility of this work in a way that illustrates the rigour and trustworthiness of the process. For example, readers need to be assured that the research has been carried out responsibly, in an organised way, with an audit trail of the process throughout. As a phenomenological researcher, the aim in this research is to represent the phenomenon being investigated as closely as possible to how it was experienced by the participant (Morse, 2018). Pereira (2012, p.19) states that

> "To be judged valid, a phenomenological study must take into consideration methodological congruence (rigorous and appropriate procedures) and experiential concerns that provide insight in terms of plausibility and illumination about a specific phenomenon".

Guba and Lincoln (1985) devised a technique that attributed key elements that, if present and clearly demonstrated would enhance the rigour, and hence the trustworthiness of qualitative research. These elements, or activities to demonstrate, relate to the ‘credibility’, ‘transferability’, ‘dependability’, ‘confirmability’, and ‘reflexivity’ of the project. Using these key elements, table 4 (below) illustrates how they were utilised throughout the study to demonstrate rigour.

Table 4

Addressing rigour in this study using Guba and Lincoln's (1985) key activities.

Key Activities	***Application in this study***
Credibility – this is achieved when the findings from the research represent a credible interpretation of the participants original data. Guba and Lincoln (1985) suggest that this can be achieved through several different actions, for example, prolonged engagement, peer debriefing, member checks.	Credibility was achieved in this study in a variety of ways. This study was conducted over a period of five years, which was a sufficient investment of time (prolonged engagement) to immerse myself in the design of the study and the literature. The richness and depth of the data collected required both repeated interactions with the participants and prolonged submersion in the data (pp.110 – 113, pp.114 – 117). Peer debriefing was accomplished in several ways. Firstly, through regular supervision consultations throughout the research process, where decisions taken, data analysis and interpretations made from the data were carefully scrutinized and challenged (p.236) Secondly, this work was extended through me presenting at conferences and seminars to academic audiences. In this study the participants were interviewed twice. This allowed for me to discuss my initial interpretations with them (member checking) of the first interview at the second interview, to clarify that

	they were a representation of our previous discussion. In addition, once the second interview had been completed and the data had been crafted into stories (pp.112-113), these were then returned to the participants for further clarification and any comments/observations.
Transferability – this is the extent that the findings can resonate to different contexts, not necessarily the same as the context of the study (Bryman, 2016). This is also applicable to how the reader recognises and interprets the findings to their own experiences (Guba & Lincoln, 1985).	The data collected in this study is what Geertz (1973) refers to as rich, thick data. This was in-depth accounts of the lived experiences of the women being interviewed of the phenomena being studied. The accounts included the socio-cultural aspects of the participant's experiences of maternity care in a pregnancy following a previous pregnancy loss, thus providing wider contextual reference to the phenomena. This provided readers with a broad database to make judgements about the possible transferability of findings to other contexts.
Dependability – refers to the need for qualitative researchers to account for every decision and change made to the research process by adopting an auditing approach. This involves leaving an audit trail through the completion of records for all phases of the research process, through the use of, for example, field notes, interview transcripts, data analysis decisions (Bryman, 2016).	In this study, copious fieldnotes were made before and after participant interviews, along with the compiling of a reflective journal for the duration of the study (and beyond). During the data analysis process a separate journal was used to document the decisions made in the interpretation of the data. The contents of these were discussed at formal supervision meetings, or informal discussion with peers and other academics (p.236).
Confirmability – is concerned with ensuring that, as far as possible, the study is not a product of the bias of the researcher, but instead	Confirmability in this study was addressed in several ways. When reporting on the findings, textual quotes from participants were used

are the product of the focus of the inquiry. This means that the researchers own personal values or theoretical inclinations should not sway the conduct of the research and the findings (Bryman, 2016). The results of the study should be able to be confirmed or corroborated by others (Guba & Lincoln, 1985).	to ensure that it was the participant's voices that were being heard. In addition, reflexive accounts were provided throughout the thesis to ensure transparency of my own pre-understandings and personal values, enabling the reader to make a judgement of far these were an influential factor (or not) in the findings reported. Finally, as in other activities reported above, confirmability was also addressed through member checking with the participants, giving them the opportunity to clarify and/or challenge the interpretations of their experiences, and through academic discussions with supervisors and peers.
Reflexivity – according to Guba and Lincoln (1985), reflexivity in this context means meeting all the above components (credibility, transferability, dependability, and confirmability) through the keeping of a reflexive journal which details the process in achieving these activities throughout the research process (Morse, 2018).	I demonstrate reflexivity throughout, by outlining from the onset my own pre-understandings, and the professional and personal influences that influenced my decision to research this particular phenomenon (pp.15 – 16). Reflexivity is considered in further detail at various stages of this work, illustrating how Guba and Lincoln's (1985) activities to demonstrate rigour and trustworthiness have been addressed throughout this study (pp.95-97; 123-126; 240-242).

5.2.3 Reflexivity

As previously mentioned, the hermeneutic phenomenological approach requires the researcher to position themselves within the research. This transparency can reveal any researcher bias and prejudices that are apparent in the research. I am mindful of my own experiences, prejudices, and professional knowledge that I bring to this research. As a sister, mother and grandmother who has experienced a pregnancy loss and a subsequent pregnancy following that loss, I am aware that my own story may be reflected in the stories of the women I interviewed. The challenge then will be not to confuse my story with their story but be open to the prospect that I may be familiar with aspects of their story. Furthermore, my professional roles as a midwife who has been involved in the care of women in this situation, and a counsellor who specialises in counselling women who have experienced a pregnancy loss has given me further insight into this phenomenon.

The success of the interview process is largely dependent on the relationship developed between the interviewer and interviewee (Ritchie et al, 2014). Rubin and Rubin (2012) suggest that “responsive interviewing emphasises the importance of building a relationship of trust between the interviewer and the interviewee that leads to more give-and-take in the conversation” (p.36). Within the interviews conducted for this research, I believe that good ‘active listening’ skills (Egan, 2007) enhanced the interview process and led to a mutual working alliance built on trust, mutuality, and respect (Joyce & Sills, 2010). However, as with all human interactions, the interactions in the interviews were also vulnerable to misunderstandings and mishaps. The effective use of active and reflective listening skills, including clarification helped to negate this risk and separate out my experiences of the phenomena from the womens’ experiences. With this in mind, a commitment to being critically reflexive throughout the whole research process was crucial. This took the form of a reflective diary, notes following the interviews, and personal and shared reflections with supervisors and colleagues of the phenomena being researched and resulted in discussions about my values and assumptions of the research process and emerging findings. In this way I ensured that these perspectives were not hidden but were made visible, both within the context of personal development and through writing about them in this work.

The roles I bring to this research are all interconnected and shape my approach to my work, including the data collection in this research. I was perhaps naively unaware how these roles would surface at times during and after the interviews. In the early interviews of this research, I found that I was thinking and listening with a midwife's or therapist's ears (or both). At times, the womens' stories touched my own story, and I was enveloped in a profound sadness. Other times, I felt consumed with anger at a woman's story. All stories were incredibly sad, and then celebratory with the birth of the new baby, and all had a profound effect on me.

I questioned what it was about pregnancy loss and subsequent pregnancy that drew me to want to know more. Yes, I had my own personal experience from nearly 30 years ago, but had things changed now? Were things different for these women, in an age when the mantra is individualised and person-centred care? My recent professional experiences working in the field of pregnancy loss suggested not, but I could not find anywhere where women were asked about their experiences, specifically the experience of accessing maternity care in a subsequent pregnancy following a loss. Hence the conception of this research, and a desire to hear and respond to these women's voices.

In relation to the gestation of the losses that occurred, I became aware of a dichotomy of my own experiences of loss and subsequent pregnancy as a woman and a professional. I knew only too painfully the personal experience of early pregnancy loss, yet professionally I had ascribed to the assumption that a later pregnancy loss was in some way more valid and tragic than an earlier one. I recalled the number of times that I had written in the notes +1, with only minimal thought to what that might mean for the woman sat in front of me. Was I a compassionate carer in these circumstances, or just fulfilling a task centred role based on the medical model of care?

One woman's story in particular led to this reflection and questioning. Laura (not her real name) was 24 years old when I interviewed her. She and her partner were carers for 2 girls for whom there was a residency order (special guardianship) in place. They had been trying for a baby for 4 years before they sought fertility treatment. Laura was prescribed clomid, which she took for 5 months before she became pregnant. As she spoke to me about this pregnancy, she spoke of her excitement at finally being pregnant, she spoke about the hopes and dreams she had for the future, the prams they had looked at and the anticipation they had about becoming parents to their own baby. She spoke with so much depth and passion that I felt that the passage of time in that pregnancy went on forever. The reality was that the pregnancy ended at seven and a half weeks gestation with the diagnosis of an ectopic pregnancy and emergency lifesaving surgery for Laura. This interview had a profound effect on me for the reasons spoken about above. I felt challenged about my conflicting set of assumptions and humbled through listening to Laura's story.

Unquestionably, I responded to the women emotionally because I could identify with aspects of their experience from both a personal and professional perspective. I was challenged to examine both the womens' and my own experiences, and reflexively work through my overwhelming emotions to come to a better understanding of them.

When thinking about personal reflexivity I found Etherington's (2004, p.32) account helpful which states that:

> "By using reflexivity in research, we close the illusory gap between researcher and researched and between the knower and what is known. By viewing our relationship with participants as one of consultancy and collaboration we encourage a sense of power, involvement, and agency. When we enable other people (and ourselves) to give voice to our experience, those voices create a sense of power and authority".

Issues of powerlessness featured predominantly in the stories that the women told. They all spoke of wanting their experiences to change things for themselves in the future if they chose to have more children, but also for others who would access maternity services in the county. I resonated with the feeling of powerlessness. This interconnectivity between myself and the women opened up the possibility of new ways of knowing and revealing the phenomena being researched.

By way of summary, this chapter has provided a rationale for the research design and methods chosen for this research. The account also explains how this design and these methods translated into the process of data collection and analysis. Guba and Lincoln's (1985) activities of credibility, transferability, dependability, confirmability, and reflexivity, were used to demonstrate how rigour and trustworthiness were addressed in this thesis. The chapter concluded with a reflexive account of my approach to the research design and methods used within this study.

The following chapter provides an overview of the findings, before the following three chapters outline the key findings from this research.

Chapter 6 -Overview of the findings

This chapter is presented in two sections. The first section provides a brief introduction to the participants in the research, which provides the reader with context when considering the findings in chapters 7, 8, and 9. The bibliographies have been compiled from field notes made at the time of the interviews and from information divulged by the participants during the interviews. They vary in detail and completeness, depending on the participants' recollections and experiences. They reveal a broad range of pregnancy loss experiences. The second section is an introduction to the key themes and sub-themes that emerged during the interpretative analytic process, to provide background for the reader to the findings presented in the subsequent chapters.

6.1 Introduction to the participants

Detailed participant profiles are outlined below. Pseudonyms have been used, and other identifiers (such as the names of partners or places, or personal exchanges during the interviews, for example, about the shopping trip of a partner who returned whilst the interview was underway) from the transcripts suitably amended to provide anonymity and protect confidentiality.

Jules was in her mid-30s. She had lived in Lincolnshire all her life, only recently relocating from the town of her birth to another city in Lincolnshire to move in with her partner and father of her unborn child. She had been employed full time but was on maternity leave at the time of the interviews. This was Jules's fifth pregnancy, having had four previous pregnancy losses. Her first three pregnancies were with a different partner and were as a result of infertility treatment. During the treatment seven eggs were successfully fertilized. She first became pregnant in 2012 when one of the fertilized eggs was implanted. She lost this child, a boy, at 25 weeks and 5 days, due to early onset pre-eclampsia in 2013. Jules had two further early miscarriages (at eight weeks gestation) from the stored fertilized eggs in 2014 and 2017. Following the breakup of this relationship, Jules donated the remaining four fertilized eggs through the IVF clinic to other couples who were having difficulty conceiving naturally. She met her current partner three months after this breakup. Her fourth pregnancy was unplanned but was conceived naturally. This pregnancy ended with a further miscarriage between seven and eight weeks. She conceived again naturally three months later. At the time of the first interview, Jules was just a few days away from having her baby by elective caesarean section at 37 weeks and 4 days gestation. She subsequently had a healthy baby boy.

Laura was in her early 20s. She had lived in Lincolnshire all her life. She lived on the outskirts of a small rural village with her long-term partner and two young girls, who live with them permanently (residency order, special guardianship). Laura had been employed part-time but at the time of the interviews was on maternity leave. Laura and her partner had been trying for a baby for over four years before seeking fertility treatment. She eventually conceived in August 2017, after using Clomid (an oral medication used to stimulate ovulation in women who have difficulty in conceiving). At seven and a half weeks gestation it was discovered that Laura's pregnancy was ectopic, growing in one of her fallopian tubes. She had emergency surgery to remove the fallopian tube and the pregnancy. Her next pregnancy was conceived naturally, without using any fertility treatment. At the time of the first interview Laura was 32 weeks pregnant. She gave birth to a healthy baby girl in July 2018 at full term.

Hayley is in her late 20s. She was born in Lincolnshire but moved away to go to university, eventually staying away for a total of eight years before returning and settling in the county, where she now lived with her partner. Hayley reported bleeding and losing unusual discharge to her GP from about 13 weeks gestation. She was referred for an emergency scan, where she was told that everything was fine. The bleeding continued, and it was discovered at the 20-week scan that there was no amniotic fluid surrounding the baby. She was referred to a specialist unit for a further consultation, where she and her partner were advised to have a termination because of the lack of amniotic fluid and a zero chance of survival for her unborn child. She gave birth to her first baby, a boy, who was born too early to survive at 20 weeks and 4 days in September 2017. She became pregnant again in January 2018. She gave birth to a boy, who was born prematurely at 36 weeks gestation in August 2018. After being treated on the Neonatal Intensive Care Unit (NICU) for some initial difficulties, they were both discharged home after six days.

Becki was in her mid-30s. She lived in Lincolnshire with her husband. She had worked full-time as a teacher but was on maternity leave at the time of the interviews. Her first pregnancy was planned, with her conceiving after about nine months of trying. This pregnancy was relatively straightforward, apart from Becki suffering from hyperemesis gravidarum at the beginning of the pregnancy. She went into labour at full-term (40 weeks and 1 day) in October 2017. At some point during Becki's labour, her baby daughter died, and was delivered stillborn the following day. Becki became pregnant again six months later. Her daughter was born prematurely at 34 weeks and 3 days in October 2018. They remained in hospital, with the baby on NICU until their discharge just after two weeks later.

Jo was in her early 30s. She lived in Lincolnshire with her husband and 2 young children, a boy, and a girl. Jo was self-employed but had recently given up work to go on maternity leave. Her current pregnancy was her sixth pregnancy. She had two early miscarriages, before becoming pregnant with her eldest child, a boy, who was 5 at the time of the interviews. Her pregnancy with him was straightforward, apart from him being born by elective caesarean section because he was in a footling breech position. Her next pregnancy was also without complications, with her giving birth to a daughter by elective caesarean two years later. With her following pregnancy, all started well, but Jo then began to feel that something wasn't right as she approached her 20-week scan. She had an emergency scan at 19 weeks and 3 days when she was told that everything was fine, but just two days later she awoke with the feeling that her baby had died. As it was a weekend, and she was less than 20 weeks pregnant with no emergency symptoms (for example, bleeding or fitting) she was told by a midwife at the hospital to contact her GP the following day. A scan at the hospital the following day confirmed that her baby had died. Her baby, a boy, was born two days later after she was medically induced. She became pregnant again just over two months later. She delivered a healthy baby boy by elective caesarean section at 39 weeks gestation in September 2018.

Elise was in her early 30s. She was born in Belgium, moving to England, first to London, and then to Lincolnshire. She lived with her partner and their two-year-old son. She was diagnosed with antenatal depression in her first pregnancy and had input from the perinatal mental health team. She had a normal labour with this pregnancy but sustained a severe perineal tear that needed suturing in theatre. She became pregnant again in April 2018 but miscarried that pregnancy five days after it was confirmed (about five weeks gestation). In the autumn of that same year, she conceived again. Apart from regular monitoring from the GP for her mental health issues, this current pregnancy had been straightforward, with her baby (a boy) due in June 2019. Elise didn't respond to requests for a second interview, so there are no further details of her experiences after the date of the first interview.

Alison was in her late 30s. She moved to Lincolnshire with her parents as a child. She moved away to go to university, before returning to live in Lincolnshire permanently. She was married with a two-year-old daughter and a 15-year-old stepdaughter. She had worked both full and part-time but was on maternity leave at the time of the interviews. She first became pregnant in 2015. In this pregnancy she began bleeding at 11 weeks gestation and miscarried her baby in May 2015. She became pregnant again in February 2016 and had a healthy baby girl at 38 weeks gestation in October 2016. Her next pregnancy was confirmed in April 2018, but she again miscarried that pregnancy at 11 weeks (although she was told that the pregnancy had actually ended at seven and a half weeks gestation). She conceived again in early December 2018. At the time, her daughter had chicken pox, and as Alison had never had chicken pox, she had the Varicella vaccine, but still contracted chicken pox in the early stages of her pregnancy. As a result, she had some extra scans throughout the pregnancy to monitor the development of the baby. It was at one of these scans that it was identified that the baby had a dilated ureter. Her baby, a boy, was born after a quick labour in July 2019 at 37 weeks and 6 days gestation. They were in hospital for eight days following the delivery because there were some concerns about the baby. He was tested for a number of chromosomal abnormalities including Down's syndrome and Muscular Dystrophy. These tests showed that the baby had an add-on to chromosome 7 (the chromosome responsible for providing instructions for the making of proteins). After they were discharged from hospital, they received extra input from the home visiting team from NICU, the community midwife and the health visitor. At the time of the second interview this extra care had ceased as the baby was making good progress. They had an appointment booked to see a consultant paediatrician at a specialist hospital the following month to discuss the implications of the diagnosis.

6.2 Key themes and sub-themes of the findings

The findings presented in chapters 7, 8, and 9 explore the lived experience of pregnancy loss, pregnancy after loss, and maternity care in a subsequent pregnancy. They present a holistic overview of Being-in-the-world of pregnancy loss as self, and with others. Three key themes have emerged which, although presented in a linear way, are in fact all connected and interlinked, with an ebb and flow between all three which illustrates the threefoldness of the womens' lived experiences. The key themes are Temporality: past experiences, future dreams, and present realities; Attunement: The all-pervading mood of pregnancy loss; Relationships of care and systems of care. The themes and subthemes (represented in italics) are presented in table 5.

Table 5

Presentation of themes and subthemes

Theme one **Temporality: Past experiences, future dreams, and present realities.**	**Theme two** **Attunement: The all-pervading mood of pregnancy loss.**	**Theme three** **Relationships of care and systems of care.**
Routine everydayness	*Hope soon dashed*	*Positive relational encounters*
The significance of 'clock time'	*Emotional suppression*	*Continuity of carer*
Time stands still	*Altered embodiment*	*Enabling relationships of care*
Difficult decisions	*Reconciliation with parental identity*	*Negative relational encounters*
Holding on and taking forward	*Feeling fear*	*Trusting relationships*
Bodily doubt, guilt, and shame	*The loss of innocence*	*Medical discourses of 'hope and cope'*
Living in a liminal space	*Living with terror*	*The consequences of medicalised communication*
The challenges of a new pregnancy	*The search for meaning*	*Inappropriate care environments*
Changed relationships in the 'here and now'	*Honouring loss*	*Inaccessible care services*
Spatial temporal relationships	*Comforting signs*	*Inflexible pathways of care*
56t78The marking of time against future milestones		
Unexpected present realities		

The pressure to be a 'good mum'		
A re-turning to the future		

Chapters 7 and 8 are presented through the lens of the Heideggerian concepts of temporality and attunement. The rationale behind this decision was that some of the dominant themes in the participant's accounts were framed to both their lived experiences of a significantly altered temporal awareness, and changes to their state of mind (attunement), including both their cognitive and emotional experiences. Presenting these experiences through a Heideggerian lens has elicited a new understanding of women's lived experiences of pregnancy loss, pregnancy after loss and maternity care in that subsequent pregnancy which, at the time of writing, has not been identified in any other current research.

It is acknowledged that across these two chapters there is a fair amount of replication. The women's moods were greatly influenced by their temporal awareness and vice versa, making it difficult at times to present them separately in different chapters. However, a conscious decision was made to present these findings in this way, to highlight separately the intricacies of the women's lived experiences of their temporal awareness and intense emotional state (attunement), whilst avoiding the pertinent points being overshadowed in an overtly long chapter.

The focus in chapter 9 is different. Heideggerian philosophical concepts are not used in this chapter, where the themes presented consider issues of maternity care delivery and the organisation of the systems of maternity care. It could be argued that several Heideggerian philosophies could apply generally in this chapter, for example, Being-in-the-world, *Sorge,* intersubjectivity. However, this work was seeking to inform maternity care practice based on women's lived experiences and was not a Heideggerian analysis of midwifery care. This chapter, therefore, is pivotal, in addressing both the research question of this study and adding to a scant database of previous research into this issue.

The aim of this study was to research the participants' lived experiences of maternity care in pregnancy after a pregnancy loss. It was important ethically to recognise and honour those experiences before exploring experiences of care in their current pregnancy. Thus, their present stories started in the past, but also shaped their present experience and an imagined, hoped for future. This is not to say that the themes emerged or will be presented chronologically within these chapters. They do, however, point to a key phenomenological theme of the temporality of the participants' experiences which are considered to be indivisible from their Being-in-the-world of pregnancy loss.

Being-in-the-world of pregnancy loss and the world of maternity care after pregnancy loss are experiences that are not encountered in isolation. That is, they are encountered within the wider context of the social world, of morals and values, cultural expectations, of relationships, care, meaning making and authenticity. Participants' stories were recounted by them from within this context and interpreted by myself from my own context. For all participants, losing a baby irrevocably changed their outlook on life, their experience of Being-in-the-world. This altering of life as they had known it, had a profound effect on their everydayness, as they struggled with transitioning to a new way of Being-in-the-world after pregnancy loss.

The findings commence with the first key theme of Temporality: Past experiences, future dreams, and present realities. Participants discussed their past, present, and future possibilities in the light of the past pregnancy loss. They compartmentalised their life as life before the loss and life after the loss. The past, the experience of the pregnancy loss (or losses) was remembered as a time of intense anguish, of bewilderment and transition. This time was characterised as a period of self-blame and bodily doubt. Significantly, participants struggled with a changed temporal experience of self; revisiting the past altered the way that they viewed both the present and the imagined future. As a result, some relationships with family and friends became fractious, with misunderstandings and insensitive comments being reported. In some cases, the women's grief became disenfranchised as they sought to find understanding and to be understood. The present was described as a period of mixed emotions, of joy coupled with a loss of innocence, increased surveillance, and the search for hope. These were largely described in the terms of physical symptoms, and the relationships of care from spouse, family, friends, and caregivers. The participants' temporal connections were constituted within these relationships of care. The future hopes, dreams, and milestones of the participants (which moved from being future to present between the two interviews, with a new future being imagined at the second interview), were described with reference to the pressure of the need to be a good mum, and the continuity of the anxiety (albeit on a smaller scale) experienced throughout the recent pregnancy. They spoke of their experiences of being a mum, and the changes they hoped to make as they made the transition to parenthood. This hoped for future was imagined within the social context of self, others, and cultural expectations.

The second key theme to emerge was Attunement: The all-pervading mood of pregnancy loss. The participants described their mood (or state-of-mind), including emotions and thoughts. It is well documented by current researchers that a pregnancy after loss is often characterised by unresolved loss and grief (See for example, Andersson et al., 2011; Fockler et al., 2017; Mills et al., 2016), and this was described by all of the participants. In addition, all the participants spoke of a deep anxiety, *angst* (Heidegger, 1927/1962) that pervaded their whole being after their loss and throughout their next pregnancy. Faced with the reality of what Heidegger (1927/1962) terms their *nothingness,* their everyday Being-in-the-world was stripped of all that was familiar and safe, forcing a re-evaluation of their thrownness, fallenness, and their own mortality. This state of *angst* was deeply disturbing and unfamiliar for the participants. It is what Heidegger calls the *unheimlichkei*t (Heidegger, 1927/1962) of the situation that they found themselves in, the unsettledness (Dreyfus, 1991) that they reported as they attempted to navigate the unfamiliar experience of a pregnancy after loss. From this position all the participants sought to make meaning from their experiences as they struggled to cope and maintain control of their Being-in-the-world.

The final key theme of the findings is that of Relationships of care and systems of care. The participants’ experience of Being-in-the-world of maternity care were varied, with all participants reporting challenges at the time of their pregnancy loss, as well as in the pregnancy after the loss. The strength of the relationships forged with others at this time, as well as the givers of care had a profound effect on their experiences. These experiences, described by the participants, revealed extremes of care, from being sensitive and compassionate, to insensitive, inflexible, and dismissive. Some of these experiences were attributed to the organisation and structure of the systems of care, or how these were interpreted and then delivered by practitioners. Others were attributed purely to the care provided by individual maternity care professionals. Most of the participants experienced difficulties with the systems-of-care available, both during their loss and the subsequent pregnancy. These were described as being inappropriate, inaccessible, and inflexible, often with a lack of continuity and aftercare. These challenges in relation to the maternity care received affected the women’s everydayness of Being-in-the-world of maternity care and the meanings they ascribed to this ongoing experience. Some of the participants found it difficult to articulate the type of care that they needed or expected in their subsequent pregnancy, but they were readily able to identify what that care should not be. Clear communication (or lack of it) was identified by all the participants as being a major factor in the extremes of care identified. That is, communication to and from practitioners was key to their experiences of care and had a major bearing on their physical and emotional well-being.

This chapter has offered an introduction to the participants and an overview of the findings, in order to contextualise the findings that are presented in the following three chapters. The first of these chapters follows, where the theme of Temporality: Past experiences, future dreams, and present realities is discussed.

Chapter 7 -Temporality: Past experiences, future dreams, and present realities.

This chapter outlines the first theme of 'Temporality: Past experiences, future dreams, and present realities.' Within this theme, there are 14 subthemes, organised under three headings of the past, the present and the future. They are organised in this way because in this research the participants framed their experiences within the temporal perspectives of past, present, and future.

Under the past heading the first subtheme introduces the routine everydayness of life before pregnancy, of decisions taken to start a family and the influence of 'clock time' in the making of that decision. The joys and challenges of pregnancies confirmed, and then lost, as 'time stands still' are explored, before considering some of the difficult decisions that needed to be taken in the wake of the loss. As a way to hold onto the baby and take them metaphorically with them, not leaving them in the past, most of the participants sought ways to make memories of the time they had with their baby, or mark in some way the loss of the pregnancy and potential baby. The participant's accounts of these experiences are considered. Finally, in this section, attention turns to the women's affective experiences of guilt, shame, and bodily doubt that characterise the immediate aftermath of the loss.

Moving to the present, the participants described life lived in a liminal space, the empty space, or void, between loss and the potential future. This includes the participant's experiences of deciding to try again and embark on a new pregnancy, and their lived experience of being pregnant again in the shadow of a previous loss. Changed relationships with both family and friends in the aftermath of the previous loss are explored, along with the quest of the participants to seek mutual understanding in their relationships, often in the form of spatial temporal relationships.

The final heading in this chapter, the future, considers the future goals and dreams of the participants, and how these are marked not in days and hours (chronological time), but in milestones reached and passed. In a cautionary note, however, the lived experiences of some of the participants were not what they hoped for, when their anticipated future dreams were not realised in the way they were expected, and there was a collision between these future dreams and the unexpected realities in the present. In the light of these experiences, consideration is given to the participant's emerging motherhood and how the realities and unrealistic self-inflicted pressures to be a good mum are shaped by the previous loss. In the final part in this section, there is a re-turning of the participants eyes to the future, as they contemplate new emerging goals and dreams.

Viewed through a Heideggerian lens, the concept of temporality provides a way to understand the participant's experiences. Heidegger calls this the threefold structure of life, in which time is seen as the horizon of *Being*. He maintained that in relation to *Being*, understanding of what it means to be, could only be reached if placed in the horizon (or context) of time (Heidegger, 2004). Heidegger's concept of *facticity* is important here in aiding this understanding, as it relates to the whole of the situation we find ourselves *thrown* into, and which includes us coming to terms with all of our future possibilities despite our thrownness. For Heidegger, all the features that constitute our Being-in-the-world, for example our fallenness, thrownness, Being-with, moods (attunement) *and* understanding, (discussed earlier) are inseparable, or equiprimordial, and are present in our way of Being-in-the-world (Heidegger, 2004). For the participants in this research, this meant that the situation that they were in had to be dealt with somehow, with every moment of life being a tension between what was given to them and how they confronted (or dealt) with it in the present. Their stories began in the past, as they recounted their life before pregnancy and the lived experiences of pregnancy loss.

7.1 The Past

7.1.1. Routine everydayness

Speaking of the past (defined as the time prior to the first interview, which was conducted during the pregnancy after the loss), participants spoke of their life and experience in the busy everyday world before their pregnancy and subsequent loss. Life for them, they reported, was full of the 'normal' twists and turns, good and bad, that Heidegger (1927/1962) asserts is a consequence of *Dasein's* fallenness. Life for *Dasein*, in its fallenness is absorbed with the practical matters of everyday survival (Watts, 2001), the average everydayness of working to earn a living, maintaining relationships through contact with others, or attending to domestic responsibilities such as maintaining a home and providing food, shelter, and warmth. Heidegger saw this as an inauthentic condition of *Dasein's Being*, the *they-self*, and at the same time a necessary function for everyday life.

The routine everydayness of the past was apparent in the accounts that the participants gave about life before loss. Activities spoken about ranged from pride in their careers, *"I'm a teacher, and I'm very good at what I do. I'm usually full of energy and put everything into my work"* (Becki), to participation in activities to maintain and improve general fitness, *"I was very very sporty, I did a lot of running and those hit workouts and things like that"* (Alison). One participant spoke of the everydayness of managing living apart from her partner due to work commitments when in the early stages of her first pregnancy *"I was down in London doing a post-doc and he was living around here so there was a massive commute"* (Elise). There was no cause to be anxious about their pregnancies, no pathologizing of their experience.

Most of the participants described life before pregnancy and pregnancy loss as busy, even hectic in some cases. There were distractions and expectations that all contributed to the normality of everyday life. For Jo, this busyness was evident in her life as a mother to young children. When speaking of her eldest son she commented: *"he did my head in a bit in the holidays, he's very like on the go, he likes to be mentally stimulated all the time, as five-year olds do".*

Life was categorized as being normal and routine when nothing adverse was experienced to cause disruption to the equilibrium. Yet even after the disruption and devastation of a pregnancy loss, there was a longing and a quest to seize back some sort of normality, whilst knowing that the experience of the loss would mean a new type of routine everydayness. Hayley described how:

> *We just pulled together as a couple and tried to make our life a new life again. We moved out of the pub and made ourselves a new little home with my mother-in-law. We began a new structure really.*

Similarly, Jules also sought a new way of life when her relationship with her lost baby's father irretrievably broke down. She spoke of seeking out a new relationship as a way of 'moving on' and building a different life for herself: *"I met up with [name of new partner] online on 'Plenty of fish' three months later. Even before I laid eyes on him, I knew that he was the one".*

The security and relative comfort afforded by living a life of routine everydayness was sought by participants, both pre- and post-pregnancy loss. This everydayness provided a sense of routine, of a belonging in society, of reassurance, and appeared significant to the way the participants constructed their past and present experience.

7.1.2 The significance of 'clock time'.

Pregnancy in the western biomedical world can be viewed as a linear temporal event, which is measured in a narrow temporal framework. That is, it is measured through the ebb and flow of bodily rhythms of change, but also in gestational timing, through the 'clock time' of dates and calendars, the tracking of menstruation to achieve conception, of contractions, of minutes and hours of labour (Beynon-Jones, 2017). 'Clock time' in the western world is socially constructed and is significant because it is constructed into divisible units that are both quantifiable and measurable (Adam, 1995).

In relation to the timing of conception, the passing of ‘clock time’ was a significant factor involved in the decision-making process. All of the participants spoke of feeling that the time was right, or that they were running out of time as their ‘biological clock’ ticked away, or that they were in a secure relationship where having children seemed the logical next step for them. There is a dominant western discourse that women have control over the timing of conception, through their choice to use (or not use) contraception and when to (or not to) have sex. Yet the reality is that women’s reproductive bodies are constrained by time (Earle & Leatherby, 2007). These temporalities of conception remain, until something happens to challenge the dominant discourse. Thus, for some of the participants, becoming pregnant happened very quickly, for others it took a bit longer before they became pregnant. Two of the participants found the temporal experience of watching and waiting more challenging than they expected it to be, with the realisation that they were not able to control when to conceive, which revealed a temporal disruption to their imagined futures. They spoke of the difficulties they had conceiving, before seeking infertility assistance from the health services. Jules recalled:

> *My first pregnancy was IVF. I tried for five years before I went for the IVF. I had Clomid and Tamoxifen, but I had bad reactions to them. I had to lose nearly five stone to be able to go for it, and it worked first time.*

For Laura, who tried for a similar amount of time to conceive naturally, before seeking help, spoke of the uncertainty of waiting each month:

> *After we got the girls, we said then that we wanted a baby. It was about 4 years before we went on Clomid. Before that, my ovulation tests kept coming back, with some saying I was ovulating, others saying I wasn’t, so it was a bit hit and miss. They gave us the Clomid to help and I thought that everything would be fine. I think I’d been taking it for about 5 months before I found out that I was pregnant.*

For Jules and Laura, the effort of trying to conceive was dominated by a stalling of time, characterised by a lack of control over the outcome and a seemingly never-ending cycle of anticipation and the *angst* of watching and waiting to see if the medical intervention had succeeded in a longed-for pregnancy. This uncertainty, where the outcome was unpredictable, at times proved overwhelming and difficult to understand, increasing anxiety and feelings of bodily doubt.

7.1.3 Time stands still.

Confirmation of a positive pregnancy test brought with it a range of emotions, from joy and elation to disbelief and concerns over health worries. Jo compared her feelings with being pregnant to her feelings in her previous pregnancies:

> *I took about a million pregnancy tests when I was pregnant with my son, but with my daughter I only took about 3 or 4, just to make sure that I was actually pregnant, and then I didn't bother after that, everything was fine. I was 100% relaxed with her, so when I conceived again a couple of years later, I just thought that everything would be fine.*

Jo used her previous experience of pregnancy as a benchmark for her next one, which aligned with the dominant cultural discourse that pregnancy equals baby equals motherhood, and assumed that as pregnancy is natural and normal, all would be well, as it was with her daughter. For others, pregnancy, although very much wanted, brought acute pregnancy related illness and complications. The imagined future of being pregnant was very different to the reality. Becki recalled the early experience of her pregnancy: *"I had a bit of a rough start to the pregnancy because I suffered from hyperemesis, so I was in hospital on drips."*

As the pregnancies progressed, all of the participants, regardless of the gestation or type of pregnancy loss, were able to recount in minute detail the events and circumstances leading up to the loss. Jules described in detail her lived experience of her first pregnancy loss. She recounted:

> *She took my blood pressure, and it was like 200 and something over 200 and something. She said 'don't move, stay where you are'………. she tried to look for his heartbeat, but she couldn't find it. She said that it's sometimes difficult to find. Then one of the consultants came in and had a look, and the next thing I know there are two paramedics at the door ready to take me to [name of hospital].*

Similarly, Elise was able to recall when the process of the pregnancy loss began:

> *I had an appointment with the GP because I was obviously on antidepressants, even though they were safe in pregnancy it was still best to see the GP as soon as possible. So, I saw them, and it was later that same evening that I started bleeding.*

Some of the participants recalled that leading up to the pregnancy loss was a period where there was a temporal disruption, of time warping, where time appeared to stand still or slow down. Their intuitive lived experience that something was not right, but no medical reason could be found for their concerns, although at a later appointment their fears were confirmed with the loss of their babies. Jo explained:

> *It's hard to explain, but as I got closer to the 20 weeks point, I just didn't feel right. I couldn't go to the doctor and say this, or this is wrong, but I just didn't feel right. Medically I was fine, and they did an emergency scan at 19 weeks because I panicked, but everything was fine.*

Similarly, Hayley originally noticed some bleeding at about 13 weeks, that was continuous from that point onwards. Despite seeking medical help and having two ultrasound scans she was constantly assured that some bleeding in pregnancy could be normal, and no cause for the bleeding could be seen:

> *Then at the 20 week scan we found out that the baby had no fluid around him, and that I'd probably had a small leak mixed in with the bleeding.*

> *They said that it would probably be around the 15-week stage that I lost the fluid, but I thought it was a long-term thing.*

These experiences highlight a huge chasm that existed between Jo and Hayley's sense of bodily rhythms, of body time versus medical/gestational time, that alerted them that all was not well with their pregnancies, and the biomedical reliance on technology to provide (in these cases false) reassurance that the pregnancies were progressing normally.

7.1.4 Difficult decisions

The actual physical experience of the loss varied between the participants, dependent on the gestation and classification of loss. These included expectant (waiting for the pregnancy to pass naturally without any medical intervention) or medical (where medical intervention is used to pass the pregnancy) management of miscarriage, undergoing emergency life-saving surgery, medical management of later pregnancy loss, or induced labour. The unexpectedness and involuntariness of their situation is reflected in Heidegger's concept of thrownness, which suggests that *Dasein* is always thrown into a situation, to which they must respond, and the facticity, or burden *Dasein* carries as a result (Heidegger, 2004). Heidegger suggests that it is because of *Dasein's* thrownness that their future possibilities are defined or limited. By this he means that our thrownness from our past (which is always carried with us) becomes the foundation of our present existence. These lived experiences influence the choices that we make in the present and define or limit our imaginings for our projected futures (Heidegger, 2004). For example, losing a baby in the past and the experiences associated with that loss will influence present choices whether to try again for another baby and become a parent in the future.

For some of the participants in this research the future was a consideration in the choices or decisions they made in the past. For example, once Laura's diagnosis of an ectopic pregnancy was made, there was the realisation that not only was she facing the loss of her baby, possibly her future fertility, but she also gained a view of her own mortality, feeling the end of life during the present, that profoundly changed her own present reality. Yet the reality for her at that time was that she was thrown into an emergency where she had very little time to consider the enormity of her situation:

> *They said that they were very sorry, but I'd got an ectopic pregnancy. They said I couldn't walk anywhere and would have to go back to the ward in a wheelchair……As soon as I got back to the room, they got me ready, and I went into surgery about half an hour later. I was 7 ½ weeks pregnant.*

Laura's experience emphasises what Beynon-Jones (2017, p.841) calls "shocking bodily disruption and temporal dislocation". For Laura, the ultrasound exposing the pregnancy as being in the fallopian tube brought the collision of bodily disruption with any hope of the current pregnancy progressing, and brought uncertainty of any future pregnancy, or indeed life.

Becki too, whose baby girl died whilst she was in labour, was faced with deciding about her future:

> *I wanted a c-section because I just wanted her out. A co-ordinator came in and sat on my bed and said to me that it's very difficult at this point to think of another baby, but if you have a c-section it's a longer recovery time and it could impact on further pregnancies. It was horrible to think about it at the time but I'm glad that she said that.*

When recalling the past, all of the participants reported the challenges of dealing with the immediacy of the situations they found themselves thrown into. Jo, whose son died in utero at 19 weeks and 6 days, spoke of having to be assertive to ensure that she got the scan that she required to confirm her suspicions:

> *I was put in a room and asked loads of questions about how I was feeling and why I was there. A doctor came in and said that he would listen with*

> *a doppler. He tried for a good 10 – 15 minutes but couldn't hear anything. He said that they were really busy and that I needed to come back 2 days later for a scan. I told them that I knew what had happened and that I wasn't leaving until they confirmed what was going on.*

7.1.5 Holding on and taking forward.

Pregnancy loss, with its tragic consequences and enforced finality of the imagined future, brought for the participants the realisation that life had changed inexplicably. They described a void, an emptiness in which time appeared to stand still, as they tried to process all that had happened, *"At that point everyone kind of went into shock. It all gets a bit blurred from that point onwards"* (Becki). For most of the participants, regardless of the gestation of the loss, this included rituals, identifying places to remember, or making memories by taking photos and hand and footprints (Bremborg, 2012). Hayley spoke of always feeling close to her son through the memories she made:

> *We have got some pictures of him, but I don't look at them very much because they don't do him justice. They don't match what is in my memory, but it's nice to have them. We've got handprints and footprints as well. I've got his handprint and footprint tattooed onto my stomach, so I've always got him close to me.*

Similarly, Laura recalled: *"*We *walked around the crem and picked a nice tree so that if we wanted to hang things on it, we could, we can go there to remember, which is nice."*

Those participants who experienced a loss later in pregnancy and were in hospital at the time of the loss described the precious time they were able to spend with their baby's following delivery, and the distress they described at preparing to leave the hospital and return to their home. Becki spoke of meeting her daughter for the first time, describing her features in detail:

> *She was absolutely perfect, there was nothing wrong with her whatsoever. She had light hair, I wasn't expecting that, and she had really chubby cheeks……. she had really chunky cheeks and quite a big nose. We got to hold her, and dress her, and to spend time with her.*

Similarly, Jules recalled of her son: *"He came out breech. He had black hair and a little button nose. His eyes were closed. It was hard because obviously we didn't hear him cry."*

For Jules and Becki, their dead babies had the physical attributes that are associated with a healthy baby, and as such, had the appearance of 'life'. Spending time with their babies and doing some of the things that mothers would do with their live babies (bathing, dressing, holding) was particularly heart wrenching, yet vitally important in their experience of loss. This made the decision to leave the hospital particularly distressing, as the realisation dawned that they would be leaving without their baby. As they recalled the experience, it was evident that time here was a dominant feature in their lived past lives, as they tried to balance staying close to their baby in a space where to a certain extent they were shielded from the everyday 'they' world, against leaving the security of this shielded space and returning to their home environment and facing the future without their baby. These experiences challenge an individual's ontological security, with the disruption of their anticipated life course (Shirani & Henwood, 2011). For Jo, that meant deciding to leave after a few hours:

> *It was getting late by this point so they said that we could stay overnight, but I couldn't face staying. They had warned me that because he was so small, they would have to take him soon, so I said for them to take him. I didn't want to watch him deteriorate.*

Becki recalled the heart wrenching decision to come home after staying in the hospital for one night, and her parenting instincts in leaving her daughter, who had the appearance of life, but was not 'there'. Her daughter's appearance of life and health had been fleeting. There was limited time for the parents to experience this, before their child became 'still in life' and the corpse of the child became the reality:

> *That afternoon in the hospital it was like [name of daughter] was there, but she wasn't. Her body was there, but she had gone. We decided to go home, but I didn't want to leave her by herself, but I felt that I couldn't stay any longer either. I asked the nurses to promise me that they wouldn't leave her by herself, and then we came home.*

Even in death, the participant's parenting instincts to comfort and protect their child were compelling, with the notion of leaving their child perceived as an act of neglect. One participant, Jules, described the acute anguish she experienced after leaving the ward: *"I would say the only thing I found quite hard was leaving [name of son] at the hospital. All I was leaving with was a box."*

The making of these memories was particularly poignant, an attempt to hold onto and not let go of what had been, or could have been, to take forward into the future. This was a way to keep the baby present, despite their absence (Layne, 2012).

7.1.6 Bodily doubt, guilt, and shame

Prior to the pregnancy loss, Being-in-the-world for the participants required a constant relating to what Heidegger (1927/1962) called the 'they' world (*das Man*), where, conforming to sociocultural expectations made their lives meaningful and understandable (Pascal, 2010). Thus, the participants spoke of taking for granted their ability to have children, assuming that a pregnancy would lead to a healthy baby, and where what could go wrong was disregarded on the grounds that it was so unlikely to happen. As a result, when things went wrong and they lost their babies, most of the participants reported an experience of bodily doubt and betrayal, of examining and questioning their ability to have children, with feelings of guilt at not being able to keep their baby safe, and shame that they had not been able to fulfil the role that they were supposed to as women. For Jules, guilt was an over-riding feeling. She recalled: *"I thought that it was my body's fault for what had happened. I couldn't blame anyone* *else but myself, because it's my body and I should have been looking after him."* Becki's experience was more of shame at not being able to produce a healthy baby: *"In some ways I feel like I've not been able to do what other women can do, that in a way I've failed, even though I understand that I haven't, I can't help feeling like that."*

For the participants, this betrayal, loss, and stigma, shaped the remembering of the past, as well as the re-imagining of the future, including future babies. Thus, as contemporary research shows (Mills et al., 2016; Meredith et al., 2017), and for the participants in this research, the imagined future pregnancy was characterised by anxiety and bodily doubt.

Their experience of Being-in-the-world following the loss included a re-evaluation of the world before the loss, and the temporal process of re-negotiation of their imagined futures. As they strived to engage in creating a new future in the shadow of their recent, but past loss, this influenced their behaviour and decision making in the present. For some, this included returning to previous employment, or making the decision not to. As the participants grappled with a different way of Being-in-the-world, changes both in behaviour and attitude became apparent. They became what Heidegger calls 'resolute' (1927/1962). For him, resoluteness points to a grappling to come to grips with our own Being-in-the-world. Often circumstances can bring us to this place, where a re-evaluation of what is significant and insignificant in life illuminates what is "truly essential in our being- in- the-world" (Harman, 2007, p. 74). For the participants in this research, the temporal space between their loss and their tentative hope for a different imagined future with a baby was characterised by a re-framing of their lived experience, to incorporate the loss into their Being-in-the-world, and to reconcile their past self with their present reality.

7.2 The Present

7.2.1 Living in a liminal space

In the present lived experience, participants described how the re-evaluation of their past experiences shaped the decisions they made in every aspect of their present everyday lives. This included decisions that would create future possibilities, for example, when and if to try for another baby. The present life, as described by the participants, was a profound tension between what had happened in the past and how they confronted it in the present. Harman (2007, p.29) suggests that “Life is a kind of unrest, forever torn between two poles of reality. Life is movement, or ‘motility’.” For the participants living in this liminal space, between what was and what next, it was the temporal relationships with self, family, friends, and supporting relationships that were significant to their understanding of the present and Being-in-the-world after pregnancy loss. It was these relationships that provided the horizon for the participants’ temporal landscape, a place of transition, of waiting in the here and now (van Manen, 1990).

Within this liminal space, the decision to try again for another baby was taken jointly by all the participants and their partners. The time between the loss (or losses) varied from between 2 months and in one case of assisted conception, 3 years, with most participants conceiving again within 9 months of the previous loss. This timeframe is consistent with research that suggests most women who have experienced a pregnancy loss become pregnant again, with 50% becoming pregnant within a year of the loss (Mills et al., 2016; Franche, 2001). Some of the participants were consciously trying to conceive again, with others reporting they were just prepared to wait and see what happened. Hayley recalled:

> *We knew a new pregnancy was a possibility because we chose not to start using contraception again after my first cycle……. We weren’t actively trying by doing ovulation kits or anything like that, we were just waiting to see what happened. It was the middle of January when we found out.*

Jo, who conceived within 2 months of losing her son, spoke of the need to be pregnant again as a way of dealing with her grief:

> *I was doing ovulation tests. I got a positive ovulation test on Christmas Eve, then I got a positive pregnancy test on 4th January. So, it was 2*

> *months from losing my son to when I fell pregnant again. Looking back, it was my grief, I felt empty, and I didn't want to feel like that. It was far too soon to be obsessing, but I was obsessing about being pregnant again. I think that mentally it was just my way of trying to cope with the grief.*

Becki spoke of the need to wait until the results of the post-mortem before trying again: *"They told us to leave it 6 months, but we started trying before, as soon as we knew that everything was ok."* Taking the decision to try again for a new pregnancy, and the subsequent conception was significant for all the participants as it signalled a changing of the horizon of the imagined future. A future without a baby was deemed as far worse than taking a risk to fulfil their need to be parents.

7.2.2 The challenges of a new pregnancy

The confirmation of a new pregnancy brought with it a very different response from all the participants. Changes in their way of thinking were reviewed when contemplating the past loss. They now all had personal experience and awareness that a pregnancy did not always result in a healthy baby. Becki recalled: "*I was thinking why are we doing this again? We'll have the same outcome. It was like my bubble had been burst and I've been exposed to what can happen and there's no going back."*

Similarly, Hayley recounted:

> *It was a massive, shocked feeling when we found out. We were happy, but we weren't jumping for joy like most people would be. There were a lot of tears and worry about what was going to happen. Everything was going through my mind at the same time, but I wanted to be happy for the new baby, not sad.*

For Jo: *"Being pregnant again was terrifying."* Thus, being pregnant again signified a loss of innocence, where the naivety in which the previous pregnancy was embarked upon was gone forever. The original temporal framework had been disrupted, the present lived reality was experienced as what Heidegger (1927/1962) calls *unheimlich* (see section 4.3.2) with the past revisioning both the present, and the imagined future.

The experience of being pregnant again with a new pregnancy brought with it many challenges to be confronted in the present 'here and now'. All of the participants reported feelings of anxiety and fear, that affected their here and now experience of Being-in-the-world to a greater or lesser extent. Increased vigilance, in part due to increased anxiety led to all the women reporting constantly making comparisons between the current pregnancy and the previous one. For those who experienced early pregnancy losses, these comparisons characterized the early days of the pregnancy, dissipating once the current pregnancy had passed the gestation of the previous loss. Laura spoke of it being: *"Completely different from the first time. I obviously didn't have any shooting pains and going to the toilet wasn't uncomfortable."* The participants who experienced a later loss also spoke of making comparisons between the pregnancies, and the emotional cost that entailed. Hayley admitted:

> *Comparing them was the emotional part, what we were doing last time and what's happening this time………. because it's not long since I lost [name of son] I still remember the sickness feeling, even the good feelings. I felt him move before he passed away, and then when I felt this one move for the first time, it's easy to compare.*

Hayley's experience suggests that there was some integration of the lost baby with the present baby, but the reality was that *that* baby was not *this* baby, and although some comparisons could be made, continuing bonds (Ustundag-Budak et al., 2015) with the lost baby remained at the same time as bonds with the new baby were forming. Becki also spoke of the continuing bonds (Ustundag-Budak et al., 2015) with her lost baby, alongside the co-existence of her new daughter. Ustundag-Budak et al. (2015) suggest that it is this co-existence of the dead and living babies that enables the mother to feel connected to the lost baby, as well as the new baby. Becki pondered:

> *If [name of dead baby] was here, [name of new baby] wouldn't be here so it's a difficult one to work out, I can't wish for one thing because of the other. Obviously, I do wish that [name of dead baby] was here, but if she was here then [name of new baby] wouldn't be here, and I would never not want her to be here.*

7.2.3 Changed relationships in the 'here and now'.

All participants described their relationships with partners and family members as particularly significant to their present well-being. Relationships with partners were enhanced by the shared experience. Supporting relationships from family and friends were especially appreciated by the participants and were important sources of comfort and care. In contrast, relationships with some family and friends that had been strong prior to the loss became tense or fractured by the loss experience.

From the participants' perspective, their relationships with their partners were a significant factor in providing support and care throughout their loss and ensuing pregnancy after loss. Jules recalled: *"[Name of partner] was there. If he hadn't had been there when I was having it done, I wouldn't have coped at all. I'd have been a mess, but he was there in front of me, calming me down, stroking my head."*

Hayley had a similar experience:

> *We were just looking after each other, supporting each other through it. Some days we wanted to talk about what happened and other days one of us might have a bad day and not want to talk, but we understood that….it was a mutual understanding.*

In turn, there was a mutual concern for their partners and their capacity to manage the experience. There was consensus that partners were often neglected in the experience when the focus was on the woman. Alison recounted:

> *I think that there should be something for the partners – there was nothing for my husband, and he won't talk about it, not even with me because he doesn't want to upset me. When I have mentioned things, he's said well it was worse for you because you were physically going through it.*

This mutual care and understanding between the participants and their partners was at times difficult to navigate. Although a shared event, experiences were different. In wanting to care and protect each other participants sometimes found that this led to isolation of thought, of not being open and talking for fear of adding to the other's pain.

Friendships also provided significant connections to Being-with-others. The friendships discussed included long-term friendships, but also more recent connections with colleagues and neighbours. Whilst providing much needed support, all participants spoke of sensing an unfamiliar tension with their friends as they tried to re-connect within these changed relationships. Three of the participants spoke of how relationships with friends and work colleagues were tense in the weeks and months following the loss. Laura spoke of how increased intolerance levels had impacted on her ability to view situations objectively. She recalled an incident on her return to work:

> *I remember when I went back to work, there was this girl who wasn't pregnant when I left, but when I went back, she had this huge bump, and I was thinking 'oh great, I have to look at you every day, lucky me'.*

Similarly, she recalled:

> *When people started telling me about their miscarriages, I was saying it's not the same thing. It sounds a bit harsh now but it's not the same thing. They've still got both their tubes, I haven't. I feel really bad about it now,*

> *but I was thinking 'yours just bled out, mine died. How is that the same thing?'*

Thus, some experiences of friendships provided connection, whilst for others there was disconnection and isolation. In these instances, integration into the 'they' world no longer provided what was needed, as their lived experience had afforded them a glimpse of Being-toward-death which, according to Heidegger (1927/1962), is obscured by *Dasein's* fallenness and absorption in the inauthentic 'they' world.

7.2.4 Spatial temporal relationships

However well-meaning relationships with family and friends were, it was often relationships with others who had shared a similar experience that assisted in overcoming feelings of isolation and afforded a re-integration into the 'they' world. All the participants, to a greater or lesser extent, had sought solace within internet groups of women who had shared similar pregnancy loss experiences. These groups provided a safe space that were away from society and their everyday life, where the participants could interact with others without fear of being judged or rejected. They were easy to access at any time of the day or night. This proved to be especially beneficial for Hayley and Laura, who spoke of how difficult it was to meet with people who had shared similar experiences, due to them both living in a rural part of the county. Hayley recalled:

> *It's a shame that Lincolnshire is so rural. There are not enough people out here to go to the Sands groups, and it's a long way to travel so I haven't done it in person. It's good that we can use the internet for support. I find the pregnancy after loss groups on there really helpful. You can put anything on there at any time of day or night and people from all over the world will comment.*

Speaking with women with similar experiences brought hope for the future, through hearing of other women's experiences who had survived the loss and had gone on to have healthy babies. Relief from isolation was sought through this shared experience and, in some instances, brought a restoration of *Heimlich* (Heidegger, 1927/1962), of feeling 'at home', settled (Dreyfus, 1991). These interactions with women in this specific social environment (*Mitwelt*) brought a level of understanding in the present. However, they were not beneficial for everyone, or were only so for some of the time. Laura and Hayley both acknowledged that these groups were a mixed blessing, and could provide a false sense of security, or become overwhelming with multiple stories of loss. Laura said:

> *I try not to do the forums and online groups. I did them a lot when I had the ectopic and thought that everything was going to be fine from the comments that I read, but it wasn't, so I don't want to do it again this time.*

Recounting her experience in an online support group Hayley also spoke of a negative experience:

> *Unfortunately, there's a lot of stories of loss, not just your own, so I became informed of everything that can go wrong. Although it's a support group I ended up with a lot more worry because I was suddenly aware of all that could go wrong.*

By way of summary, for the participants, their present temporal context had changed their way of Being-in-the-world. Everyday life after the loss, and in the subsequent pregnancy were reviewed against life before the loss. The changes made were revealed in the present context of relationships with self, family, friends, and others.

7.3 The future

Participants projected themselves into the future, by their hopes and dreams and the passing of anticipated milestones. There was a changed temporal proximity between the first and second interview. The imagined future at the first interview had become the present reality by the time of the second interview, with a new imagined future emerging.

7.3.1 The marking of time against future milestones

At the first interview, the participants' main focus was on the goal of delivering a healthy baby. The passing of milestones, such as reaching the gestation of the previous loss, the management of current health issues, the uneventful navigation of future screening tests, all contributed to reaching that goal, a symbolic step before moving onto the next milestone. Some of the participants measured their pregnancies through the passing of these milestones. Jules recalled:

> *I'd thought I'd be able to get to 26 weeks and then chill out a bit. I got to 26, 27, 28 weeks and then that fear of having another stillbirth disappeared a bit, but then the fear of getting him here safe started to kick in.*

Hayley also recounted the fear of passing approaching milestones at her first interview: "*Last week was the hardest part I think because we were in the run-up to the 20-week scan, and that's when things changed last time, that's when we found out that everything was wrong."*

For all of the participants, confirmation of the pregnancy following the loss signified a time of trying to keep their emotional hopes and fears in check. This manifested itself in different ways. For Laura, this involved delaying seeking confirmation of the pregnancy or engaging with maternity care professionals in an attempt to 'hold onto' her pregnancy so that it continued into the future and defer any possible negative interventions: *"I went to the doctors to tell them I was pregnant, but I did put it off a bit because I wanted to enjoy it, to have a bit of time."* Hayley and Becki both spoke of a period of denial, a time when facing the future seemed fraught with danger. Becki said: "*I haven't done anything for this baby. I haven't thought about it or bought anything. It's not because I don't want to, it's because I daren't, I daren't hope."* Similarly, for Hayley, denial of the pregnancy was significant, especially in the early part of her pregnancy:

> *I’ve held back from getting things ready this time in case things go wrong. Other people go out and buy lots of things as soon as they find out that they’re pregnant. With this pregnancy there was a lot of denial going on, especially in the early days.*

Ultimately, as the participants approached the anticipated birth, their anxiety levels increased. This was a surprise for Becki: *“Coming up to the birth my anxiety just grew and grew the closer we got. I thought it would dissipate towards the end, but it didn’t.”* Laura spoke of anxieties about the actual birth process: “*I’m a bit scared about giving birth because I’ve heard so many stories. I try not to listen because after what happened last time I don’t want to listen to any more stories, but I’m petrified.”*

The fear that they could lose these babies was never far away. Jo explained: *“I was so nervous; I think that I still had it in my mind that I could lose him at any point.”* As the anticipated and feared for the future merged into the present, both Jules and Becki reported being comforted in the knowledge that a known and trusted care professional had planned to be present at the birth.

7.3.2 Unexpected present realities

In some instances, the anticipated future brought unexpected present realities that weren’t foreseen during the pregnancies. Both Hayley and Becki’s babies were unexpectedly born prematurely and needed support on the Neonatal Intensive Care Unit (NICU) in the early days of their existence. The dreams that they had about delivering a healthy baby were broken, with the disruption of both the present and their imagined future. Neither of them had considered this as a possibility. Becki recalled:

> *That’s why I was so worried and anxious when she was born because I was still thinking that she was going to die. I’d not mentally prepared myself for that, because I thought that as soon as she was out, she would be fine, and she wasn’t.*

Thus, there was a changed temporal proximity, a collision of an unimagined future with the present reality. Managing this, for Hayley, meant approaching each task and day one step at a time:

> *We were in hospital for 6 days……. he got a bit of jaundice, so he was fighting that for a few days as well. I think he had 2 sessions under the lights to help him flush it out, and because he was early and jaundiced, they were tube feeding him as well as me breastfeeding him. So, we had to wean him off the tube and make sure that he was getting enough from me, we were waking him up every 3 hours to feed him.*

Alison's imagined everydayness following the birth of her son, was also very different from the reality that she was thrown into. Her son, although not premature, had some unexpected problems following delivery:

> *We had quite a few problems and he had a difficult start, there was lots of things that he was being tested for – there was Down's Syndrome and Muscular Dystrophy, all sorts of chromosomal things, and of course my mind started wandering.*

Thus, for these participants, the imagined future had become a very different present reality, with the ensuing tension of confronting that reality in the present here and now.

7.3.3. The pressure to be a 'good mum'.

Following the birth of their babies, and once any initial difficulties had resolved, the reality of being a new mum set in. This involved a reconstruction of the present self as they adjusted to their new re-embodied identity as "mother". The temporality of this adjustment was significant, with the present 'here and now' of being a "mother" often very different to how they had imagined it. For Jules, this realisation was immediate when she first saw her son following his birth by caesarean section: *"I thought 'shit, I've got somebody to rely on me now'."* Having someone to rely on them brought with it a fear which contrasted with how the future had been imagined. Laura recounted: *"It was scary, really scary coming home with her. I had this expectation about what was going to happen, and then I got home, and it was just so different."* It was very different too for Becki, who spoke of her need for increased vigilance in the first few days at home:

> *Obviously, it's scary coming home because I kept thinking she was going to stop breathing most of the time and I was used to all the monitors. We bought a monitor that you stick on her belly, and it tells us that she's breathing, if she rolls over onto her belly, or if she stops breathing. It's an alarm, but we don't use that now. It was just to make us feel better in those first couple of days.*

Alongside the adjustment of being a new mum, participants spoke of the added pressure to be a good mum. This was particularly poignant, especially in the shadow of the previous loss (or losses). Any guilt that they still carried surrounding the first loss merged with the second chance they had been given, with intense pressure (often self-imposed) to 'get it right' and be what they perceived to be a 'good mum'. The experience of the pregnancy loss had given the participants a new perspective on the fragility and precariousness of life. There was an added imperative to be extra vigilant and to 'do the right thing', even when 'doing the right thing' proved difficult, or impossible due to circumstances beyond their control. In the early days, these issues centred around the choices they made about the way they fed their baby, and the guilt experienced if they perceived they had made the 'wrong' choices. Becki, who changed her mind about the method of feeding due to her daughters' prematurity, spoke of this pressure and guilt as a conflict:

> *I wasn't going to breastfeed at all, but I know that it's best for her. I got into this haze where it must be breastmilk! It must be breastmilk! I hand expressed and then moved onto a pump, so we had loads of milk to come home with, but I'm in a conflict at the moment with regards to milk.*

> *When she's on my boob she doesn't settle, but if we give her a bottle she tends to settle straight away. I just need not to beat myself up now for not breastfeeding her.*

Similarly, Jules spoke of the conflict she experienced at changing her method of feeding:

> *He'd had a bottle by then and I'd cried because I was so tired and said just give him a bottle. Then I said 'no, don't give him one', but he'd already had it by then. But he was so hungry, that was the problem.*

Alison's concern was that the circumstances surrounding her son's birth and early difficulties meant that the decision of how to feed her son was very different to how she had imagined it would. Having successfully breastfed her elder daughter, Alison assumed she would have no problem breastfeeding her son. The reality of her present situation was very different to her imagined future. She recalled: "*when it came to feeding, he wasn't responding. I was very upset about that…………. I did wonder why he didn't breastfeed very well. With [name of older daughter] the first feed happened immediately."* For all the participants, there was movement and change as they confronted their present reality and their developing identity as "mother". In some instances, this meant integrating the collision of past experiences with the imagined future in the lived present reality.

7.3.4 A re-turning to the future.

Inevitably, some of the participants in this research spoke of the completeness (or incompleteness) of their families, with thoughts turning to the possibility of future pregnancies. For Jo and Alison, who already had surviving children before the birth of the current baby, there was the feeling that their families were complete. Jo voiced this when speaking of her experience on the postnatal ward in hospital: *"I'm not planning on having any more children."* Of the participants that did not have any surviving children prior to the birth of their new babies, there was the feeling that, although the recent pregnancy experience had been stressful, they reported that at some point in the future they would want to try for another baby. Projecting into the future Jules said: *"I'd love to have another, even after all we've been through to get this one it's been totally worth it."* Becki also spoke about the possibility of a future baby, although she was cautious about the effect that it would have on her and her family:

> *I think that I will have another baby, although I don't like to admit that to myself, because I feel like I've been pregnant forever, but I do think that I'll have another baby. I don't want to, I don't want to be pregnant, but I do want another baby. I would even consider adopting if [name of partner] would do that, because the pregnancy was horrific……. I think if it were to happen again, what effect would that have on [name of daughter], what impact will that be on family life.*

In summary, for the participants in this research, their present life of Being-in-the-world was experienced within the temporal horizon of past, present, and future, and being experienced not in a linear fashion, but all in one moment, with the past shaping the present realities and future possibilities. Understanding is challenged as the participants sought to reconstruct their present selves in light of the pregnancy loss, with changes to their everydayness of Being-in-the-world. Although presented separately, it should be noted that the three-fold structure of temporality (outlined in section 4.3.5) do not work independently of each other. Instead, they are always at work together.

Chapter 8 – Attunement: The all-pervading mood of pregnancy loss.

This chapter introduces the theme of Attunement: The all-pervading mood of pregnancy loss. This theme links with the Heideggerian concept of attunement, which is used to denote state-of-mind. Yet it is much more than this, with Heidegger (1927/1962) suggesting that attunement, or moods, allow us to view the totality of our existence in a particular way, which in turn influences our feelings and behaviour in the world (a fuller explanation was provided in section 4.4.6). Polt (1999) adds that moods are disclosive and show us things in a more fundamental way. Heidegger (1927/1962) asserts that we are always attuned to the things that matter to us. Attuning allows lived experiences, such as pregnancy loss and pregnancy after loss, to become intelligible. Using Heidegger's concept of attunement as a lens to understand the participants' experiences of pregnancy loss, this chapter, with 10 subthemes, considers the participants' experiences of *Being-in-the world* of pregnancy loss, where hopes are shattered. The challenges encountered re-entering, attuning, and reconciling in this changed world are explored. Many of the participants described existing in a state of deep anxiety after the loss, which was characterised as being overwhelming and all consuming. This was identified by a palpable feeling of fear throughout in their everyday life, where the innocence present when they embarked on the previous pregnancy had been lost for ever. For some, a new pregnancy meant living in a state of terror, with *angst* a defining feature at this time. Finally, in this chapter, we consider the participants' search for meaning in their experiences of pregnancy loss, which includes ways that they found to honour the loss, and the comforting signs felt in the subsequent pregnancy, that elicited glimmers of hope for the future birth of a healthy baby.

8.1 Hope soon dashed.

For most women, a pregnancy elicits a huge emotional investment in the future, with the ultimate goal being to have a healthy baby. Affective emotional states, such as stress and anxiety, are linked to this emotional investment and can be triggered when there are concerns about the pregnancy. This was illustrated in the experiences of Jo, Hayley, and Laura, who all sought medical help over concerns in their earlier pregnancies, that sadly resulted in loss. They all spoke of fluctuating levels of hope, at the same time being attuned into the feeling that something was not quite right with their pregnancy. Hayley explained: *"Waiting for the scan for 10 days was just dreadful, we were told not to worry, but that made it even more worrying."*

During the consultations with maternity care professionals, they all spoke of feeling hopeful following reassurances given. Although these reassurances initially gave them hope, this hope was soon dashed, the relief was short and ended when they ultimately lost their babies. Hayley recalled: *"They said that everything was fine and not to worry about the bleeding, as some ladies do bleed in pregnancy and it's quite common."* Laura reported that the hope she was given by these reassurances did not prepare her for what could actually happen. She said: *"They didn't really set us up for it because they'd said they were sure that everything would be fine and that we just needed to wait for the scan."* For these participants, the embodied instinct of knowing that there was something wrong with their pregnancies was inconsistent with the reassurances given by the maternity care professionals. This inconsistency elicited a confusing array of emotions, from glimpses of hope when they allowed themselves to believe the words of the professionals (who they felt had more knowledge and experience of pregnancy than them and therefore what they were saying must be true), to the in-built attunement they had with their own bodies that persistently whispered that all was not well with their pregnancies.

8.2 Emotional suppression

For those who had been in hospital at the time of the pregnancy loss, coming home afterwards was distressing, not only because they had to leave their babies behind, but also because in hospital they had been somewhat sheltered from the everyday world. Leaving the hospital meant that they had to re-enter Being-in-the-World*,* that had changed significantly for them. Some initially struggled with this change, and as a result tried to suppress the accompanying emotions in an attempt to block out and escape the enormity of their loss. Jo recalls:

> *I didn't cope very well at all with losing him. I coped by drinking myself to sleep every night, that was the only way. I was suffering with gallstones at the time, so I was on really strong painkillers. Those combined with a bottle of wine or two, that was how I coped with it.*

The emotional suppression of wanting to 'escape' the reality of the loss sometimes collided with the practicalities of everyday living, forcing attunement to the enormity of their loss. Becki described the distress this caused:

> *Once we got home, we had to face telling everyone what had happened. The messages started coming in asking if we'd had our little girl yet, and people were posting things through the letterbox saying 'Congratulations on the birth of your baby'……my mum did a lot, she messaged a lot of people and told family……..They gave us something from the hospital to fill in to stop getting things through the post, but that doesn't stop the emails, so we had to deal with the aftermath of that.*

Other women tried a different approach to escape attuning to the reality of the loss, instead attempting to return to some semblance of 'normality', a returning to *das man,* by returning to work as soon as possible, to try to reclaim the life before the loss and extinguish the overwhelming grief the loss had triggered. Alison struggled with the dichotomy of life as it had been, compared with life she had now been thrown into. She spoke of the challenges she faced when returning to work after her second miscarriage:

> *I went back to work on the Monday (I'd miscarried on the Friday before). I nearly collapsed at work. I had wanted to get back to normal, but someone ended up taking me home. I had about a week off in the end.*

In her quest to suppress her emotions and return to some kind of normality, Alison had underestimated the extent to which her altered affective state of mind had permeated her whole being. Through her loss, the encounter with death had profoundly changed her experience of Being, so that although physically she was able to return to work, emotionally her distress, *angst,* and sadness signalled she was far from ready to take such a big step so soon.

All the participants spoke of trying to make a new life after the loss. For Hayley this included:

> *We moved out of the pub and made ourselves a new little home with my mother-in-law. We began a new structure really. [name of partner] started a new job after about 6 weeks. We were just looking after each other, supporting each other through it………We were lucky because we had a holiday booked………so we had something to look forward to, a break away, which was nice.*

The experience of loss had profoundly changed the women, who now viewed the world very differently. Re-entering a world that was changed through loss involved trying to re-engage with the everydayness of that world as it was before the loss. This was far from easy, and for some, initially proved too much as they tried to escape and suppress the emotions that engulfed them. Plans that had been made before the loss were followed through, perhaps in a misguided attempt to return to the *Heimlich* everydayness of life. The participants, however, described realising that their attempts to re-capture their old life as it had been were futile. Becki described the experience as *"my bubble had been burst, and I've been exposed to what can happen and there's no going back".* For her and others, the only way to re-engage with Being-in-the-World was through attuning to a different way of Being-in-the-World.

Attunements are not only private and individual but also represent ways of Being - with-one-another in the social and public arena (Crowther, 2014). The participants spoke of some of the challenges they had in adapting to their Being-in-the-World, that was still familiar, yet different. Of significance was the change in relationships with those close to them as well as acquaintances. Friends and relatives, who were not acutely attuned to the situation or failed to attune to the mood of the moment, would try to offer comfort and support but were often unaware of how hurtful their comments were perceived. Participants faced dilemmas of who to tell and how. Laura recalled the difficulty she faced when telling people about her ectopic pregnancy, and how hurtful she found people's responses to her loss: *"A few people have made annoying comments, such as 'does that mean you can't get pregnant again?' I'm sure the nurses told us something like that would happen, but I did get a bit angry with people."* One participant, Becki, spoke of the burden of how her loss had affected her pregnant friends who were now anxious about their own pregnancies: *"Friends have said that they don't mean it in a bad way, but they haven't been able to enjoy their pregnancies like they thought they would because they now know what can happen."* These interactions illustrate the difficulties that some of the participants faced when their expectations of Being-with-one-another collided with how those interactions were experienced in the here and now. The loss had created a barrier to their Being-with-one-another in an authentic way, that in some cases was permanent.

8.3 Altered embodiment.

Several of the participants recounted how their trust in their body's ability had been broken with the loss of their babies. In keeping with Heidegger's (1927/1962) assertion that attunements are only uncovered in times of breakdown, for some of these women, this had been the first significant time that they had experienced their bodies letting them down by not functioning as expected. This realisation was expressed in several different ways. For some (as discussed earlier in section 7.1.6), it was in the form of bodily self-blame and betrayal. Jules recounted: *"It's my body and I should have been looking after him."* For others, it took the form of blame and self-punishment of their bodies, through binge drinking following their loss (as in the case of Jo discussed earlier in section 8.2) or taking up smoking. Becki said:

> *I started smoking after [name of lost daughter] was born. It broke up the day and I found it a release. It gave me something to focus on and I enjoyed it…….it was something else to feel guilty about because I knew I shouldn't be doing it.*

Others, through a comparison of what they perceived to be a normal physiological function of womanhood, reported a sense of guilt and failure at not being able to successfully deliver a healthy baby. This was significant for both Laura and Becki and exacerbated the feelings of bodily doubt and betrayal that accompanied the feelings of loss and grief they experienced. Laura recalled thinking: *"Why my body did this and not that person's."* Becki explained: *"There's almost like a sense of embarrassment because I've not been able to do something that other women do and brought a baby home."* The emotional responses of not being able to do what other women had been able to do, apparently without any problems, ran deep for the women, infringing on every aspect of their being. Their trust in their body to function as they expected it had been irretrievably broken.

8.4 Reconciliation with their parental identity

Some of the participants spoke of the difficulty of reconciling what had been their emerging parental identity, with the loss of that identity before it had been realised. They questioned whether they were a mother to the lost baby, and how to articulate that to themselves and those around them. For Jules, Hayley and Jo, their lost babies were integrated into everyday family life, through talking about them to family, siblings, and friends, and remembering them at times of celebration, such a birthdays and Christmas. Jo explained: *"If we ever talk about the children, we always include [name of lost son]."* Hayley too spoke of her intention to include her lost son in family life bringing up her new son: *"This one [current pregnancy] will be brought up with the things of [name of lost son] around him, so he will know about him."* She also explained how she tried to reconcile her identity as a mother to her lost baby as well as to her present baby: *"I really don't know how to describe the emotion, because I've felt like a mother since having [name of lost baby], it's just now that I've got one baby* *here, that’s the main difference.”* Celebratory events such as birthdays, Christmas, and anniversaries can be a particularly difficult time for bereaved parents and can signify an unanticipated re-surfacing of grief. Jules described how she channelled that grief into a positive act of remembrance of her son, and how the empty white box that she had left the hospital with following the loss of her first son had now become a focal point for the family to send cards and gifts: *“Now there’s birthday cards, Christmas cards, Mother’s Day cards, everything’s in there. He has his own Christmas tree every year, where everyone buys a little something to go on it.”* Laura, who had no physical reminder of the baby she had lost, spoke of how lighting a candle on significant anniversaries, such as the baby’s due date, brought comfort: *“We’ve got things at home, a thing on the mantlepiece. When the baby was supposed to be born in April, we lit a candle and put it in it.”*

Thrownness into the world of pregnancy loss for these women was neither welcome nor volitional. Attunement to this world of pregnancy loss, whilst painful, opened up new possibilities to participate in a world that was previously denied to them, for example, through making new connections with others who they would not normally be in contact with in everyday life. These new connections could be a vital means of support, especially as the women sought to make sense of their situation and their overwhelming feelings of fear.

8.5 Feeling fear.

Fear can arrive suddenly and unexpectedly. This was Becki’s experience as she recalled the shocking moment when she was in labour and was told that her first daughter had died. She said:

> *Then they got a consultant in, and he brought a different machine and looked in depth. There were so many people in that room at that point, he just said I can’t find a heartbeat. I literally screamed ‘what the fuck has just happened’. I just didn’t understand it; there’d been literally nothing, nothing at all.*

The shock and fear described by Becki was mirrored in the other participants' accounts, regardless of the stage of their loss. Laura not only had to process the loss of her pregnancy, but also the potentially life-threatening situation that she had been thrown into. She recounted:

> *They did say that they would have to remove my tube because the baby was growing quite rapidly, and that I'd probably die if they left it any longer. I'm thinking 'thanks' – there's not much else you can say to that…………I remember waking up after the surgery and thinking that I was never going to have my own baby, like it wasn't going to happen for us.*

Pregnancy loss is where feelings such as intense fear, bodily doubt, loss of parental identity and continuity may be experienced for the first time. Cumulatively, these can lead to an unfamiliar feeling of being 'not at home' *(unheimlichkeit)*, of unsettledness in their Being-in-the-world, in a world that had become *unheimlich*. Outwardly, to the participants the world appeared the same, but their experience of it after the loss was unfamiliar. Becki spoke of her lack of awareness of the existence of this unfamiliar world before she lost her daughter: *"Until it happened to me, I didn't really know anything, I was oblivious…………but unfortunately it does happen, and it happens more than I thought. It's shocking!"* Thus, the unfamiliar had become uncomfortably familiar.

8.6 The loss of innocence

When another pregnancy was embarked upon, the new pregnancy was often characterised by overwhelming fear, anxiety, and mental anguish, which was re-ignited when the pregnancy was confirmed. The women reported wanting to be happy but were aware of a background, pervading feeling of *angst,* and an accompanying fear that they would lose this pregnancy, as they had the last one. These experiences reinforced the sense of *unheimlich.* The loss of *Heimlich* was described by the participants as a loss of innocence, or in Becki's case as a naïve ignorance. She recalled:

> *There's an ignorance as well, not a malicious ignorance but a bliss, like they say ignorance is bliss. I understand that concept now because I don't have that ignorance anymore. With this second pregnancy I feel like this ignorance has been lifted.*

For Jules, this loss of innocence was apparent through the way she monitored her pregnancy as she passed through self-identified milestones:

> *From the minute I got that positive pregnancy test that was it. I was thinking I wasn't going to get past 8 weeks, then we got to 20 weeks and found out what we were having. Then we got to 26 weeks, and he was still here and moving, his heartbeat was still going so I wasn't going to have a stillbirth….*

Laura spoke of how the new pregnancy was experienced differently from the first one. Her previous experience had affected how she approached the current pregnancy, with her becoming fearful as they waited for their first scan: *"Then it was our turn, and we went in. I remember just looking at the ceiling, thinking I don't want to go through this all again, I'm not ready."* Hayley too spoke of how this loss of innocence had changed her view of routine screening tests:

> *Most women who start a pregnancy innocently think they'll wait until the 20-week scan to find out the gender. It's not like that for me now, it's about checking that the organs are there and that everything is going ok – the gender is an entirely different issue……. I now know that things can go wrong, and people don't always think about that.*

This feeling was echoed by Elise, who spoke of her delight at being pregnant again (as opposed to her husband who she said was far more cautious). She spoke of the paradox of feeling that intuitively the outcome of this pregnancy would be positive, yet still having an underlying awareness of *angst* as she waited for her first scan; *"It was nerve racking until that point, and then such a relief when we saw the heart beating."*

Carel (2016) suggests that there is no turning back once this loss of innocence is experienced, as the possibility of further loss is now a part of a person's 'experiential horizons' (p.95). Whilst this proved to be the case for the participants in this study, it did not stop them from pursuing ways to distance themselves from it.

Accompanying this loss of innocence, some of the participants distanced themselves from their pregnancies to avoid considering the possibility of a further loss. For some, this avoidance was apparent in the early days of pregnancy. Hayley recalled:

> *With this pregnancy there was a lot of denial going on, especially in the early days. I didn't feel pregnant so I thought that maybe I wasn't, I convinced myself that it might not actually be happening just in case.*

Jules also spoke of this uncertainty about being pregnant, and the possible explanations for her symptoms: *"I thought I might be pregnant, but I wasn't sure. I just thought my body might be playing tricks on me."*

Both Hayley and Becki spoke of trying not to think about the pregnancy and delaying any preparation for their baby's arrival. Becki said: "*It's like I've been going along not ignoring this pregnancy but trying my best to think of anything else but the pregnancy."* Another way that some women try to distance themselves from their pregnancy is by delaying announcing the news to family and friends. Elise spoke of the dilemma of who to tell and when:

> *So those first early days and weeks, I suppose we were a lot more cautious, in as do we tell people or not, but to me it intuitively felt better, and I told my mum pretty soon. I told close people that would understand that I didn't want the whole world to know, but also those who I would like there in case something went wrong.*

This avoidance or distancing from their subsequent pregnancies is significant. Having been thrown into a situation that requires a response, often in the form of *angst*

(Harmen, 2007), the anxiety that follows can be what Polt (1999, p.77) suggests is "a deep crisis of meaning". The avoidance was the response from the participants to the new pregnancy. It was the way that they managed the *angst*, through distancing themselves and trying to escape the experience by throwing themselves into the routine everyday world as a means of distraction. However, this resolve was not long term, and the participants in this study, left with little choice, became what Heidegger calls *resolute,* as they battled to adjust to this new way of Being-in-the-world. For some of the participants, this *resoluteness* became apparent in their involvement of their maternity care. For Becki, this meant challenging the decision of one midwife who said that the cardiotocograph heart monitoring taken was normal: "*I wasn't convinced because I knew that it was different from the ones before, so I asked [name of bereavement midwife] to look at it."* No longer passive recipients of care, they questioned, trusted their instincts, and persevered until they got the care that they needed.

For these women, the fear and *angst* manifested itself at different times and in different ways throughout their current pregnancies. As mentioned, some of the women distanced themselves from their pregnancy, as a means of self-protection. Others focused intently on their pregnancy symptoms which were a source of comfort to them. Most sought confirmation and reassurance from maternity care professionals, often requesting increased antenatal testing as a means to gain reassurance. For some, there was a lack of trust in maternity care professionals, which led to them becoming increasingly hypervigilant, scrutinising everything that was said to them. The intense mood of anxiety, or *angst,* was at times overwhelming, often because with it comes the realisation that the essence of who they were was beyond their control. With pregnancy loss, the fragility of human life was laid bare.

8.7 Living with terror

The intense mood of *angst* invades *Dasein's* normal sense of things, leaving us exposed, threatened and vulnerable (Carel, 2016). It disrupts daily living, and all that is familiar, and is characterised by a constant feeling of uncertainty. Fear, as mentioned in the previous section, is often an accompanying affective state for those experiencing *angst.* Some of the participants in this study spoke of how fear and the all-pervading mood of *angst* characterised much of their current pregnancy, infiltrating their very being, and the battle they had to remain hopeful amidst their *angst*. Jo related how: *"Being pregnant again was terrifying, because I spotted in the first few weeks."* This feeling of apprehension and dread continued until short-term relief (and a brief returning to *heimlich*) was achieved when a scan revealed that the pregnancy at that point was progressing normally: *"…. there was a pregnancy, and everything was in place. That was such a relief to me."* Similarly, Alison recalled: "*At an appointment after the 20-week scan I was getting anxious because I didn't feel pregnant. The midwife got the doppler out so that I could hear the baby and that reassured me."* Whilst this reassurance did bring a sense of comfort, it was often only temporary, with the feeling of fear and terror never far away.

It appeared that most of the participants in this study switched between two ways of living with terror. Whilst the unsettling mood of *angst,* and associated terror, was constant, for most of the time the participants were able to escape the uneasiness by immersing themselves in the, albeit now unfamiliar *they* world. However, there were times during their pregnancies, often in the lead up to important milestones or antenatal appointments, where their experience of terror shifted to being extreme and all-consuming, and disrupted their ability to be able to engage in the ordinary everyday world.

However, for one participant, Becki, this was not the case. Her descriptions of her everyday life and her pregnancy indicate that her experience of the terror of being pregnant again was extreme: "*I'm normally a very level-headed person, more rational than emotional normally, and I was just at my wits end."* It disrupted every aspect of her life, with both physiological and psychological consequences: *"I ended up in A&E one night because my heart was just racing, for about 4 hours. I just couldn't stop it."* Like Jo and Alison above, the offer of, and the time leading up to maternity appointments was fraught with fear and *angst*: *"…. it's like we're just waiting for them* *to find something bad".* Having extra tests, even when the results were favourable, did not bring the anticipated relief that Jo and Alison described. Instead, she explained: *"I don't think that it was good for me because it only made me more obsessed with things."* For Becki, living with *angst* was profound, and pervaded every aspect of her life.

The mood of *angst,* terror, and fear described by the participants was a complex state of mind. Although it varied in intensity, and various strategies were employed to overcome it, it never disappeared completely. The participants feared a recurrence of their previous pregnancy loss and lived with the terror of that thought. Increased awareness of the fragility of their pregnancies meant that fear and *angst* were constant, unwanted companions. Heidegger states that *angst* is a state of loss of meaning (1927/1962). Yet, for the participants in this study, they described desperately needing to understand and make meaning from their experiences.

8.8 The search for meaning.

In an attempt to comprehend the meaning of lived experience, *Dasein* strives to understand its function within the network of significant relationships with other entities that constitutes Being-in-the-world for them (Heidegger, 2004). In other words, making meaning from events and experiences includes seeking explanations in a quest to understand. It involves both detailed inward scrutiny (did they inadvertently do something that caused the loss?) and outward surveillance of activities (were mistakes made in the management of the pregnancy that contributed to the loss?). For the participants in this study, trying to make sense of the lived experience of pregnancy loss, and the loss of their parental identity was an ongoing process that began almost instantaneously at the time of the loss and continued throughout the subsequent pregnancy and early postnatal period.

Whilst trying to navigate the unexpectedness of their loss and ongoing grief, and in their quest to find meaning in the midst of the tragedy, some of the participants reported an inward scrutiny of their actions leading up to and after the loss in an attempt to answer the question why. Why did this happen? Was it something that they did that caused it? Describing this time, Becki said *"My mind was just going crazy with questions."* Later she commented: *"I kept racking my brains, thinking what I had done to have caused it. I wondered if it was because I sometimes woke up on my back, and I was on my back in labour. I was just looking for an answer, that is what I did."* As well as looking inwardly for answers, some found that they had to seek answers externally to answer those inward questions. Alison recalled:

> *Leading up to the miscarriage I'd had some funny turns when I'd felt really dizzy and sick. I'd had that a few times, so after the miscarriage I went to see the doctor about it because I thought it was linked to when I lost the pregnancy.*

In this search for meaning, some of the participants were faced with having to make difficult decisions about offered medical investigations on their babies. Both Hayley and Becki agreed to post-mortems being carried out, as a means of trying to answer the why questions and determine the causes of the loss. As the procedure was unfamiliar to them both, it was a decision that added to their distress. Being attuned to both the present time, but also possible future dreams of having a child, and in an attempt to try to make sense of the world, both expressed the need to know if there were any concerns before they considered embarking on any further pregnancies. Whilst the results of the post-mortems did not point to any specific cause for their losses, the women reacted very differently to the news. For Hayley, this was welcome news, as it confirmed that there had been no underlying health issues with her lost son:

> *There was no actual cause for the loss, other than the fact that I'd lost the fluid. It was a relief to get the results and find out that there was nothing wrong with him……For some people it might be worse to find that out because they'd rather have an answer, but it was nice to know that there was nothing wrong with him, that he could still have been a healthy baby.*

Becki, however, found the lack of any specific cause difficult to deal with:

> *So, there were things there but nothing concrete, and each of those things in isolation would not have caused her death. It was the combination of things that did and that almost makes it harder because while we're glad that there's nothing specific wrong that still does not give us any answers.*

These steps taken to bring understanding to their experiences of loss involved a search for answers, which yielded very different outcomes. For Hayley and Becki, both intrinsically attuned in their search for meaning, these experiences represent what is cared for in the aftermath of their loss, and an attempt to integrate the trauma of that experience through seeking answers to prevent it happening again.

In their attempts to understand their experiences of loss some of the participants spoke of trying to gain understanding by comparing their loss with other losses, both their own (in the case of Jules and Alison who had experienced more than one loss) and others. The hope was that by comparing and hearing about other women's experiences of loss, they may become aware of information that may give them the answers they needed about their own loss(es). They did this through either recalling accounts that they had heard about other women's losses, or through entering discussions in social media forums. Jules, who had experienced four pregnancy losses, compared her experiences to those of imagined others in an attempt to make sense of her experiences:

> *I never thought that I would struggle to get pregnant, let alone lose four. But then I think that there are people much worse off than I am. They have more losses or get their baby for a while and get to play mum for three or four months and then their baby, their child dies……. Awful as it sounds, I do believe that there are people a lot worse off than I am.*

Both Laura and Hayley used internet forums and chat rooms as a way of engaging with and comparing with those who had experienced a loss, and in Laura's case, as a means to explain the symptoms she was experiencing in her ectopic pregnancy. She said:

> *My pregnancy sounded like someone's on the forum, and it was ok for her, but it wasn't for me. I was reading stuff that made me delay going to the doctors because I just thought it was growing pains, so I left it.*

The experience was significant and alerted her to the dangers of consulting unregulated online forums for medical advice. As a result, she made the conscious decision not to engage with the online forums in her current pregnancy: *"I try not to do that now, because I thought that everything* (with the previous pregnancy) *was going to be fine from the comments that I read, but it wasn't."* As well as having some negative experiences of using the online forums, Hayley spoke of the positive side of belonging to a pregnancy after loss forum: *"one of the good things is that they post pictures of their baby after they are born, so it gives me hope thinking that will be me one day."* This hope, to a certain extent, assisted in the restoration of *Heimlich* and reducing *angst.* The sharing of experiences, and mutual care (*Sorge*) in the online community provided them with comfort and understanding as they re-entered Being-in-the-world after pregnancy loss.

8.9 Honouring loss

As a way to honour the loss of their babies, three of the participants who had losses later in pregnancy spoke of the comfort they experienced at being able to organise the blessings and funerals of their babies. This appeared to bring a sense of calm to them as they navigated the difficult existential questions about the nature of meaning, of *Being-toward-death,* and existence that had been activated with the loss. Jo recounted:

> *I'm a Catholic, and it really upset me that he couldn't have a baptism. My other two have been baptised, but they said that they did the blessing and that was the next best thing. It meant a lot for me to have that.*

Similarly, Becki recalled:

> *We rang the vicar at [name of village] because we wanted her blessed. We'd never spoken to him before, but he was there within half an hour. He was amazing, everyone came in and we had some more pictures with her.*

For Jo, organising her son's funeral brought a sense of purpose and fulfilment to the experience:

> *One thing that did keep me going during this time was organising his funeral. That gave me something to do……. I felt like I couldn't do anything else for him as his mum, so the least I could do was organise his funeral and give him a good send off.*

These acts of honouring their lost babies served a twofold purpose. In addition to honouring their babies, arranging the funerals assisted in reinforcing their identities as mothers, through being enabled to demonstrate one final act of love and care for their lost babies. In addition, honouring their losses in this way brought them face to face with Being-towards-death*,* the existential awareness of their own and their unborn baby's mortality.

8.10 Comforting signs

This meaning making continued in the subsequent pregnancy, with hypervigilance and close scrutiny of the progress of the pregnancy. The causal explanations sought in the previous pregnancy did not provide any real solace in the subsequent one, with an ongoing tension between the chance and probability of it happening again, and feelings of uncertainty moving forward. Thus, signs and symptoms of pregnancy, such as nausea and vomiting, breast tenderness, increased tiredness, and urinary frequency, whilst troublesome for some, were welcomed by the participants in this study as a sign that they were still pregnant, and all was well. Conversely, a diminishing or disappearance of these symptoms reignited the terror, fear, and *angst* described earlier. Laura compared her lack of pregnancy symptoms in her previous pregnancy with those she experienced in her current pregnancy, as a way to self-reassure: *"It was completely different. I had no shooting pains or anything like that. Going to the toilet wasn't uncomfortable, and I felt sick and hormonal, it felt different."* Similarly, Jo recalled how experiencing morning sickness was reassuring, but did not negate the worry altogether: *"I started to feel sick which I knew was a good thing because I'd always felt sick with my successful pregnancies, so the sickness was a good thing, but I still felt worried."* A lack of pregnancy symptoms, especially after a previous loss was reported as being anxiety provoking, often accompanied by a sense of urgency to receive medical confirmation that the pregnancy was still viable. Alison recalled:

> *I didn't have any pregnancy symptoms, so I was getting a bit anxious. I rang my midwife, but she wasn't very quick at ringing me back, so I arranged a private scan. The midwife rang me back then but couldn't get me in for a scan until after my private one, so I went to that, and everything was fine.*

Significantly, Becki spoke of experiencing guilt at not appreciating her previous pregnancy, with its accompanying symptoms, and how the experience had taught her to try to appreciate every aspect of her current pregnancy. Even so, it proved difficult to achieve this. As we are always attuned to the things that matter to us, it is understandable that the participants were cautious about letting themselves hope that they would have a healthy baby in the current pregnancy, as a way of self-protection. Becki recounts: *"I did feel glimpses of hope in my pregnancy that I would get a baby at the end. But I thought that if I thought like that, I would be jinxing it."* Similarly, Jules spoke about her reluctance to hope, that was present until her son was born, and she could see for herself that he was alive and healthy: *"I'd never let myself believe that I would have a live child. Even the day before I had him, I thought that something would go wrong."* These accounts point to the dilemma that these participants faced in trusting their bodies that had previously betrayed them to now be a source of reassurance in the nurture and growth of their current pregnancies.

The findings in this chapter reveal multifaceted lived experiences of Being-in-the-world of pregnancy loss and pregnancy after loss, and the challenges each woman faces by existing in this world. These challenges do not happen in a chronological, linear way but are experienced simultaneously. The process of grief and loss, experienced as emotional suppression, unfolds through time, and is characterised by a shifting understanding of self as a Being-in-the-world that is different yet the same (*unheimlichkeit*). The ultimate goal of all the participants was to deliver a healthy baby, yet this goal was held alongside the uncertainty of terror, fear, and *angst* at having a recurrence. Thus, the *angst* experienced by all the participants at different stages of their subsequent pregnancy journey sat alongside joy and hope as temporal experiences as both a confusing and complex reality. This fear, characterised by *angst* and Heideggerian *unheimlichkeit* brought to the foreground of experience the fragility of human life, the search for meaning, and the need for a re-evaluation of their way of Being-in-the-world.

Chapter 9 – Relationships of care and systems of care

In this chapter the attention now turns to the focal point of this research, women's experiences of care, specifically maternity care, in pregnancies after pregnancy loss. In doing so, the findings in this chapter seek to answer the research questions of "How do pregnant women experience maternity care and support following a previous pregnancy loss?", and "How are these experiences meaningful?"

The focus of this chapter is somewhat different to the previous finding's chapters, in that the findings are not viewed through a Heideggerian philosophical lens. This is because in this chapter the focus inevitably shifts to issues of maternity service delivery and organisation of systems of maternity care, as a way of seeking to inform maternity care through these women's lived experiences. It was therefore not intended to be a Heideggerian analysis of maternity care or systems. In this study, systems refers to how maternity services are structured and resources (including, but not limited to finances, workforce, and infrastructure) allocated to provide maternity care that is accessible and equitable for all pregnant women. The guidance for the commissioning and structuring of these systems rests with the Department of Health nationally, but with Clinical Commissioning groups locally, who commission maternity care to meet the needs of the local population (National Audit Office, 2013). It was encounters with these systems of care that in part, shaped the women's experiences of maternity care in their pregnancy after the loss. Moving from the personal to the professional in this way does bring a tension to the work that needs to be addressed. For the participants, their encounters with maternity care were experiences that were important regardless of whether these were with individual practitioners or the way that services were organised, and as such are worthy of consideration in this study. The findings have fundamental implications for the delivery and organisation of maternity services both locally and nationally.

The chapter outlines the participants experiences from the perspectives of ten emergent subthemes, that are arranged under two headings of Relationships of care and Systems of care. Although acknowledging that relationships of care can mean relationships of care with anyone, in this chapter it relates purely to the relationships that the participants had with maternity care professionals. The subthemes in the first section focus on the participants' relationships of care with maternity care professionals encountered throughout their pregnancy, in labour and in the early neonatal period journey. These include anything from brief, one-off encounters, to relationships that became more established through regular, continuity of carer interactions. Consideration is given to the unique formation of relationships when women are in labour, and how these shape the birth process. Pivotal to the women's experiences was how trust was perceived in the relationships, and how the illusion of trust was crushed when well-meaning reassurances turned out to be empty promises. This leads to how insensitive and hurtful communication can leave an irrevocable imprint on women's memories, long after the comment has been forgotten by the professional.   Under the second heading, Systems of care, attention turns to the women's experiences of the existing and available systems of maternity care in Lincolnshire, how they were organised, and the consequences that had for their experiences of care in a pregnancy after loss. These are organised in the subthemes of inappropriate care environments, inaccessible care services, and inflexible systems of care.

9.1 Relationships of care

The strength and quality of the participants' relationships with practitioners had a profound effect on their health and well-being. These relationships, whether a one-off encounter, or a cherished continuing relationship throughout the pregnancy and beyond were significant for the women for their understanding of Being-in-the-world of pregnancy and pregnancy after loss. The quality of these relationships had the capacity to build up, or knock down, the womens' confidence and self-esteem. That is, they reported their interactions with maternity care professionals were either useful by meeting their needs at that particular time, or not useful. In highlighting maternity services as useful they revealed what they wanted and valued as service users. This service was perceived as offering support and information, whilst valuing them through hearing and listening to their concerns, looking after them in a way that acknowledged their previous loss and the ongoing effect of that loss, and of valuing and respecting them as individual service users. Conversely, the maternity services that were perceived as not meeting their needs and purposes were experienced as encounters where they reported being unheard, unseen, un-informed, uncared for, devalued and disrespected as service users.

By far the most powerful comments from the participants was about the standard of communication, *"there have already been failings, they've already shown that they don't understand my situation…."* (Becki). The participants in this study spoke of incidents where they just weren't listened to by maternity care professionals and having to navigate maternity care systems that were bureaucratic and impersonal, leading to disempowerment, helplessness, and despair. It would be unfair to suggest that all communication was problematic, because when instances of clear and appropriate communication were reported by the participants (section 9.1.1), they recalled feeling empowered, listened to, and valued. However, the opposite was true when poor, irrelevant, or lack of communication was reported (section 9.1.7). There is no suggestion that the examples of poor communication reported were malicious. However, it does suggest a need to be addressed in any training undertaken by maternity care professionals.

9.1.1 "We had a relationship".

Several of the participants spoke of the special relationships that they had with maternity care professionals, that provided support, encouragement, and an experience of care that indicated that what mattered to them also mattered to their carers, the birth of a healthy baby. In these relationships there was a connection, an alignment of Being-with-others *(mitsein),* a partnership of working together towards an imagined future with a positive outcome. Some of these relationships proved to be long standing, continuing through the pregnancies and beyond, others were short, one-off episodes at significant times, for example, during labour. All were recalled warmly by the women as times when they experienced being valued, empowered, informed, cared for and safe. Becki and Jules spoke of how blessed and privileged they were to have such supportive relationships with some practitioners throughout their pregnancies and beyond. Jules explained:

> *I've had a lot of care from a lot of people, which I don't mind, but I get uncomfortable when I don't see [name of midwife] and [name of consultant] ……… They were both brilliant, it's hard to pinpoint just one specific thing about them because just as a whole they were a fantastic team. I wouldn't hesitate in going back to them both.*

It was when experiences of *angst* were high that these relationships were valued the most. Becki spoke of the care she received from the bereavement midwife, highlighting it as the single most important factor in getting her through her subsequent pregnancy, when her anxiety levels were reported to be *"off the scale".*

> *I really trust that [name of bereavement midwife] does her job properly. I know that she cares, and that when I'm with her I'm her sole focus. It's not like a midwife who is doing her rounds on a ward, quickly moving from one to the other. She knows my history and she knows me. I'm not saying other midwives don't care or want what's best for me, but I'm just another patient to them. To [name of bereavement midwife] I wasn't. We had a relationship, she knows everything, she knows what I've been through, she just knew.*

Here the distinction is made between being "*just another patient"* to having a real connection *"we had a relationship"*. This seemed to be the crux of what all the participants in this study wanted from their relationships with maternity care professionals. They wanted and valued the connection of this kind of personal relationship, which was closely linked to satisfaction of the care they received.

9.1.2 Continuity of carer

Being valued and respected by the maternity services was experienced by the participants in different ways. Being treated equitably, by a service that recognised their holistic needs was viewed as a minimum requirement of the service. All of the participants spoke of wanting a maternity system that was more than just a treatment delivery service. They wanted a service provided by practitioners who treated them holistically and were consistent in caring for both their clinical and emotional needs. This was rarely provided by the same practitioner, with participants differentiating between those who provided for their emotional needs and those that provided for their clinical needs.

When consistency in approach was missing, comparative evaluations were common between those who were seen to provide a clinical approach, and those who were more person centred in their delivery of care. The participants who did report that they received emotional support and had their concerns taken seriously by the maternity care professionals, highlighted how this type of support was provided more by midwives, with the doctors and consultants more focused on the clinical care and the needs of the baby. Becki explained: *"My consultant appointments are a different kind of meeting, where the focus is on what the baby is doing. It's not really about how you are."* Hayley's experience was similar: *"When we saw the consultant, she would be more clinical and straight to the point."* By contrast, both Becki and Hayley identified midwives who they reported provided both the emotional support they needed by valuing them and taking their concerns seriously, and by making time to listen to them, not belittling their experiences. Becki explained about how comforting she found being able to identify professionals who could give her the support she needed:

> *I think I'm getting the emotional support from [name of bereavement midwife] and [name of community midwife], which I appreciate. I have their numbers and can ring or text them and they'll get back to me as soon as they can. That's a nice feeling.*

The participants in this research who had regular, holistic, and continued care with the same caregiver, spoke of how beneficial they found this service in addressing both their clinical and psychological needs. In contrast, one of the issues for many of the participants was the distress caused by having to repeat their story to different care professionals who did not know their circumstances, perhaps through not taking the time to familiarise themselves with the participants notes before a consultation. When women saw the same caregiver at consultations, any risk of distress for them was reduced or eliminated. The security that these continued relationships provided was immeasurable to the participants throughout their pregnancy, helping to alleviate the experience of helplessness and vulnerability, instead providing a sense that they were being looked after, and that they mattered. One of the participants, Hayley, spoke warmly of one midwife who provided the continuity of care she needed so that she didn't have to explain her situation at every consultation:

> *She would always greet us as if she saw us every day. It was the little things like that that made all the difference. I felt like I could ask her any questions if I had anything on my mind. She knew the full story without having to refer to the notes.*

Thus, the benefits of having the same caregiver at consultations were immense for the women, who reported it changed the context of care to one of security, mutual understanding, and respect.

The women, however, did accept that it was not realistic to be able to see the same maternity care practitioner at each appointment. This was not an issue, as long as the practitioner caring for them provided them with care that was compassionate and understanding, a consistency in approach that demonstrated to them that they were valued and respected as service users. Vicki spoke of an experience of compassionate care from practitioners she had not met before:

> *The nurses were really good. They spoke to me about it. One nurse was telling me that her mum had her ovary removed from one side, and the tube from the other, and that the remaining ovary and tube worked together well, a bit weird, but she was saying that you've always got hope no matter what happens*.

9.1.3 Enabling relationships of care.

Short term or occasional encounters with professionals were deemed as just as important as a source of support. These were commonly (but not exclusively) reported when the women were in hospital to deliver their baby, when there was mostly a one-to-one interaction. These relationships have to be forged quickly at a time when women are often experiencing trepidation and concern. At the time of labour and delivery for women who are pregnant after loss, these experiences are likely to be heightened, which is why the quality of the relationship with the care giver is so important and will have a direct impact on a woman's emotional well-being and experiences of care. Although not able to fully articulate why an experience with a care giver was good, the participants were able to distinguish between good and not so good interactions. Jo recalled: *"My favourite midwife was the midwife that was in theatre with us, she was so lovely, she was with us for the whole day. She came into theatre with us, and then was there afterwards."* Some participants had more than one caregiver during labour, often due to staff changeover between shifts. One participant, Laura, recalled her experience of different practitioners when there had been divergent experiences of care:

> *It was a bit of a nightmare, but when the other midwives came in, they were really good. They were at the bed with me, whereas the other lady was just sat at her desk the whole time……… the others were at the bed, checking how far down she was and my contractions, asking if I needed to push and trying different positions.*

Laura perceived that the care she received from practitioners later in labour was superior to the care she received from her original caregiver, suggesting an emotional connection of Being-with (*mitsein)* those practitioners as opposed to a clinical, task focused encounter with the previous one.

In some cases, these connections endured through different pregnancies, being re-kindled in the subsequent pregnancy, often through a chance encounter. Alison recalled a chance encounter with a midwife who had delivered her previous daughter: *"We had a nice chat; she was the one who listened in for me when I was worried because I talked a bit more freely with her."* Hayley spoke of how a chance encounter with a midwife who acknowledged her involvement in her care with the baby she had lost provided comfort when she was in labour with her subsequent child:

> *The first midwife that originally welcomed us said that she remembered [name of lost son], which was nice. She wasn't in the room with us, but she was part of the team that night. It was nice that they knew our situation.*

When communication was clear and inclusive between the participants and care givers, it was often linked to when trusting relationships had been built up with members of the maternity care team caring for them. Information sharing in an unhurried and caring way was particularly valued and added to their feelings of worth and well-being. Participants shared an awareness of how stretched the maternity services were, and a feeling of gratitude and empowerment when practitioners took the time in their busy schedules to go beyond what was expected of them and provide information that would act as a source of reassurance. Elise revealed an experience of being cared for when contrasting the information provided at two different scan experiences:

> *"The first scan was like there's a baby in there, fine, and that was that. Whereas at the 20-week scan we both said 'Woa', he was very informative, he took his time, he was excellent. That's what we wanted, to not feel like it's a rushed process and your part of a conveyor belt, which you are but we weren't made to feel like that."*

This description from Elise is significant, in that when the experience of care was deemed satisfactory, the care giver was given an identity as 'he'. Elise's use of the personal pronoun here signifies referral to a person, a connection with the practitioner*,* as opposed to the previous sonographer who was referred to in the role they were undertaking, and where no connection was made.

For the participants, an important aspect of receiving a service that was helpful and supportive encompassed being fully informed as service users of the reasons for any treatment or plan being offered. This had the dual effect of enabling them to make informed decisions about their care, or the care of their baby, whilst also enhancing their capacity in addressing their own future health needs, and those of their baby/child. For both Hayley and Becki, whose babies were born prematurely and were being cared for by staff from the NICU, this clear and inclusive communication was vital. Hayley explained:

> *The staff explained everything really well, what jaundice was and how the system flushes it out, and the reason why he needed the top ups to make sure that he had enough fluids to flush it out. That information was key because my mind was all a blur at that point.*

This 'knowing' enabled her to make informed choices about his care, and contributed to her understanding, and positively influenced her confidence and autonomy as a mother to be able to care for her son when they were discharged home: *"I wasn't worried about caring for him once we got home……it was more about practicing what they had taught us."*

Sometimes the communication was not through the spoken word but was through a staff member intuitively knowing what the woman needed. Becki recalled:

> *The NICU nurses were amazing. There was an older one, [name of nurse], she wasn't airy fairy, but very much to the point. I think that she knew that I needed her (her daughter) because I was in an absolute state. She got her out and just put her on my chest. From that point I just picked myself up and thought that she might be alright.*

These relationships with caregivers were experienced as enabling at a time when both Becki and Hayley were feeling vulnerable and frightened. This communication provided both hope and assurance that they (the women) were the right ones to be caring for their babies, with the kind, informative words providing encouragement they needed.

The previous pregnancy loss had changed how some of the participants approached interactions with practitioners in the subsequent pregnancy, with them reporting being more assertive in their communications. Hayley spoke of being listened to and taken seriously in the current pregnancy:

> *This time they are listening to me, but it's a shame that something has to happen first for them to do that. In terms of the care that I'm getting this time, we're both more confident, because the senior midwife is listening to us, and takes what we say seriously.*

Another participant, Alison, spoke of having to be more assertive in the pregnancy following her loss in her quest to be heard and understood: *"I went to the doctors the next day, but I was more assertive about it this time, telling them what had happened and asked if I could go for a scan".*

This section illustrates how being informed, heard, and understood invoked in the women a clear sense of being supported and helped. This in turn revealed a strong connection of the women's perception of services that were supportive and helpful and their experience of being valued and respected as service users. Descriptions of these pockets of care were held up as exceptional, inclusive, non-judgemental, and compassionate. Often, these exceptional experiences of care were due to one practitioner, or group of practitioners, treating the women with kindness and respect, irrespective of their background and circumstances. Conversely, when these factors were not experienced as being present in the maternity care received, services were experienced as not useful.

9.1.4 “It was like I didn’t matter”.

It was when there was no credible connection, or a disruption in the connection between caregiver (maternity care professional) and care receiver (expectant mother) that levels of dissatisfaction with the care increased. Many of the participants encountered what they classed as extremes of care, often in the same pregnancy, with different professionals, and the descriptions of care ranging from compassionate and supportive, to dismissive and dehumanising. Jules described how the dismissive nature of one professional caused her unnecessary upset:

> *There was just this one lady once, an older lady, who did my 10-week scan and made me cry. She wasn’t very nice, turning around and saying I didn’t need to be there and not to bother going in next week, even though they had agreed to see me up to 12 weeks. She was just very dismissive. We call that one the drive thru scan.*

Another participant, Alison, described an encounter in which her breastfeeding technique was called into question:

> *They were very good, except one who made me feel quite anxious. She was training someone else, and it felt like she was telling me off, that I was doing it wrong. She showed me what I should be doing, which is what I thought I was doing, so that got me a bit worked up, so when I came home I was very anxious thinking that [name of daughter] was starving.*

It wasn’t only actual encounters that caused distress, but also encounters that were perceived to be avoided as well. This was the case for Becki, who recalled the actions of a midwife who she was sure was purposely avoiding her:

> *She was working pretty much all the time and she knew we were there. There was a massive investigation after [name of daughter] died, and for her not to even acknowledge us at all was………… I thought you horrible,*

> *horrible cow. It wouldn't have taken much, just a sentence to say I'm glad to see you here at this point, I'm glad that this is happening for you.*

This experience of feeling unseen was a common factor in the participants' accounts, where they recounted experiencing that their needs were often ignored, with the focus being on clinical needs and the development of the baby. Whilst expressing gratitude that this was the case, the women considered that their health, especially their emotional health and concerns were not taken into consideration. One participant, Jo, stated: *"I do feel like I'm just a walking incubator………It's like I don't matter, I'm not ok."* Similarly, Laura reported that the emotional support was lacking from her care. She explained: *"It was just the emotional support that let them down. They don't know if someone's going to walk out of the hospital and say it's fine, or if someone's going to walk out and want to kill themselves."*

For these women, their experiences of pregnancy loss and subsequent pregnancy had caused a major revision to their world, and the experience of being ignored, dismissed, or belittled by dominant, ambivalent, avoidant, and authoritarian professionals was not seen as acceptable anymore, with many challenging their carers' attitudes either directly or through the official complaints system.

9.1.5 Trusting relationships

For the participants, trust was the dominant factor in the formation of any relationship with professionals. Without trust, there was no relationship. Through action and communication trust was formed and facilitated the establishment of a strong therapeutic alliance, where the participants felt they were at the centre of the care being offered and were thus accepting of any advice being offered. In this research, the participants spoke of how the presence of trust (or lack of it) affected how their levels of fear and anxiety fluctuated, depending on how trustworthy they perceived their carers to be. When trust in the maternity care professionals was lacking, some of the participants questioned the advice they were given, and spoke of anxiety, increased vigilance, and extreme surveillance of the words that were spoken in an attempt to retain some control over what was happening, as opposed to their lack of control over events leading up to the loss. Experiences of care were perceived as authentic when trust was present, inauthentic when it was not. Often, previous experiences were instrumental in the amount of trust (or lack of it) afforded to professionals. Alison explained: *"In the next pregnancy I didn't trust what they were saying. I was more assertive…"* Becki also spoke of feeling that the care she was receiving didn't reflect the care that she felt that she should be getting, which led to a lack of trust in those who were caring for her at that particular time. She recalled:

> *I'm getting to the point now where I don't trust the care that I'm going to get. I don't think that they are doing everything in their power to make sure that everything is ok with this pregnancy.*

In contrast, when there was trust in the maternity care professionals and the care provided, often when a special relationship had been formed with one or more practitioners, the women reported being understood, secure and less anxious. At a later stage in her pregnancy, Becki spoke of how her trust in the bereavement midwife at the local hospital had helped to ease her intense *angst,* albeit briefly:

> *I don't know what I'd have done without [name of bereavement midwife], I was in pieces, and she was just there. I knew that she couldn't actually do anything, but it was just having that professional caring person who would listen in to the baby's heartbeat and would talk to me and try to rationalise things.*

Jules also spoke of how a trusting relationship with a midwife helped her to navigate her current pregnancy:

> *I knew I could always talk to [name of midwife] ……. Whenever I had any concerns, I would just have to tell her about it, and she would do something about it. She would sit and talk to me and take extra time in the appointment with me.*

These relationships, Being-with-*others (mitsein),* provided affirmation for these participants that their concerns were credible.

9.1.6 Medical discourses of 'hope and cope'

Closely aligned to trust is what is termed medical narratives of 'hope and cope' (Pascal & Sagan, 2018). Coping can be defined as what an individual does in response to a perceived problem in order to elicit some relief and sometimes resolution of the problem. When coping is positive, it is an integral part of psychological well-being (Clayton et al., 2005). Hope can be seen as an essential element in human life which is integral to a person's well-being. It is focused on a future orientated expectation of attaining something significant, whether that be material, spiritual or physical. For some of the participants in this research, their hope was that the adverse symptoms they were experiencing in their pregnancies were nothing sinister, or something that could be explained away, and their pregnancies would continue with healthy outcomes. When people are seeking help and support it is often the case that they rely on others (for example, family, friends, professionals) to relay hope to them (Saelor et al., 2014). However, Weingarten (2010) cautions that this hope should be what is termed 'reasonable hope' if it is to be put into practice, as it should focus on what is in reach, whilst preparing us for what lies ahead. This was the case outlined in section 8.1 above, where the women sought support and reassurance from others (in these cases, the maternity care professionals), but the hope they were given could not be classified as 'reasonable hope', and in no way prepared them for the heartache that lay ahead.

Using this description of hope, in the pregnancies that were lost, five of the participants spoke of being given hope that was not reasonable from the maternity care professionals caring for them. By this they meant that well-meaning platitudes delivered by maternity professionals as a means to reassure, in fact led them to a false sense of security, where they believed that everything would be fine with their unborn babies. Hayley, in relation to her pregnancy loss, recalled the numerous times she was told not to worry when she reported concerns about her pregnancy: "*They [maternity* *care professionals] were the ones who said don't worry, so you have to trust them a little bit as they're the ones who have trained and see pregnant ladies every day."* As a result, in her following pregnancy, Hayley reported being much more cautious and scrutinising everything that was said to her about her baby's wellbeing.

Jo, Alison, Laura, and Jules all reported similar experiences, where their concerns were not taken seriously by those caring for them. For some, this led to a lack of trust in the maternity care professionals. Alison recounted: *"In the first pregnancy people were saying that it was fine so I thought that it must be, I didn't want to overreact. In the next pregnancy I didn't trust what they were saying."*

Some of the participants spoke of how the maternity care professionals were reluctant to listen to their concerns and consider that there were any problems with the pregnancy, preferring instead to rely on clinical evidence to support their notion that the pregnancy was progressing normally. This was Hayley's experience:

> *They said everything would be fine and that closed the communication down. They didn't appear to be open to the fact that there could be anything wrong because the scan looked ok. We knew that there was something wrong.*

Hayley's experience illustrates the apparent inequity in a relationship between a service user, and in this case a maternity care professional. Hayley's lack of medical knowledge inhibited the choices that she perceived she had, with her experience of having the communication closed down. This points to a loss of control for Hayley and the realisation that the protection she thought medical science and technology afforded was no more than an illusion.

9.1.7 Medicalised communication and unspoken acknowledgments of loss

The way that language was used by the professionals was described by the participants as at times being inappropriate, insensitive, or badly timed. In some instances, the women spoke of not being listened to by the maternity care professionals, who carried on with their agenda regardless. Laura recalled a discussion with her consultant the day after she had surgery for an ectopic pregnancy. The consultant was with a group of trainee and junior doctors by her bedside when he said that he would send her an appointment to return to the fertility clinic. Laura said that she did not want to attend, but the consultant persisted, saying an appointment would be sent out for 3 months' time:

> *It didn't feel like he was hearing me at that point, I was just in such an emotional state. I had all those people staring at me, I was like I don't want to have another baby, but they were talking about my chances.*

She similarly spoke of another incident following the birth of her subsequent daughter, where a doctor was delivering information to her that was badly timed:

> *When he was telling me all this, I couldn't keep my eyes open, so he was telling me it, but I really hadn't got a clue. I think that he could see that I was so tired, I literally could not keep my eyes open…. I couldn't remember what he said.*

Communication that was inappropriate was a common issue for the participants, in particular in relation to the medical terminology used that was difficult to understand, bringing further distress. Jo recalled the time a doctor was talking to her following the news that her baby had died. She said:

> *When he was going through what our options were and explaining things really clinically it was hard for us to hear. We didn't really understand some of it, and instead of calling him a baby he kept calling him products of conception. That was so upsetting.*

In addition to medical terminology being used inappropriately Becki recounted that her lack of medical knowledge put her at a disadvantage when wanting to ask for further screening in her subsequent pregnancy. She said:

> *As far as I'm aware there isn't a plan to do any wider screening, that's something I'm going to ask about tomorrow, although I'm not medically trained so I'm not sure what I should be asking for.*

Sometimes the tone, as well as the words used in communication with the participants was perceived as sharp, lacking empathy, or insensitive. The words, if delivered at a time when the women were not feeling so vulnerable may not have been perceived as so hurtful. But at a time of increased anxiety, the words stuck and added to the distress, both at the time or just after the pregnancy loss, or in the subsequent pregnancy. Alison described what she perceived as a lack of empathy when a nurse spoke her following her second miscarriage:

> *The person who spoke to us about it was the same person who spoke to us after the first one. She was very matter of fact, saying we had to have 3 in a row before they would do any further investigations. It must be awful giving people that news, she must be doing it all the time, but it's hard when you're on the receiving end of it.*

Sometimes throw away comments delivered by professionals, not maliciously, were perceived by the participants as hurtful. Becki recalled an incident when she went into hospital in labour with her first daughter who was later stillborn. She said:

> *I hadn't really eaten much that day because I didn't feel like anything. When she found out the midwife said that we were now behind before we'd really got started. I didn't really like that midwife to be honest.*

Another issue highlighted by the participants was what they described as a lack of joined up communication. What they meant by this was the lack of communication between professionals and different areas of the health services such as between different hospital departments and GP's. This miscommunication added a further layer of distress to women who were already grieving and vulnerable. Jo recalled an incident after she had lost her baby where she thought she had a urine infection and took a urine sample into the GPs for it to be analysed. She explained:

> *When I rang up for the results, I spoke to the doctor who said that it was very common to have a urine infection in pregnancy. So, I had to tell him that I wasn't pregnant anymore. Then about a week later I had a phone call from the hospital asking why I'd missed the glucose tolerance test that I was supposed to have, so I had to explain again. There was a real lack of communication between the people that needed to know.*

Becki recounted a similar distressing incident when she was trying to get an urgent appointment to see the GP following her stillbirth. When she did eventually manage to see a GP:

> *When we told her that we weren't happy with the way that we had been treated she said that a lot of people will make up stories as a ruse to get to see her. I told her that I would not make up the death of my child just to get to see her. I don't think she meant it to sound like it did because she's been really good to us, but I don't think people realise the weight of their words a lot of the time.*

Sometimes a lack of appropriate communication, where the right questions were not asked between professionals and participants led to assumptions being made about a participant's medical history. For Alison, this led to a shocking incorrect diagnosis of infertility, and led to a further deterioration of Alison's well-being, and unnecessary medical testing for both her and her partner:

> *They didn't really tell me what those blood tests were for, I presumed it was to see if there was an issue and if they were linked to those funny turns. The doctor told me that my progesterone levels were too low to be able to conceive, so I was unlikely to ever get pregnant again. I was devastated."*

Later, she explained what happened following further investigations:

> *"I went for a scan and my husband had some tests, but when we went back for the final test, I found out that I was pregnant. My cycles are 35 days, but they'd taken those blood tests for a 28-day cycle…. they didn't ask me what my cycle was, just assumed it was 28 days.*

It was not only spoken discourses that proved upsetting for the participants – it was often the unspoken, in the form of lack of acknowledgement of the previous pregnancy loss that was particularly disturbing. This was a common issue for those (with the exception of Elise) whose loss was at less than 20 weeks gestation, and is in keeping with medical and social thinking, that later pregnancy losses are graded as being somehow more significant than earlier losses. However, for the women in this study who experienced early losses, a kind word to acknowledge their loss from the professionals caring for them would have made all the difference to their experiences of care. For Laura, this lack of acknowledgement made it difficult for her to ask further questions about her plan of care. She recounted her discussion with her community midwife at her booking in appointment:

> *I told her about the ectopic and that was it really, we didn't have any further talks about it. It just went on file. I went through so much with the ectopic and I didn't know if it would change things this time round. It would have been nice to be told, rather than having to ask………… I wonder if it will affect this pregnancy.*

Similarly, Jo reported the same: *"I don't think they took into account my previous loss; it wasn't really brought up."* Laura and Jo's experiences illustrate how the lack of acknowledgment of her previous loss by the midwife and left her with unanswered questions about how her previous ectopic pregnancy may have impacted on her current pregnancy. A kind word of acknowledgement from the midwife could have opened that conversation for Laura and saved her from the unnecessary pain of having to ask. In subsequent pregnancies, women long for their previous loss and pain to be acknowledged and that their experience is valued (Rajan & Oakley, 1993; Caelli et al., 2002), which directly impacts on their perceptions of the standard of care received. Whilst this may be the case for many women, for practitioner's caution is needed to check with women first about their needs in the subsequent pregnancy, as different women may have different needs. This was the case with Elise, who was given the choice about having her miscarriage recorded in her notes when the midwife asked her about it in her booking appointment. She explained:

> *I thought it was a very thoughtful thing to do, because to me the pregnancy was so short. I think I would have felt different if I had lost the baby at 8 or 9 weeks, but I thought no, I actually don't want it recording.*

This lack of acknowledgement uncovered a different concern for one participant who had a later loss. Becki spoke of the dilemma of being cared for by a team of professionals, some of whom she wasn't sure were aware of her stillbirth:

> *I would like to know if they were aware that we had lost a previous baby. They didn't acknowledge that they did so I'm not really sure………. It would be good to know if they knew because I feel on edge when I don't know if someone knows.*

In summary, the findings in this section reveal that relational encounters with maternity care professionals were viewed as constructive when they were perceived to be empathic, supportive, uplifting, and respectful. These relationships were characterised by the actions of a caring professional, who was mindful of the participants' previous experience in the way that they delivered care that was holistic (attending to both clinical and psychological needs), compassionate, informed, and honest. These were the factors that contributed to the development of a trusting relationship, where a therapeutic connection was made between carer and care receiver. In addition, women wanted consistency in their relationships with carers, and communication that was open and patient centred. In contrast, negative relational encounters were experienced as dismissive, dehumanising and in some cases derogatory. Women in these relationships experienced being unseen, unheard, and ignored. Instead of these encounters fostering a sense of inclusion and partnership, the women were left feeling that they were spectators of their own care, their bodies given over to clinical tasks with some professionals displaying no regard for their holistic wellbeing. This imbalance of power was further perpetuated by the inappropriate use of medical jargon, or some well-intentioned platitudes that instead cultivated a sense of mistrust.

We have seen how significant relationships with maternity care professionals are on the levels of satisfaction reported on the care that women in this study received. Sometimes, however, the women's experiences of care were not directly attributed to the actions (or inactions) of maternity care professionals, but to the way that maternity services were arranged or provided.

9.2 Systems of care

The participants in this research frequently spoke of the care they received as being inappropriate, inaccessible, and inflexible. Sometimes it was an inappropriate environment, or a service that was needed but not available in their local vicinity, or an inflexible system that caused distress. It was often difficult for the participants to distinguish between a problem with a system (as defined at the beginning of this chapter), and the approach of the practitioners who worked within that system. In reality they are closely connected, for example, in the way the flexibilities and constraints of the system are interpreted by the practitioner, and how this is then revealed in the care received by the service users. The issues raised in this section are not new phenomena. Indeed, there are numerous accounts, nationally and internationally, of health services that do not meet the needs of their service users (see for example, Dahlen et al., 2020; Collier, 2011; Haith-Cooper, 2014). However, at the time of writing there is only a small amount of research that examines experiences of UK NHS maternity care in a pregnancy after loss (Mills et al., 2014; Mills et al., 2016). The findings from this current research adds to what is already known from that individual study.

9.2.1 Inappropriate care environments

A number of the women spoke of systems that were perceived as inappropriate for their needs and circumstances. Sometimes this was due to what they experienced as an inappropriate care environment. It was often reported that the ‘systems’ failed to accommodate their differing needs. This was Alison’s experience when she attended the local accident and emergency (A&E) department at the local hospital, bleeding heavily with a suspected miscarriage. She spoke of a lack of dignity of care for her situation, and recalled returning to A & E, after already being there for 4 hours earlier in the day before being sent home:

> *I had to sit in the waiting room in A & E for another 4 hours. I was bleeding heavily; I was literally covered……. I was wearing my walking trousers because they were elasticated and when I stood up my husband was so shocked because it was all over the chair. That was pretty awful to be honest.*

Alison’s experience reveals that it was the infrastructure of the building, the business of the department, and the organisation of that department that collectively led to a lack of regard for her dignity at a time of deep distress for her and her partner (and possibly to those also present in the department who were witnesses to her distress). Other participants also spoke of how the care environment they were placed in was not suitable for their present needs. This was a cause of great distress for Becki after she had delivered her daughter prematurely. Her daughter was being cared for on the NICU and Becki was placed in a ward with other women who had delivered their babies and had them with them:

> *One of the things that they do after you’ve had a section, which I think is ridiculous is to put you in a bay with other ladies who all have their babies with them. That was torture, so hard because we didn’t have [name of daughter] next to us.*

This incident illustrated to Becki a lack of awareness and care of both her previous experience of loss and her present predicament of having a baby on NICU.

Even when environments were characterised as being appropriate for purpose (in this case a woman in labour in the delivery suite of a maternity unit), traumatic events and circumstances that unfolded changed the participants' experience to feeling the environment was unsafe, and therefore not appropriate. Becki described feeling invisible, almost a spectator, when it was discovered that her baby had died whilst she was in labour:

> *Then it was absolute chaos, it felt like the staff were in absolute chaos at this point, the room looked like a bomb had hit it………. They'd taken so much blood they had to get an anaesthetist down to take some more because 3 doctors had tried and failed. In the end [name of partner] told them to get off me.*

In contrast, she described how a change in staff brought a different perspective to the situation: *"She just tidied them up and cleared the room. It had been chaotic, but she gave me a sense of 'someone's looking after us now'.* This perhaps suggests that although care environments can sometimes be experienced as inappropriate or unsafe, a caring and thoughtful practitioner can bring security and order to proceedings that can make the environment more acceptable.

9.2.2 Inaccessible care services

Some of the participants spoke of the problems they had with accessing some services. This difficulty was identified as a lack of available appointments, reduced availability at weekends, and not having the appropriate contact numbers of relevant care givers. The rurality of the county was identified as a contributing factor to these issues, with some participants expressing being disadvantaged because of where they lived. Five of the participants reported having problems accessing services at some time during their pregnancies, with two of the women describing having to use private services because of the wait they had to access the NHS services they perceived they needed immediately. Laura recalled the difficulties she sometimes had booking in to see her community midwife at the local GP surgery. In the end she had to book in to see the GP: "I *just feel like I'm wasting my doctor's time because I should be asking the midwife for pregnancy related things. I feel really bad, because it's a village, and the appointments go really fast."* Laura was highlighting the issue with limited availability of midwife appointments at the rural surgery where demand outstripped the supply, so that when she had concerns that she needed addressing she often had to book in to see her GP instead. Even when she did manage to secure a midwife appointment, this often had to be in her own home instead of the surgery, as the midwife was: *"only here [at the surgery] for total of two hours on a Wednesday."*

Jo, Hayley, and Alison had similar problems accessing services when they needed them, due to either requiring access at weekends, or requiring a scan when there were no available immediate appointments, or it wasn't deemed a clinical need. Alison recalled:

> *I didn't have any pregnancy symptoms, so I was getting a bit anxious. I rang my midwife, but she wasn't very quick in ringing me back, so I arranged a private scan. When she did get back to me, she couldn't arrange a scan until after my private one, so I had that instead, and everything was fine.*

For some, another inaccessibility issue was that they had not been given their community midwife's contact phone number. Instead, a centralised number had been provided where women could ring if they had any non-urgent concerns. The messages would be passed on to the community midwife who would then return the call when she was able to. For the women, this system was experienced as less than satisfactory. Jo explained:

> *It would be better if I could call my community midwife, but I don't know how to get hold of her. I have to go through the hospital now…. you have*

> *to ring and leave a message. They used to give you their number on the front of your notes.*

Laura recalled similar problems trying to get hold of the community midwife to chase up some urine results, whilst Alison reported not having the contact number of her community midwife when she started bleeding prior to miscarrying. The women's inability to access the professionals or services they needed to answer any queries or concerns they had was expressed as a cause of frustration and highlighted a lack of consistency as outlined in section 9.1.2 above. This frustration, due to the amount of time taken to get to speak to the correct person or being passed from one person to the next added to the sense of being divorced from any chance to be actively involved in their care. Instead, the women's self-confidence and esteem were gradually eroded by systems and professionals that disregarded and discounted them as women who wanted and needed to be actively involved in their care.

9.2.3 Inflexible pathways of care

The pathways of care were deemed by the women as inflexible if they adhered rigidly to national and local protocols of care, without considering care on an individual basis and the needs of the women involved. One example of this was when the women in this study who experienced early losses, expressed a desire for an enhanced care package but instead were assigned to the normal care pathway. Laura, who had a previous ectopic pregnancy, spoke of how she hoped that her previous experience would mean that she would be offered extra care in her current pregnancy:

> *Everyone was saying that they hope they're taking extra care of me this time and checking up on me, but they're not really, just those two extra scans* (in early pregnancy to confirm that the fetus was in the uterus) *and that was it.*

Alison, who had had two previous early miscarriages, also spoke of not having any extra care, apart from that identified for a different issue: *"Since then I've had a couple of extra appointments but that was because of the chicken pox risk."* Jo also expressed a concern that she was assigned to the normal care pathway, when she hoped that a few extra appointments to monitor what she classed as mental health concerns would have been beneficial and negated a lot of the worry and anxiety that she reported experiencing.

The decision of whether to offer an enhanced care package to these women was taken solely by the maternity care professionals caring for them, and was based on their obstetric history, as well as local and national protocols and guidelines. Only two of the women in this research were offered routine extra care because of their previous loss, although others were offered extra care because of complications that were identified as the pregnancies progressed. The gestation of the previous loss appeared to be a factor in whether extra care was routinely offered to the women, with those with early losses assigned to the normal maternity care pathway. An exception to this was Becki, who reported grave concerns that her need for extra care was not being taken seriously by those caring for her, especially in early pregnancy. She reported that this was, in part, due to the fact that the post-mortem results on her stillborn daughter had not identified any specific cause for the stillbirth:

> *What I'm finding out now with this pregnancy is that because I don't fit into any specific category, I'm just kind of floating. I haven't got lupus or diabetes, it's like there's nothing wrong……. obviously, I'm consultant led, but so far, I've had nothing extra than I would have got with a normal pregnancy.*

Both Jules and Hayley, who had losses in the middle trimester, spoke of the reassurance they experienced that their concerns were being taken seriously when a plan of extra care was put in place by the maternity care professionals. Hayley recalled having a lot of appointments, especially in the early part of her pregnancy, that provided her with the reassurance that the maternity care providers were monitoring her closely for any problems that might arise:

> *Even though it seemed like a lot of appointments that was reassuring in a way because at each one they were checking the cervix, and it hasn't changed so that's good, and of course we got a glimpse of baby at each one so that was nice.*

For those who received extra care, most spoke of relief at being taken care of, although this was often short term, with an increase in anxiety leading up to the extra screening, followed by relief again until a further appointment was due. Jules explained:

> *I had a scan last week and the first thing that they do is say 'look there's the heartbeat', and then I can relax, but until I see the heartbeat, even though I can feel him moving about I'm still in a major panic about it. I get nervous before a scan.*

As well as the benefits of receiving extra care, one participant spoke of what she perceived as a disadvantage, although she did say that she would never turn down extra care if it was offered. Becki was offered extra screening later in her pregnancy, due to concerns that the baby was not growing as expected. The extra screening involved Becki travelling to the hospital daily to be monitored on a cardiotocograph to assess the baby's heartbeat, movements, and any uterine contractions that Becki might be getting. In addition, the staff offered a further screening on the same day for reassurance if Becki felt that she needed it – an offer that Becki said that she couldn't turn down, even if there was no indication that it was needed:

> *When they offered it to me, I didn't want to say no in case something happened and then I'd think if I'd have had this it might not have happened, so it's a kind of catch 22 situation. So, when they offered, I was there…*

In this instance, the extra care, although gratefully received, led to further uncertainty and distress for Becki. Being looked after, for Becki, included the opposing sense of both reassurance and apprehension.

Inflexible systems of care were not only experienced by those with early or late pregnancy losses. This inflexibility was experienced as being bureaucratic in the organisation of services that left little room for people to be treated as individuals. Alison recalled a particularly distressing time when the doctors were taking some blood from her new-born son.

> *"I asked why they couldn't do the all the blood tests at the same time because it was distressing for both him and us……. I get that they are so busy they probably don't have the time to look at different ways of doing things. They did say that this is the way the NHS works, but that doesn't make it right. Surely it doesn't help the NHS if they are working in that way – would it not save money if they only did the blood tests once?*

Difficulties in accessing inflexible systems of care were distressing at any time for the women, but when this was at times of perceived emergencies or at a weekend when reduced services were available this was especially difficult. Women were left with a sense of being unheard and disregarded when delays in being able to access care were experienced. Jo explained:

> *When I woke up on the Sunday morning, I just knew that he'd (her son) gone. I couldn't explain it to anyone, but I just knew that something really bad had happened. My husband was at work, so I rang him and told him that I didn't really know what to do. He said to phone the hospital so I phoned 111 and spoke to a doctor, who said that unless I was bleeding, they couldn't really do anything. He put me through to a midwife who said that there wasn't much they could do because it was a Sunday and there was no service on a Sunday. I was 19 weeks and 5 days, so just 2 days short of being able to go in and be seen in the assessment centre.*

Here, Jo is highlighting the inflexibility of a service that would have attended to her immediately if she had presented two days later at 20 weeks gestation (the criteria for accessing the assessment centre), regardless of it being a weekend, and the distress that this inflexibility caused. Being denied access to services in times of need by professionals created dependency and helplessness in women, reinforcing the positions of power and authority held by practitioners. The resulting erosion of the women's sense of Being, added to their experience of the depersonalisation of their care, where the women's sense of urgency for their concerns were not taken seriously by the maternity care professionals. In practice this often meant waiting a significant amount of time for interventions to assess the well-being of their babies. Hayley recalled:

> *Waiting for the scan for 10 days was just dreadful. We were told not to worry, but that made it even more worrying. It's such a long wait when you know that something might be wrong.*

This imbalance of power between care givers and women was evident in many aspects of the care described. For example, the experience that their needs were not considered above the needs of the professionals caring for them. Laura spoke of a distressing incident the day after her surgery for an ectopic pregnancy, where a consultant had brought a large group of trainee doctors and junior doctors to her bedside to discuss her clinical diagnosis and treatment: *"I'd had a lot of morphine the day before so I can't remember if they asked permission, but I felt like I was in a zoo because they were all just staring at me."*

Jo had a similar experience of her needs not being considered. She spoke about how she needed extra reassurance at her 20-week scan (her previous baby had died in utero at 19 weeks and 5 days) but due to a change in the way that the service was run it wasn't available:

> *It wasn't explained to me that you don't see anyone anymore* (after the 20-week scan)*, so we sat there and waited. They said to me that I didn't*

> *need to see anyone, but I asked to see someone. I was told no, and just sent off home.*

The issues highlighted in this section raise important questions about how the systems and pre-determined pathways of maternity care are organised, and how they often do not match with the women’s needs, thus creating a tension between what is needed and what is available. The findings suggest that although there are obvious limitations to be considered (for example, the accessibility and availability of appropriate infrastructure), a little forethought as to how services are organised and provided could result in meeting the needs of both service users and practitioners.

Overall, the findings from this chapter convey a contradictory picture of maternity care. On the one hand, women were extremely complimentary about aspects of the quality of care that they received in both their previous pregnancy and their pregnancy after loss. In contrast, however, they also reported worrying aspects of care, where they described poor or inappropriate communication with practitioners, and systems of care that were deemed inappropriate, inaccessible, and inflexible. These findings will be discussed at length in Chapter 10.

Chapter 10 - Discussion and conclusions

The aim of this research was to explore pregnant women's lived experiences of maternity care in a pregnancy after a previous pregnancy loss. This was in order to generate greater understanding of this phenomenon from the participants' perspectives, and the meaning that they assigned to these experiences. Using a hermeneutic phenomenological approach has enabled these original aims to be achieved, whilst also creating new knowledge, an original contribution, to the field. The previous three chapters presented the findings of the lived experiences of pregnancy loss, pregnancy after loss, and maternity care in that pregnancy after loss. This complex Being-in-the-world included the temporal, attunement and care aspects that constituted the participants' lived experiences.

In this chapter, the research question and aim of the work is revisited, to demonstrate how these have been addressed through the completion of this thesis. Following on from this, the findings are situated, where appropriate, in the context of the existing literature, as reviewed in Chapter three (a full summary of the findings can be found in section 6.2). The focus then moves to consider how the findings can explicitly be related to a Heideggerian phenomenological approach, and how that interpretative framework enabled an understanding of the phenomenon being researched. Next, a discussion of the limitations of the study, and the recommendations both for further research and for practice are outlined. Penultimately, a reflexive account is provided of the experiences of undertaking the study. This study has shown that pregnancy loss is more than just a medical event that needs clinical management. It has demonstrated that pregnancy loss pervades every part of a woman's Being-in-the-world, beyond the clinical context, into a new pregnancy and beyond. In addition, it has shown how relationships of care are an inherent part of the meaning making process following such a loss, and it is within this context that meaning-making is constructed. These aspects are discussed in the concluding part of the chapter.

10.1 Research aim and questions.

As previously discussed in section 1.1, to meet the aim stated above, the lived experiences of maternity care in a subsequent pregnancy after loss were viewed through the context of the experiences of the previous loss. Doing this had two purposes, firstly, to honour and not ignore the previous losses (which had been the experience of many of the women in this study), and secondly, to acknowledge that the accounts of the experiences told to me were done so in the shadow of that loss. The intention was to reveal the phenomenon of care in a pregnancy after loss as it appeared in the everyday Being-in-the-world, and to understand the meaning and significance that women placed on these experiences. In addition to the aim, this study set out to answer the research questions:

a. What are pregnant women's lived experiences of maternity care and support following a previous pregnancy loss?
b. How are these experiences meaningful?

In answering these questions, this present study has revealed the complex and broad experience of women pregnant after loss, and how this permeates every aspect of their everyday Being-in-the-world. This was not just restricted to the pregnancy world but infiltrated every aspect of that world. In addressing the first question, the findings reveal how the women's present-day realities were interlinked with their past experiences and future dreams, in a threefold connectedness to their 'here and now'. This was the position from which they entered the world of maternity care in the subsequent pregnancy. Other findings, as disclosed in the participants in-depth accounts of their experiences, considered the state-of-mind, attuned aspects of life during and after the loss, and into the subsequent pregnancy. Finally, from the perspective of receiving maternity care in the subsequent pregnancies, the women reported a mix of experiences that had long-term, profound consequences for their emotional, psychological, and physical health. The second question exploring the search for meaning for the women, included a need to understand (but not necessarily to answer). This was a temporal, ongoing process, where meaning was revealed through the relationships of care with others and with themselves. It was through these relationships of care that the women began to understand the meaning of their pregnancy loss, subsequent pregnancy, and maternity care in that pregnancy experience.

Through employing a Heideggerian hermeneutic phenomenological framework, this thesis has contributed new awareness and insights into the trauma of pregnancy loss, and the long-term implications of life after loss, through a subsequent pregnancy and beyond. There are several implications for us as individuals, maternity care professionals, and organisers and providers of maternity care associated with this study. Firstly, cumulatively the findings call for us all as individuals to question our way of Being with women who have lost a baby, to show compassion and understanding of the enormity of the experience, regardless of the gestation of the loss. It calls for us to treat these women holistically, attending to their whole person and considering the scope of factors that contribute to their present 'here and now' reality. Secondly, for the practitioners caring for these women, both at the time of loss and throughout the subsequent pregnancy, a commitment is needed to attend to all women with compassion and kindness, to not make assumptions, and to really listen to and hear what women have to say about what they need, especially in those subsequent pregnancies. Thirdly, for the organisers and providers of maternity care, as well as the implications outlined above, the new insights gained from this thesis should open a dialogue, ideally with service users, about how local and national maternity services are designed, managed and care delivered, giving consideration to new and innovative ways of working that will address the needs of both service users and service providers.

10.2 Pregnancy loss

The existing literature exploring the experience of pregnancy loss for women considers pregnancy loss as an unexpected and traumatic life-changing event for women that can trigger both physiological and psychological responses, influencing every aspect of their Being-in-the-world. For some women life is changed forever as they try to navigate a multitude of differing emotions, ranging from shock and numbness (Peel, 2010), loss and grief (Brier, 2008), guilt and blame (Adolfsson, 2010; Deas, 2017), and in some extreme cases, post-traumatic stress disorder (Daugirdaite et al., 2015). Thus, a pregnancy loss is a powerful disruption that affects every aspect of a woman's life, not only in the short-term, but also long-term (Swanson et al., 2007; Bennett et al., 2012). These disruptions to everyday life influence women's interactions with significant others (Kelley & Trinidad, 2012; O'Leary et al., 2011), wider society (Murphy, 2012), as well as with herself through self-blame (Deas, 2017), bodily doubt (Meaney et al., 2016) and shame (Bellhouse et al., 2018).

When recounting their own lived experiences of pregnancy loss, some of the women in this study told of their own battles with the physiological and psychological disruptions that engulfed them. The routine everydayness that they had taken for granted before the loss was no longer recognisable in the shadow of the loss. Prior, the routine everydayness described by the participants suggests that there was no pathological anxiety present in relation to the ongoing pregnancy, so the extreme and unexpected nature of the loss was traumatic. There was a temporal disruption, in some cases described as time standing still, as the shock and numbness of the reality of their loss sunk in.

Similar to the observations of Peel (2010), and Peel & Cain (2012), the women in this research who had early losses all experienced stigma and inner confliction in relation to their perception of their right to grieve such early losses. It is accepted with pregnancy loss that levels of grief are not linked to gestational age of the pregnancy (Swanson et al., 2007), yet Peel and Cain (2012, p.87), in relation to early pregnancy loss describe an "emotional suppression, the unacceptability of grief for the loss". Lang et al (2011) suggest that this emotional suppression is a contributing factor that leads to the experience of disenfranchised grief (Brier, 2008), as there is often confusion for women of how to grieve such an ambiguous loss. For some of the women in this study, especially those who had early pregnancy losses, this disenfranchisement led to emotional suppression, and was apparent in different ways.

Of significance, the present study found that some of the women sought to overcome this disenfranchisement through the emotional suppression of the enormity of what had happened to them by returning to work a few days after the loss. Others, who could find no appropriate outlet for their grief, tried to escape, or block out the feelings through adopting self-destructive behaviours (albeit, in the short-term) through the use of substances such as alcohol and tobacco. Although these actions could be considered harmful, they may in fact be a means of self-protection for the women, although ironically, replacing one form of harm with another. These findings are an extension to the current knowledge in the literature of what is known of women's grief responses following loss and contribute to the discovery that some women will adopt self-destructive behaviours as a way to manage the emotional suppression they experience.

The ripple effects of a pregnancy loss are felt not only by the bereaved mother, but also by the intimate partner, extended family, friends, and associates (refer to section 7.2.3). This study extends the literature on how changes to these relationships had a direct effect on the woman's experience of Being-in-the-world post loss (see for example, Rinehart & Kiselica, 2010; Kersting & Wagner, 2012; Roose & Blanford, 2011; O'Leary et al., 2011; Kempson & Murdock, 2010; Ustundag-Budak et al., 2015). All the women in the present study recounted how supportive their intimate partners had been both during the loss and afterwards. This finding is in keeping both with the relevant literature (see for example, Kelley & Trinidad, 2012; Kersting & Wagner, 2012; Rinehart & Kiselica, 2010), and prevailing western societal attitudes that the intimate partners should be supportive of the mother and will often minimise or dismiss their own loss. One participant expressed high levels of concern for her husband, who she felt was not afforded the same level of support as she was through the maternity services, and as a result had no outlet for his grief.

As noted in the broader literature (Rinehart & Kiselica, 2010; Kersting & Wagner, 2012; Kelley & Trinidad, 2012) some of the women in this study reported a gendered difference in grieving styles, an incongruence, where their partners seemed to not want to talk about the loss, for fear of causing upset, or by suggesting that the affect was far greater for the woman as she had the physical experience of the loss. Thus, for some of the women in this study, there was an unfamiliar tension present in their relationships with their partners. For most of the women, at the time of the second interview these differences had been reconciled and their relationships were reported to be strong. In keeping with the findings of Gold et al. (2010) that suggested that up to 40% of relationships can break down after a pregnancy loss, one participant though, did speak of how in her previous relationship, after three losses, this tension became too much, and the relationship irretrievably broke down.

In accordance with the literature, significant relationships with extended family such as grandparents were important in providing support and care for the bereaved couple. This support often took the form of undertaking practical activities such as notifying people about the loss, in an attempt to protect the couple from well-meaning congratulations from those who were unaware or undertaking domestic activities such as cooking or looking after older siblings. These relationships were also important in providing much needed emotional support for the woman and her partner.

The women who had older children at the time of the pregnancy loss reported the challenges of parenting when they were emotionally vulnerable (refer to section 8.4). For some women, these challenges included how to explain to the older siblings about the loss of their expected new brother or sister. These women all reported plans to include the lost sibling into family discussion and celebrations as a way of maintaining and continuing the bonds with the lost baby. In fact, all of the women, except for Elise, and regardless of their current parenting status spoke of plans to do this, as a way of remembering and acknowledging their role as parents. These acts of remembering are in accordance with the findings on continuing bonds in the relevant literature (Kempson & Murdock, 2010; Grout & Romanoff, 2000).

Although most relationships were deemed to be caring and supportive by the women after the loss, there were some that became awkward, fractured or broken. This often happened when family and friends failed to attune to the enormity of the loss for the woman, and would unintentionally dismiss the woman's experiences, effectively shutting down any open and honest dialogue and contributing to the woman's increasing sense of isolation. When this happened some of the women looked for other forms of support where they felt that they would be heard.

Often, the help they sought often took the form of internet forums specifically for women who had experienced a pregnancy loss, or who were still pregnant but were displaying worrying symptoms that could be associated with an imminent pregnancy loss. The evidence reviewed suggests that women who used these groups were overwhelmingly comforted by belonging to such a network, where there was a shared solidarity with other users (Gold et al., 2012; Gold et al., 2016). Speaking about their loss and grief enabled a sense of community and belonging, where the isolation of their loss was ameliorated, speaking about their lost baby was 'normalized' and seen as part of the healing process, providing hope that, in time, they would be able to have another baby. The findings from this present study, in part, agree with the findings of Gold et al. (2012; 2016). Of significance was the finding that this was only part of the experience of using internet forums. Two women spoke in detail about the negative impact that some of the discussions had on them. Both reported experiencing a conflict between feeling supported and part of a community, yet at the same time being alerted to all that could go wrong in a pregnancy. This could be attributed to a re-triggering of fear and anxiety for these women, and the realisation that individuals have differing needs that may or may not be met by these forums. Worryingly, one woman reported delaying seeking medical help for the later diagnosed ectopic pregnancy, because of comparing her symptoms with those of another woman on the forum and concluding that there was nothing to worry about. These findings provide new insights to the literature and suggest that further research is urgently needed to ascertain how widespread self-diagnosis through using these forums may be, to alert all who have contact with pregnant women or use these forums of these potential dangers. Although not wanting to restrict the use of what has been shown to be a vital source of support for women in these circumstances, there is an argument for moderation and regulation of these groups, or at the least the provision of a statement in each forum warning of the dangers of self-diagnosis based on the discussions being held, with advice to contact their medical provider with any concerns.

This section has considered some of the issues that a woman who has lost a baby has to face following that loss. These issues do not disappear when the woman becomes pregnant again, but instead are cumulatively carried forward into the subsequent pregnancy and beyond.

10.3 Pregnancy after loss

Evidence suggests that there is no recognised recommendation for the time interval between the pregnancy that was lost and a subsequent pregnancy (Fockler et al., 2017). Instead, in most cases, the decision was left to the woman or couple to decide when the time was right for them to embark on another pregnancy (Radestad et al., 2010; Lee et al., 2013). Once a new pregnancy was confirmed, instead of being an overly joyous occasion, evidence overwhelmingly points to a time of conflicting emotions (DeBackere et al., 2008; Andersson et al., 2012), described by some as an “emotional rollercoaster that they could not get off” (Hunter et al., 2016, p.372). The innocence that was present in the previous pregnancy was gone (Moore & Cote-Arsenault, 2018). The coping strategies employed to manage these conflicting emotions included not preparing for the new baby by avoiding purchasing equipment or clothing (Cote-Arsenault & Donato, 2011), delaying seeking care and announcing the pregnancy (Lamb, 2002; Ockhuijsen et al., 2014); and delaying bonding with the baby in utero (Gaudet, 2010). The accompanying anxiety was present throughout the pregnancy and beyond, with a distrust in their body to maintain and nurture a pregnancy to a successful conclusion (Meredith et al., 2017), increased vigilance of pregnancy symptoms, and increased attempts to seek reassurance from professionals that the pregnancy is progressing as expected (Meaney et al., 2016; Andersson et al., 2012).

In accordance with the findings in chapter seven, all the women in this present study were faced with the decision of when and if to try for another baby. All the women spoke of taking the decision jointly with their partners. Most of them conceived again within nine months of the previous loss, which is in keeping with the time frame identified in the literature (Franche, 2001; Mills et al., 2016), although one participant, Jo, spoke of an urgency to get pregnant again, to fill the void that she described experiencing after her loss and to fill her arms with another baby. For all the women, the decision to try for another baby represented a future, a moving on, as well as present possibilities. There was a shift in their emotional well-being, as the possibility of another baby, in part, signified that there was hope for a future as parents.

A confirmation of a new pregnancy, although longed for and welcomed, elicited a very different response from the women. In keeping with the findings from the literature, all reported conflicted emotions, ranging from joy and celebration, to fear and anxiety (Mills et al, 2016; Andersson et al, 2012). These did not appear to be dependent on the gestation of the previous loss, although the intensity, duration, the extent to which these disrupted daily life, and the coping strategies employed as a tactic to manage these emotions was different between the women. Some of the women reported delaying seeking confirmation of the pregnancy and announcing it to family and friends (Cote-Arsenault & Donato, 2011). This is reminiscent of wanting to keep the baby close and safe, and as a way to retain control, as any announcement or medical intervention such as a scan to ascertain fetal viability and well-being could jeopardise the lived experience of being a newly expectant mother, especially if the previous pregnancy loss was discovered through a scan. Other ways used as a strategy to retain control (where in the previous pregnancy they felt that they had little, if any, control over events) included being hypervigilant of pregnancy symptoms, an intense focusing for any changes, however small, and seeking frequent interactions with care providers for reassurance (Moore & Cote-Arsenault, 2018). Of note in this present study, the participants who had early pregnancy losses reported difficulty in accessing the reassurance they craved from maternity care providers, as they were often assigned to a low-risk care pathway by the professionals caring for them. This may be in line with national guidance on the provision of antenatal care in the UK maternity system (NICE, 2008), however, the service offered did not meet their needs in providing surveillance, support, and reassurance above what was deemed ‘normal’ antenatal care. These guidelines do not take into account the findings from literature that make the observation that women who have had an early pregnancy loss are often in need of additional support (Cote-Arsenault & Donato, 2011; Andersson et al., 2012; Ockhuijsen et al., 2014), as the previous losses are often not acknowledged by individuals or society, suggesting that there is therefore no need to provide additional support. In addition, the NICE antenatal guidelines for antenatal care focus predominantly on clinical care, with little mention of provision to address emotional and psychological needs. This was a point that was raised by some of the women and will be expanded on further in section 10.4 below.

When speaking about being pregnant again, women spoke of an embodied mistrust of their bodies’ ability to sustain and nurture their current pregnancy. The trust that they had unquestionably in the previous pregnancy was interrupted by the loss, with the result that they now lacked confidence in their body’s ability to do what they wanted it to do. Feeling unable to share these experiences with family and friends contributed further to the social isolation discussed earlier. The perceived failure of their body to nurture the previous pregnancy to fruition contributed to a sense of shame, of feeling a failure, and despair that the same thing would happen again. These findings are consistent with the findings of Meaney et al. (2016), Meredith et al. (2017), and Cacciatore (2010), who all point to bodily mistrust as a contributing factor of maternal distress in these subsequent pregnancies.

10.4 Lived experiences of maternity care in a pregnancy after loss.

To meet the needs of women who are pregnant and accessing maternity care after a previous pregnancy loss, more research is needed to uncover exactly what those needs are. Reflective of societal attitudes and accepted provision of care, the majority of the literature identified in this section focuses on women’s experiences of care after stillbirth and neonatal death (Mills et al., 2016; Wojcieszek et al., 2016; Mills et al., 2014), or care in a pregnancy that was labelled as high-risk (which by definition excludes women with earlier gestational losses unless further underlying risks are identified) (Rajan & Oakley, 1993; Simmons & Goldberg, 2011; O'Brien et al., 2010). Few studies considered women's experiences of maternity care in a pregnancy after an earlier gestational loss. This is of significance to this present study, which partially addresses this identified gap in the evidence, as this study considers experiences of a broader spectrum of losses, including early and late miscarriage, ectopic pregnancy, elective and medical termination, stillbirth, and neonatal death.

Consistent with the findings in the literature (Mills et al., 2016; Wojcieszek et al., 2016; Caelli et al., 2002), the women in this present study reported a variety of experiences of care, both at the time of the pregnancy loss, and in the pregnancy that followed. Common themes across the findings in this present study included vast differences in the quality of relationships with caregivers, and the standard of communication in these encounters. These relationships were viewed as a central source of support for all the women. They had the power to build the women up, instilling confidence that they were receiving the best possible care and providing hope that the current pregnancy would result in a live, healthy baby. Alternatively, when they were experienced as being less than adequate, women perceived that they were not being kept safe, with the experiences crushing any confidence and self-esteem they had and increasing feelings of fear in the midst of the uncertainty of the situation.

Furthermore, in this present study relationships with care providers were viewed positively when the women felt valued, respected, listened to, and included in discussions of plans of care. These aspects of care, along with sensitive communication were foundational to women's perceptions of receiving high-quality care, providing them with a sense of inclusion and assurance that any concerns would be taken seriously, thus enabling them to retain some control over the provision of care. This assisted in them having a different experience of care in the subsequent pregnancy, as often they reported having no control in the events and decisions throughout the pregnancy loss. Frequently, and predominantly in the pregnancies where the previous loss had been at a later gestation, or the women were classified as high risk, this care was provided by the same carer, or team of carers.

It has long been recognised that providing continuity of care/carer for all pregnant women results in improved health outcomes and increased levels of satisfaction (RCM, 2020; NHS, 2017; NICE, 2008; NHS England, 2016). For the women in this present study who had regular care from the same carer or team of carers, it was the development of trust within these relationships that elicited a high level of satisfaction of the care received. This made the difference between an experience of being just another patient where clinical tasks were performed on them, to being a valued part of a reciprocal relationship with a connection and a shared goal of the delivery of a healthy baby. These relationships were credited in providing the holistic care that these women needed and craved, through addressing both their clinical and psychological needs.

Conversely, when the women's care was provided by several different caregivers, the reported satisfaction levels with that care were significantly lower. Of note, is that these experiences were often (but not exclusively) reported by the women whose previous pregnancy loss had been at an early gestation, and who were not classified as high risk in their current pregnancy. In these interactions the women had less time to develop any level of trust with the caregiver, with the result that they reported increased anxiety during the consultations, as well as being hypervigilant of everything that was said, scrutinising every word long after the consultation had ended. These findings concur with the relevant literature (Mills et al., 2016; Rajan & Oakley, 1993; Caelli, 2002; Simmons & Goldberg, 2011; Meredith et al., 2017; Cote-Arsenault & Donato, 2007), and therefore highlight the benefits of continuity of care/carer, not only for women who are pregnant after loss, but for all pregnant women in the antenatal and postnatal period.

Some of the women in this present study made the distinction between professionals who they felt addressed purely their clinical needs and those that also met their emotional and psychological needs. Overwhelmingly they spoke of their emotional needs being met by midwives who cared for them, with consultations seen more as clinical encounters. Although recognising that these consultations were important in monitoring the well-being of mother and baby, some of the women did feel that they were ‘unseen’ in these consultations, and that their emotional well-being was not important. These findings do suggest that it is pure chance as to whether these women receive a holistic package of care.

Since this research project was started, there have been several changes to policy and provision of maternity care for women bereaved by pregnancy loss, both at the time of the loss and in future pregnancies. It is worth noting that the women in this present study were interviewed at the time, or just after when the National Bereavement Care Pathway (NBCP, 2018) was launched (see section 2.1.3). It is therefore uncertain whether their experiences would have been reported differently if they had received bereavement care under this pathway, although it would be hoped that, for those who reported receiving substandard care, their experiences would have been substantially improved. The first evaluation of the NBCP (2020) has suggested that for those areas where this type of bereavement care has been offered, there has been a reported improvement both for parents receiving bereavement care and the professionals providing it. However, the evaluation does admit that there remains an inconsistency in the level of care that women receive in the UK, due, in part, to only 50% of trusts signing up to the NBCP (2020). Of concern to this present study, is the fact that the evaluation admits that improvement is needed in the sensitive handling of appointments and meetings at the hospital, and the provision of emotional and psychological care. Indeed, the evaluation admits that the provision of emotional and psychological care is outside the scope of what can be provided by the trusts following the NBCP and is resourced to support services in the community (NBCP, 2020). Whilst this is not a problem in itself, it does mean that the care offered could be perceived as being fragmented at a time when women are vulnerable and sensitive. The added burden of having to tell their story to yet another care provider may add further to this vulnerability and be too much for the women to pursue.

One aspect of care offered to pregnant women is ultrasound scans, mostly to assess fetal well-being and development at defined times in the pregnancy, but also sometimes offered where there is no apparent clinical need, as a means to reassure women that all is well with the pregnancy. Scans alone though, do not necessarily identify every anomaly associated with fetal well-being and can therefore provide a false sense of security for women when indeed there is a cause for concern. This was the experience for some of the women in this present study who were offered scans prior to their pregnancy loss, after voicing concerns that there was a problem with the pregnancy. The professionals offered reassurance based on the findings from a scan, but only a short time later it was discovered that the baby had died or was so severely compromised that termination was advised. Retrospectively, the women reported how this discourse of positivity, of 'hope and cope', effectively closed down any further communication, with technology and medical knowledge perceived as being prioritised and favoured over their intuition and concerns. The socio-cultural pressure of positivity, voiced here within a clinical setting, fleetingly encouraged feelings of over-optimism (with the women thinking that the professionals must know what they are talking about, so there is nothing to worry about). Prevalent within society, and embedded within health professional narratives, the implications are that concerns voiced by service users are overlooked or dismissed. Although not meant to be malicious, these discourses often have the opposite effect, and add to the issues that they hoped to alleviate.

In agreement with O'Leary's (2005) study that cautions against the use of scans above what is clinically required, this present study found that all the women found the period leading up to scans anxiety provoking. This was regardless of whether the scans were provided for clinical reasons, or to provide reassurance. Feelings of fear and uncertainty were re-ignited, increasing the perception that pregnancy and birth were fragile, with fears of recurrence, especially if the previous pregnancy loss had been discovered by a scan. Thus, there was a conflict for the women in this study between them wanting and needing scans to provide them with much needed reassurance, whilst at the same time having to manage the anxiety that they provoked. Other screening tests (in this case, regular cardiotocographs) were also found to elicit an anxiety response in this present study, with one woman moved to extremes to ensure that she did not turn down any screening test offered. In this situation, the fear, which manifest as an uncomfortable, persistent, anxious feeling, was that turning down any screening would lead to a recurrence of the previous loss and overrode any rational thought. Extra screening, therefore, far from providing the reassurance it was intended to provide, instead increased the feelings of the precariousness of their current pregnancies.

One of the key findings of this present study was how the organisation of the systems of maternity care was deemed inadequate, inaccessible, and inflexible for the participant's needs. This feeling was not attributed to any one individual, but to the organisation of the local maternity services around service delivery, and management and distribution of resources. Whilst recognising that the services delivered needed to be financially and clinically sustainable, they felt that this was often at the cost of their physical and emotional wellbeing. For example, one woman reported being left in shared care environments with other members of the public, whilst miscarrying and bleeding heavily. What was already a distressing event was made worse by a lack of recognition for the situation and failure to attend to her with compassion and dignity at her point of need. This has important implications for the woman. This treatment is likely to reinforce the socio-cultural discourses around miscarriage that fail to acknowledge early gestational losses as credible (and therefore her right to expect any different prioritisation over someone who has another need such as a broken arm or cut finger) and could lead to an increased risk of future co-morbidities.

Other dissatisfaction with the care systems available included the perception that at times service delivery was found to be inaccessible and inflexible. This was experienced as not being able to contact their community midwives when required, (due to a local policy of women having to use a centralised telephone system and then leaving a message for their midwife, who would return their call at a later time) or being denied access to services because they did not meet the criteria. The perceived unwillingness or inability of the care providers to use discretion when making these decisions was particularly distressing. Instances when this happened included being denied access to assessment centre services for being two days away from the gestation required for admittance, and not receiving enhanced packages of care because of not having had the required number of miscarriages (three) to qualify. In part, these findings about perceived inadequacies with the organisation of the systems of maternity care in the UK concur with the findings of Mills et al. (2016). They do, however, also extend these findings, particularly in relation to raising awareness of how inappropriate care environments and inaccessible care services significantly add to the distress already experienced by this group of women. This has important implications for policy makers, commissioners of maternity services and organisers of these services at a local level. Further research is needed to ascertain just how widespread dissatisfaction with maternity systems is in the UK. In addition, it is suggested that local consultation between service users and providers of maternity services may be instrumental in improving some of the issues raised.

10.5 The findings viewed through a Heideggerian lens.

In this section, I explicitly relate the findings outlined in chapters 7 and 8 to the Heideggerian concepts of temporality and attunement, and care, illustrating how this provides an understanding of the lived experiences of the women in this study. This understanding illustrates how we interpret the world through the context of our traditional and cultural values, and how these enable us to make sense of our different ways of Being-in-the-world.

10.5.1 Temporality

The Heideggerian concept of temporality provides a lens through which to understand the lived experiences of Being-in-the-world of pregnancy loss, pregnancy after loss, and of receiving maternity care in these subsequent pregnancies. As such, they provide an original contribution to the literature, highlighting the significance of the past, present, and future to women's lived experiences of loss. A full explanation of this concept is provided in section 4.3.5.

In this present study, the women described a temporal landscape of past, present, and future experiences. These were not necessarily chronological but did highlight a changed awareness of Being-in-the-world after a pregnancy loss. Prior to the loss, most participants described a world that was often busy and stressful, normal, and predictable, with the focus on engaging with life, whether that be through work commitments, physical activity, or family and social relationships. They described a life that was familiar and secure (although not necessarily exciting or fulfilling), where conforming to socio-cultural expectations made their lives meaningful and understandable.

The pregnancy loss shattered this predictability, and with it brought a disruption to the temporal landscape. There was an interruption to self-time as they had previously known it. Their accounts were suggestive of a time warping, of the perception of time slowing down, expanding, even standing still, so that passing minutes felt like hours, hours felt like days (Carel, 2016). For one woman, this included facing the feeling of the ending of life (her own mortality) in the midst of the present as she was rushed into theatre for emergency surgery. Thus, the loss of the pregnancy triggered a disruption to the concept of time, with a misalliance between familiar chronological clock time (Beynon-Jones, 2017), and the experience of time standing still. The pregnancy, which had been measured in medical/gestational time had misaligned with the bodily rhythms of time, which for a time continued to provide sustenance for the lost baby through the production of breast milk.

In the immediate aftermath of the loss, the slowing down of time coincided with the loss of meaning (Carel, 2016). Being pregnant had provided the women with a sense of purpose that had been grounded in action to have a baby, and nurture and protect that baby throughout the pregnancy, but this had been lost when the pregnancy had ceased. In an attempt to cling onto the lost baby so that it didn’t disappear totally from their minds’ eye, to gain some comfort some of the women engaged in the making of memories, through the creation of artefacts or physical engagement with the dead baby (Johnson & Pascal, 2016; Neimeyer et al., 2006). This embodied memory making in the present was carried into the future (Garrod & Pascal, 2019), and in a small way enabled the construction of new meaning, incorporating past, present, and future possibilities in the wake of the pregnancy loss.

Although time appeared to stand still for the women, for others, the ‘they’ as Heidegger (1927/1962) refers to them, time continued as normal. This incongruence became apparent in changed relationships in the wake of the pregnancy loss. These relationships, with self, family and friends, caregivers, and others who had shared a similar experience, provided present context for both social and relational meaning. The women spoke of the importance of their relationships with family and friends and the significance of these relationships to their understanding of the pregnancy loss. It was apparent though, that these relationships were forever changed in their present lived experience of the loss. This was evident in the way people engaged with them (or not) following the loss, and how they experienced that interaction. Some participants reported a tension, a precariousness in relationships where there had previously been no issues. Some relationships did not survive. For all parties, there was a shift in the temporal landscape of relationships. Relationships forged in the past were re-evaluated in the present. If women did not receive what they needed from their present relationships, they sought new ones in their quest to make meaning of the loss. These new relationships existed on a different temporal plane (refer to section 7.2.4) and were often with others who had shared similar experiences, such as support groups or social media chatrooms, and who provided further understanding of Being-in-the-world. The relationships formed in these arenas provided a sense of safety for those who used them, as they were engaged with outside of the women’s usual social context, out of time and away from society and everyday life, providing a sense of belonging but also an element of anonymity, of being in time, but also out of time. Thus, these disrupted relationships were a major focus of the women’s present “here and now” temporality.

The time between the loss of the baby and the new pregnancy was described as a void or a space*,* a period of emptiness that was characterised by a search for meaning and authentic understanding. There was also an unsettledness *(unheimlichkeit),* a marking of time and a longing for some semblance of normality to return to their routine everydayness. Once a new pregnancy had been confirmed, this too was characterised by a marking of time against the goal of a new baby. This was not counted in days and hours, but as milestones to be passed. In the present here and now of a new pregnancy, time stalled for the women. There was a metaphorical holding of breath, in some cases a hiding of the news until some of the identified milestones had been passed. Approaching the imagined and anticipated birth was fraught with anxieties. For three of the women the birth of their babies was especially distressing, (two whose babies were born prematurely, needing specialist care, and one who was born at full term but had unexpected difficulties following the birth), when there was an unexpected change in temporal proximity with the collision of an unimagined future against their present reality. Thus, they were *thrown* into another situation not of their choosing, with all the associated *angst* that accompanied them.

A key finding of this study was that the women's concept of time after the loss was different to their everyday concept of chronological 'clock' time before the loss. Pregnancy loss was an interruption to their temporal framework, explicit in the uncertainty and change of their lived experiences, and incorporated in their past, present, and future realities. The implication for the women in this study is that this temporal disruption can be hugely influential on their ways of being in the present here and now, in the way that they behave, make decisions, interact with others and themselves. The significance of this knowledge for practitioners who care for women who are pregnant after a previous loss cannot be underestimated and needs to be considered in the clinical context. Practitioners have no way of knowing before a consultation how a woman may have experienced this temporal disruption, and the strategies she has put in place to try and manage the associated affective interruptions. An investment of time, particularly during assessment, but also throughout the rest of the pregnancy, is therefore needed to build trusting relationships with women, along with relevant contemporary training that highlights the complexities of pregnancy loss for women, not only at the time of the loss, but into future pregnancies and beyond.

10.5.2 Attunement

Attunement in times of pregnancy loss may be considered impossible to name due to it being an existential experience (Crowther, 2014). Yet, attunement through the ontic display of emotion can illuminate the ontological background of Being-in-the-world. Emotions are usually triggered by an action or event (for example, a pregnancy loss, or receiving maternity care in a pregnancy after loss), whereas the pervading mood or attunement is not something that is accessible. Watts (2001) suggests that an essential characteristic of moods is that they come and go as they please. Heidegger (1927/1962) contests that we are always in a state of attunement, or mood, and that this influences what we see and pay attention to in the world. For the participants in this study, the state of attunement after the pregnancy loss facilitated access to a previously unseen finite existence. That is, their own mortality, the totality of their existence, as if seeing the world in the clearing (the place in which Being reveals itself for the first time in a more comprehensive way (Heidegger, 2004).

Heidegger (1927/1962) suggests that it is when *Dasein* is in a state of deep anxiety, of *angst,* that the nothingness of human existence is revealed. Closely linked to *angst,* is Heidegger's notion of *unheimlichkeit.* The German word *unheimlichkeit* has been translated as uncanny or uncanniness, and literally means that we feel 'not at home' (home = *Heim*). To explain, according to Heidegger, Being-in-the-world gives *Dasein angst* regarding their own potentiality for being, and this is the true state of *Dasein*, which is hidden from us most of the time (Heidegger, 2004). Dreyfus (1991, p.179) calls it unsettledness, and speaks of *angst* as a total breakdown "a revealing of the whole world as if from the outside." The mood of *angst*, and of not feeling 'at home' creates a sense of emptiness and insignificance. At the same time, *angst* takes away not only our understanding of our self, but also the world, so that the world that was once familiar becomes unfamiliar and alien to us. Heidegger explains it like this:

> All things, and we with them, sink into indifference. But not in the sense that everything simply disappears. Rather, in the very drawing away from us as such 'things turn towards us'. This drawing away of everything in its totality, which in angst is happening all around us, haunts us. There is nothing to hold on to. The only thing that remains and comes over us….in this drawing away of everything….is this 'nothingness',
>
> (Heidegger, 1927, 40).

Heidegger (1927/1962) suggests that there are two ways of experiencing *angst.* The first is an indistinct, background feeling that elicits an uneasy response, with *Dasein* seeking to escape the feeling by emerging themselves in ordinary, everyday activities to block it out. The second is much more extreme, an intense, unambiguous, overwhelming sensation that disrupts daily living and the familiar experience of Being-in-the-world.

To avoid confusion, a distinction should be made between fear and *angst.* Fear is a physiological and psychological reaction to a perceived threat or danger that is sensed as being imminent or in the future. When the threat stimulus is received, it elicits a motor response in the individual known as fight, flight, or freeze, where the instinct is to fight, withdraw, or freeze from the perceived threat. In pregnancy loss, and pregnancy after loss, fear and *angst* are connected, in that the former triggers the latter. The uncontrollable fear of the imminent and perceived danger of pregnancy loss is an affective state (Harman, 2007) that, although familiar, is not usually experienced as constant. Living in a state of constant fear creates an experience of *unheimlich,* an unsettledness of not feeling at home in the everyday world. In turn, *angst,* which was both acute and chronic, as described above is activated. This was the acute and chronic world of pregnancy loss, and pregnancy after loss that the women in this study described.

Women's experiences of the moods of pregnancy loss, pregnancy after loss, and care in a pregnancy after loss can be understood as feeling *unheimlichkeit,* and ultimately *angst* in their Being-in-the-world. As discussed in Chapter 8, this state of *unheimlichkeit* in Being-in-the-world permeated every aspect of the participants' lives, from their emotions, their embodiment, and their relationships. Some of the women spoke of this state of *unheimlichkeit* even before their babies were lost, through instinctively knowing that something wasn't right with their pregnancies. In accordance with Heidegger's assertion that we are always attuned to the things that matter to us (1927/1962), the women felt *unheimlichkeit* and *angst* at being given a false narrative of hope from the professionals and experienced first-hand the epistemic injustice of their voices not being 'heard' (Fricker, 2007; Carel, 2016).

In an attempt to try to escape the feeling of *angst,* a number of the women unconsciously sought ways to supress the ontic expression and display of emotions, often through adopting self-destructive behaviours or attempts to return to the 'normal' everyday life that they had before the loss. Fleeing into everyday life from these unsettling feelings was not successful, because the everyday life that was known before the loss had now been disrupted. Life after the loss was not recognisable, nor familiar, to the life they had before. It was not that the world had changed, but that their experience of it had changed irrevocably in the shadow of the loss. Here, there was a double jeopardy in that it was not one loss that they were living through, but two.

The mood of *angst* was also influential on their experience of embodiment. For many of the women there was an embodied change immediately after the pregnancy loss, continuing throughout the next pregnancy and beyond. There was a distrust in their bodies, which were viewed as letting them down with the pregnancy loss. This was often followed by the existential questioning why. 'Why had their bodies let them down when other women's hadn't?" Other explanations offered for the loss included fate and self-blame, with intense scrutiny of actions leading up to the pregnancy loss. The new pregnancy flamed this distrust, and the women struggled to accept that their bodies would be able to nurture and carry the new pregnancy to fruition.

Angst in the following pregnancy was a revealing of *Being-in- the-world* as an authentic being. Described by most of the participants as ‘a loss of innocence’, the world was seen and experienced differently following the loss. This is explained by Watts (2001, p45), who suggests:

> Anxiety allows me to realize the shallowness of a self-concept based upon work, social status, achievements or material wealth, influenced by living as the *they-self.* So anxiety reveals the task of choosing who I am – it inspires me to make a change of course in my life.

The existential response to the pregnancy loss had revealed a re-evaluation and engagement to the world in a different way. Some of this re-evaluation included a re-visioning and shifting priorities in their relationships.

As mentioned in 10.4.1 above, there was a re-prioritising of relationships in the light of the pregnancy loss. The effect of *unheimlichkeit* meant that relationships were changed, even when they had previously been described as strong, with many of the women describing a disconnection of which they hadn’t previously been aware. They were hesitant to discuss the pregnancy loss even with those close to them, for fear of causing discomfort or being met with shallow social niceties that misunderstood and minimised their reality. For the women, this meant that their long-term relational needs were often unmet, further increasing their experiences of social isolation.

In part, there was an easing of *unheimlichkeit* for the women who joined online support groups. Here, they were part of a community with shared experiences, and had an increased chance of being ‘at home’ with others who had experienced pregnancy loss, and who were pregnant again. It was beneficial that those in these groups were relative strangers with whom they had no close emotional connection. These groups afforded them the freedom to speak openly without fear of causing discomfort or upset. However, experiences of pregnancy loss and pregnancy after loss are complex, and membership of these groups is not unproblematic. There are dangers associated with possible self-diagnosis, or an increased awareness of other pregnancy related complications (discussed in 3.2.3, 7.2.4, and 8.8 above) which, instead of alleviating feelings of *unheimlichkeit,* may in fact perpetuate them.

10.6 Strengths and Limitations

As with all research studies, several strengths and limitations are apparent in this research. One of the key strengths of this study is that it has taken a comprehensive and holistic exploration of lived experiences of maternity services after a significant life event, that of a previous pregnancy loss. In doing so, it is one of only a small number of studies that has drawn attention to the needs of this group of women to access maternity care from compassionate practitioners in systems that complement and acknowledge their previous loss(es). In addition, this study has demonstrated how a hermeneutic phenomenological approach can assist in understanding the complexity of these women's lived experiences, through the lens of the Heideggerian concepts of temporality, attunement, and care *(Sorge).* Use of this approach has provided rich theoretical understanding, and a depth of findings that has enabled a model of maternity care to be created to provide further understanding of this complex phenomenon (refer to section 10.5 above).

The emotional well-being of the participants was at the forefront of this research study. A key strength was the ethical integrity with which this project was undertaken. It was known that the subject and the phenomenological data collection method was likely to elicit tears from the women and would be emotionally moving for myself as well. Acknowledgement of these lived experiences ensured that the process was as kind, respectful, holistic, and inclusive as it could be. Support mechanisms that the women were made aware before the interviews were available not only at the time of the interview, but afterwards if needed.

However, as with any research design, there are a number of methodological limitations to consider. These include the limitation of sampling diversity, as the sample was purposely restricted to a particular geographical location. The reason for this has been identified earlier in section 5.2.2. However, imposing this criteria is likely to have led to different findings than would have been found in a different area, for example, a metropolitan urban area. This limitation does not negate the findings of this present study. Indeed, the findings are a useful consideration for women and maternity care providers within rural settings, as these types of settings present challenges for populations and providers of healthcare. The findings from this research could inform the providers of healthcare of the needs of a rural/regional population, so that a local response in the provision of maternity services for this group of women is developed.

In addition, problems with recruitment meant that a smaller sample of seven women were recruited than the revised intended sample size of between eight and ten (see section 5.2.3 for a broader discussion of sampling techniques). A larger sample size may have provided a broader depth of experience for analysis, although it may also have been prohibitive due to the constraints of doctoral study. Although small, the sample size was sufficient and in keeping with sample sizes used in other studies using a hermeneutic phenomenological methodology, with two interviews with six women, and one with another (13 interviews in total) providing much rich information for analysis. A further limitation with the sample recruited could be the lack of cultural diversity. Of the seven women recruited all were white, with six being British and one being European. In part, this is representative of the lack of cultural diversity of the county of Lincolnshire (see previous discussion in 5.2.2), but also the absence could be explained by the unavailability of funds to purchase translation services for women of a different ethnic orientation.

Several limitations were encountered as a single researcher working alone, and not as part of a research team. Although supervision was available and provided much needed insights and guidance, a PhD is necessarily a project for a sole researcher. Throughout, I have maintained a reflexive position in the design and methodology of the project. However, these alone do not negate the risk of bias and power imbalances. Working as part of a team may have assisted in reducing these risks further than reflexivity alone.

Utilising a hermeneutic phenomenological approach in this research may also be viewed as a further limitation. It is acknowledged that there are many interpretations of lived experience, meaning, and knowing, and that if the interpretation was carried out by others, or indeed myself at a different time, different interpretations may have been made. It is accepted that these are my analyses of the women's interpretations of their experiences. Furthermore, as outlined earlier in section 1.2, as a researcher this study has been influenced by my pre-understandings, including my personal and professional beliefs and experiences. The disclosure of these from the outset has ensured transparency and credibility of the research process, which enables the reader to make a judgement of the rigour of the study and its findings.

10.7 Recommendations

The present study set out to investigate and gain a deeper understanding of the complex phenomenon of pregnancy loss, pregnancy after loss, and the lived experiences of receiving maternity care in that following pregnancy. In the process of answering the research question, and meeting the aims of the study, a number of implications for practice and recommendations for further research have been raised.

10.7.1 Implications for practice

Although this was a small study, and it is recommended that further research is undertaken on this subject, several implications for practice have emerged from its findings. Firstly, it is clear that women who are pregnant after a previous pregnancy loss have a number of complex needs that are not being met by receiving routine antenatal and postnatal care. It is recognised that women with a complicated medical or obstetric history will be afforded an enhanced clinical care package on the 'high risk' care pathway, but this is not offered to all women, especially those whose pregnancy loss was an early gestation. Nor does this enhanced clinical care package necessarily provide the emotional and psychological care that these women frequently need (although it is acknowledged that in some cases, it may do). To meet this need, some areas have developed 'Rainbow clinics', where women who are pregnant after loss can receive antenatal care with practitioners who are sensitive to the need to offer emotional and psychological care as well as clinical care. However, this service is not offered in all areas (in this study, one trust did offer this service, the other did not), and there is no national guidance on how they should be run and the criteria for accessing them. At the time of this study, the trust that offered this service only did so to those who had later pregnancy losses. Given what we know and the knowledge that is developing around the psychological impact that an early pregnancy loss such as a miscarriage or ectopic pregnancy can have on women (see for example, Farren et al, 2019), a similar service that is offered to all women pregnant after loss, regardless of the gestation of that loss would be beneficial. As mentioned earlier in section 10.3, the NBCP (2018) had just been launched at the time the data collection in this study had commenced. The women had therefore not experienced care under this pathway, which had they done so, may have changed their perceptions of the care that they received. An audit of this service (NBCP, 2020) noted that any requirement for emotional and psychological support had to be resourced to support services within the community. Although this recognises the importance of the provision of this type of support for women, it is suggested that this would be better accessed under the NBCP, so that women could receive a holistic model of care that can provide for all of their needs under one care pathway.

Secondly, to be able to provide the complex care these women need, maternity care practitioners need specialist training that raises their awareness of the emotional and psychological complexities the women may have when accessing maternity services after a previous loss, alongside their clinical needs. This training needs to be contemporary, and delivered at regular points in a practitioner’s career, not just during their initial training. This will have the dual benefit of ensuring the workforce is fully up-to-date and have the skills to care for these women but will also ensure that the emotional burden of caring for these women is not just shouldered by a few individuals, reducing the risk of burnout.

Finally, the findings in this study suggest that although most women receive maternity care that is kind and compassionate, there are still a proportion of women who do not, instead reporting that practitioners are insensitive, dismissive, and paternalistic. This finding is not unique to this study, or indeed this area of practice, with written complaints about issues with communication in the NHS reported as making up the largest proportion of complaints in 2019-20 (NHS Digital, 2019). Furthermore, the recent Ockenden report (2020) into maternity services at a trust within England highlighted communication and the lack of kindness and compassion in the delivery of maternity care as “one of the most disappointing and deeply worrying themes to emerge” (p. 11) from the investigation. Although not directly related to the trusts in this present study, the findings from this report, alongside this study and other research (Mills et al, 2016) suggest that there is an endemic lack of these qualities within NHS maternity services in England. Further training for all members of the multidisciplinary team in counselling skills to assist in the enhancement of communication would, in part, go some way to addressing this issue.

10.7.1.1 Towards a model of good practice for maternity care in pregnancy after loss

In view of points raised above, it is proposed that a model of good practice for maternity care in pregnancy after loss is needed that offers care over and above what is currently available on the NBCP. Whilst the improvements in maternity bereavement care under the NBCP since implementation are to be commended, the findings from this research, the most recent evaluation of the NBCP, and current high-profile campaigns (Tommy’s, 2021; The Miscarriage Association, 2021) to improve the care for women following a miscarriage, suggest that this pathway now needs extending to incorporate these issues. In addition to what the NBCP provides, the following are proposed:

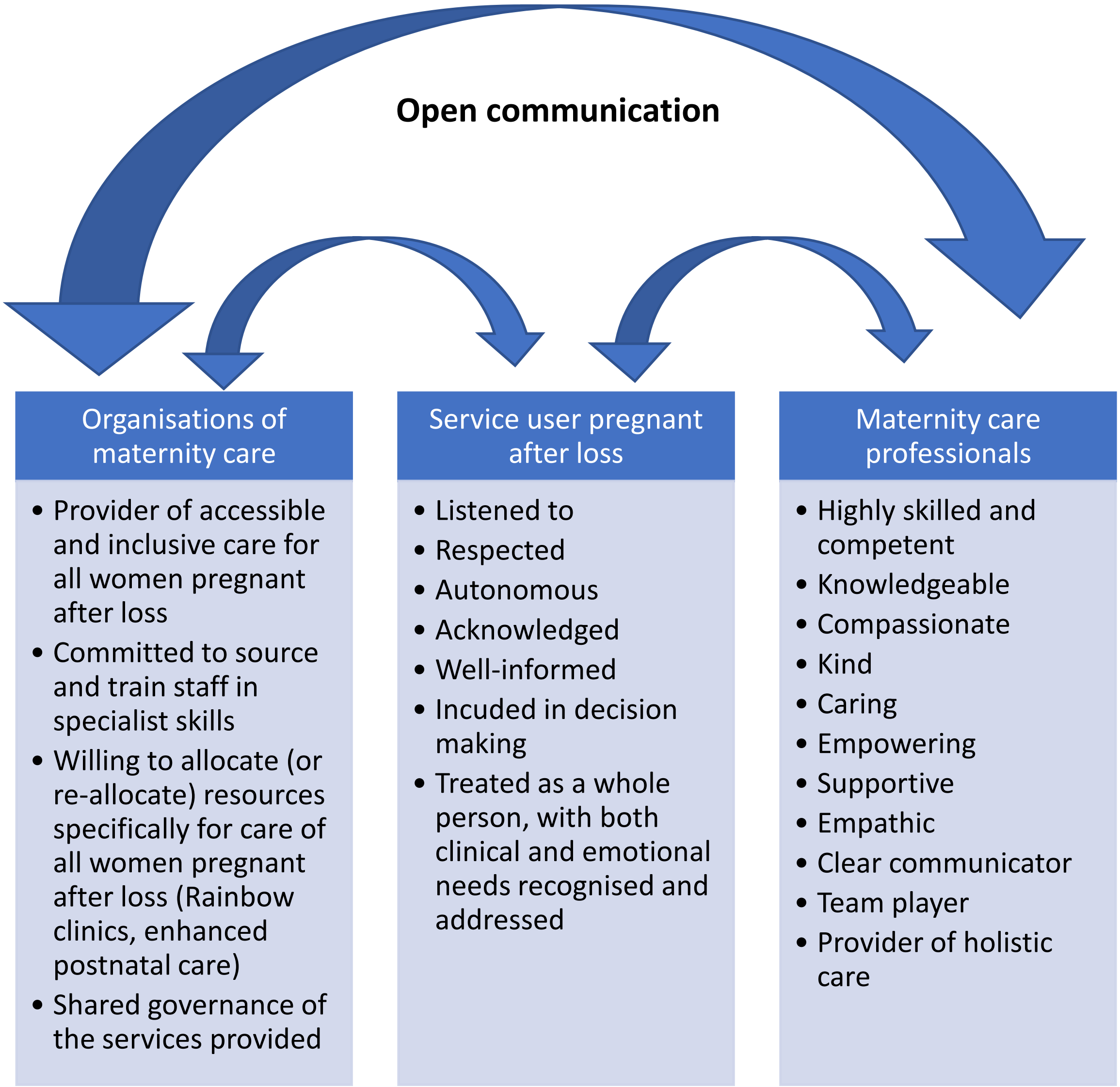
- An increased focus in the NBCP literature, perhaps in a separate publication to the ones available at present, on the complexities that many women carry to the next pregnancy following loss. To include more information in the guidance for both health professionals and parents of how these complexities may influence and impact on the package of maternity care offered in the new pregnancy.

- Enhanced specialist training for professionals to include not only the skills to care for the women in the present, but also to provide extensive background knowledge of how some women can be affected by pregnancy loss (as highlighted in chapters 7 and 8 of this research, and the literature identified in chapter 3), and how this is influential on women's cognitions and emotions in the current pregnancy.
- The extension of current maternity multidisciplinary teams, to include practitioners (preferably midwives) who have undertaken further training in either counselling, or (at the very least) advanced counselling skills to enable them to provide both the emotional and psychological support to women within the current care pathway, thus eradicating the need for these women to be referred to an outside service, and the added stresses associated with such a referral.
- **ALL** women who are pregnant after loss, regardless of the gestation of their previous loss, to be offered the chance to be cared for by a multidisciplinary team that is separate from the 'normal' clinical pathway, who are highly skilled, knowledgeable, and compassionate, and who can offer the full range of care, both clinical and emotional to women pregnant after loss.
- In the antenatal period, specialist 'Rainbow clinics' to be offered in all trusts, where women who had experienced a loss (of any gestation) can be cared for by members of the multidisciplinary team. At present, these are not available in all trusts, and the provision of care offered differs between trusts, leading to inequality and inequity for service users.
- The design of a package of postnatal care provided by midwives for women from post-delivery to discharge to health visitor and GP services, that considers the possible increased anxieties these women may have with the transition to motherhood and caring for a baby born after loss.

Based on these points, Figure 2 is a proposed model of good practice for maternity care in a pregnancy after loss.

Figure 2

A proposed model of good practice for maternity care in pregnancy after loss.



Open communication

Organisations of maternity care

- Provider of accessible and inclusive care for all women pregnant after loss
- Committed to source and train staff in specialist skills
- Willing to allocate (or re-allocate) resources specifically for care of all women pregnant after loss (Rainbow clinics, enhanced postnatal care)
- Shared governance of the services provided

Service user pregnant after loss

- Listened to
- Respected
- Autonomous
- Acknowledged
- Well-informed
- Incuded in decision making
- Treated as a whole person, with both clinical and emotional needs recognised and addressed

Maternity care professionals

- Highly skilled and competent
- Knowledgeable
- Compassionate
- Kind
- Caring
- Empowering
- Supportive
- Empathic
- Clear communicator
- Team player
- Provider of holistic care

10.7.2 Further research

A recognised limitation of this study was that the study focused on a large rural area, with the participants (except one) coming from a shared cultural background. Although this perhaps is representative of the lack of cultural diversity within the county, it does suggest that a similar study undertaken in an urban area, with a rich cultural diversity may offer new insights into these complex phenomena. Furthermore, as this subject has so far received scant research attention, a comparison of studies undertaken in rural and urban locations could yield new knowledge, for example, on how the organisation of maternity care systems in these different locations, discussed in chapter 10, are experienced and perceived.

One of the key findings from this present study was how the available maternity systems in the county were perceived as not providing what some of the women needed at a time when they were extremely vulnerable. Research into this subject, from both a national and local perspective, and perhaps in consultation with service users from a variety of social, emotional, and clinical backgrounds, could provide new insights into any perceived gap between what service providers feel they are providing against the actual experiences and needs of service users. In time, this may lead to a re-organisation and development of maternity services that meet the needs of all its service users.

This present study focused on the lived experiences of women, with only cursory mention to the experience of the partners of these women. This perhaps, unconsciously, reinforced the sociocultural expectations that the partners should be emotionally strong and supportive to the women who have endured both the physical and psychological effects of the loss and subsequent pregnancy. There is now growing recognition that partners too suffer deeply following their partner’s pregnancy loss, and that there is the likelihood that this emotional suffering will continue throughout any subsequent pregnancy. It should also be acknowledged that although the women in this study were all in heterosexual relationships, that partners of any gender or sexual orientation could be equally affected by a pregnancy loss (see the work of Peel and Cain, 2012). Further research is needed to investigate both the short- and long-term implications that these experiences have on partners, whatever their sexual orientation, which, by association, will also affect those close to them.

Finally, this study focused on the experiences of women who were pregnant and receiving maternity care after a previous pregnancy loss. Further research into the experiences of practitioners who deliver this care, and their awareness of the complexities that these women present with could provide new knowledge on how to support and care for practitioners who work in emotionally difficult situations, which in turn will assist them in providing the best possible care for women.

10.8 Reflexivity of the researcher

Throughout the duration of this study, I have sought to main both a reflective and reflexive stance. At the beginning of the study, I declared both my personal and professional motivations for undertaking such as study. Further reflexivity was provided in section 4.5 and in appendix A. It is therefore fitting that I conclude by provide a reflexive account of my experiences of the study.

I am mindful of the part that I played in bringing this study to fruition, how my pre-understandings, personal and professional motivation and experiences shaped the design and approach of this study. Others are likely to have approached this topic in a way which may have yielded very different results. I am also mindful that this work is my analyses of the women’s interpretations of their experiences, and you, as reader, will be adding your own interpretations to what you read. This work is only thus, a glimpse of the women’s experiences as described to and seen through my eyes. The use of other theoretical approaches would have provided a different picture.

This study has taken place over almost five years of my life, in a full-time and then part-time capacity. Although this project was not about me or my experiences, completing it has resulted in growth and development on a personal, professional, and academic level. Early in the study I became aware that my pre-understandings on the subject, which I thought were considerable, were in fact quite minimal, and did not include an in-depth comprehension of the complexities of Being-in-the-world of pregnancy loss and pregnancy after loss. I am humbled and grateful that the women through the sharing of their stories, have added to my knowledge and understanding. Academically, I have been challenged and stimulated (and at times frustrated at my difficulties with understanding) by the works of Heidegger and other phenomenologists. His work, especially through the concepts of temporality, attunement and care, offered an explanation and understanding for the phenomena revealed in the study. Professionally, this study has prompted a retrospective sadness of the times that as a midwife, I may have been guilty of minimising the losses of women, especially those who had an early gestational loss. This was prompted when conducting the interviews. Although all the interviews conducted were special in different ways, there was one that had a profound effect on me. As I listened to this woman describing her experiences of pregnancy loss, her descriptions were so intriguing and intricate, it felt that she had been pregnant for a long period of time, when in fact her pregnancy had lasted two and a half weeks. I was enthralled by her recollections. These experiences prompted me to reflect deeply on my past and current professional roles, with the awareness revealing a deeper sensitivity to my work.

10.9 Conclusion

By way of conclusion, this study has shown that pregnancy loss and pregnancy after loss is experienced at a deeply personal level. Yet it is not experienced in a vacuum. Women exist within a broader social context, where relationships with significant others provide a connection with everyday life at times when they perhaps feel removed from the everydayness of Being-in-the-world. Their re-emergence in the everyday world often brings with it an altered sense of "*Being*", with their relationships with significant others assisting or hindering them in making meaning of their experience. It is from this altered sense of Being-in-the-world that women enter the world of maternity care in the pregnancy following loss.

Using a hermeneutic phenomenological approach, informed by the work of Heidegger (1927/1962) has enabled an understanding to develop of the temporal, attunement and care lived experiences of Being-in-the-world, that are all affected by the experience of pregnancy loss, pregnancy after loss, and of receiving NHS maternity care following a previous loss. The findings from this study have important implications not only for those who have experienced such a loss and their families and friends, but also for the providers of care, maternity care professionals, and those responsible for the organisation of maternity services. The creation of a model of maternity care shares new insights into how this may be achieved. Further research is now needed to extend the findings of this present study, and thus increase further understanding of this unique and complex phenomenon.

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Appendices

Appendix A – Letter to participants

IRAS ID: 232475

Mrs Teresa Garrod

Bishop Grosseteste University

Longdales Road

Lincoln

LN1 3DY

September 2017

Dear

Thank you very much for your interest in this research project and your enquiry about potential participation.

Following on from our initial discussion, please find attached a copy of the participation information sheet and consent form for the project. If after reading them you are happy to proceed, please sign the consent form, keep one copy, and return the other one to me within 10 days of receiving it. If you would like to ask further questions before considering your response, please do not hesitate to contact me and I will be happy to answer them. You are not under any obligation to participate if you decide not to do so.

Thank you once again for taking the time to enquire about potential participation for this project.

Kind Regards

Teresa Garrod

PhD Student

teresa.garrod@bishopg.ac.uk

07956658757

Appendix B – Participant information sheet

Participant information sheet

Title of the research project:

Women's lived experiences of maternity care in pregnancy after loss: A Heideggerian perspective.

What is the project about?

The project involves an exploration of pregnant women's experiences of midwifery care in the NHS when they have previously lost a baby. All types of baby loss are included, for example, miscarriage, elective and medical terminations, stillbirths, neonatal deaths (the loss of a baby in the first 28 days after delivery). This is a new area of research and I am interested in understanding your experiences from your perspective.

Who is the researcher and the research institution?

My name is Teresa Garrod, and I am a PhD student at: -

Bishop Grosseteste University

Longdales Road

Lincoln

Lincolnshire

LN1 3DY

IRAS ID: 232475

Contact details:

Email: teresa.garrod@bishopg.ac.uk

Telephone: 07956658757

Supervisor's contact details

Dr Caroline Horton: Email: caroline.horton@bishopg.ac.uk , Tel: 01522 583711

Dr Sue Becker: Email: susan.becker@bishopg.ac.uk , Tel: 01522563890

Dr Gianina-Ioana Postavaru: Email: gianina.postavaru@bishopg.ac.uk, Tel: 01522 563858

Independent contact details

Professor Chris Atkin: Email: chris.atkin@bishopg.ac.uk , Tel: 01522 583704

Immediate contact details

Dr Andrew Jackson, Director of Research: Email: andrew.jackson@bishopg.ac.uk , Tel: 01522 527347

What will my participation in the research involve?

As part of my project, I will be interviewing pregnant women who are currently receiving midwifery care in the NHS after previously losing a baby. I would like to interview you on two separate occasions. The first interview will be in the antenatal period, ideally in the second trimester. The second interview will be in the first three months after you have had your baby. In the interviews, the types of questions I may ask will include

- Tell me about your previous pregnancy when you lost the baby/name.
- Can you tell me how you felt when you found out about this current pregnancy?
- What have been your experiences of NHS midwifery care in this pregnancy/labour/after the baby(name) was born this time?
- What impact did these experiences have on you?
- Did these experiences match with your needs and expectations?
- What did you expect from your NHS midwifery care in this current pregnancy?

I am aware that talking about these experiences might be quite emotional for you. I will make sure I am sensitive to this possibility by allowing you time to compose yourself between questions. I will be guided by you in the interview process to protect your emotional wellbeing as far as I am able. You will not be pressurised to respond to any question in the interview that you do not wish to answer. Both interviews will last for about an hour each and will be audio recorded so that I can listen to them again.

Who can take part in the research?

To take part in the research you need to: -

1. Be aged 18 or over at the time of participation.
2. Be pregnant and currently receiving NHS maternity care.
3. Have previously had a previous pregnancy loss, for example, miscarriage, elective termination, medical termination, stillbirth, neonatal death.
4. If English is your second language, you must have a good understanding of written and spoken English.
5. Be resident in Lincolnshire at the time of participation.

What happens if I lose the capacity to give consent during the study?

If, in the unlikely event, you lose the capacity to give consent during the study no further interviews will be conducted. This is a legal ruling outlined in the Mental Capacity Act (2005) to protect your best interests. Any information gathered up to this point will still be used.

Will there be any benefits in taking part?

There are no financial or material benefits to taking part in this research, although reasonable travel expenses will be reimbursed to you if you choose to be interviewed in a location that is not your home. The perspectives you offer will however, enable me as researcher to gain valuable insight into your experiences. As participants in this study, you may find the process and the results insightful. A summary of the research findings will be made available to you upon request.

Will there be any risks in taking part?

Your participation in this project is voluntary. I would prefer to interview you on your own, but if you wish to have a friend or family member present this could be arranged. You may find taking part in the interviews emotional or distressing. If this happens, you may stop the interviews at any time, or ask for a break before resuming. Should you become upset by what we are discussing I will provide initial support. It is recommended that you also have a family member or friend available close by to provide further support if needed. Referral for further help such as GP support or counselling will follow if deemed appropriate.

What happens if I decide I don't want to take part during the actual research study, or decide I don't want the information I've given to be used?

You can withdraw from taking part in the research at any time without having to give a reason, and with no prejudice to yourself. Any information collected from you will not be used in the study and will be destroyed in line with data protection laws.

If I decide to withdraw, how can I let you know?

If you decide to withdraw, you can let me know by email or phone. Alternatively, you could contact one of my supervisors and let them know.

Who will have access to the information collected?

All interview material will be stored in a locked, secure cabinet or a password protected computer at Bishop Grosseteste University and will only be accessed by myself as principal researcher. Similarly, all notes made by me relating to the research will be stored and accessed in the same way. An identifiable (one of the supervisors named above) third person will have access to your personal details at the time of the interviews. This is to ensure the personal safety of both you as participant and myself as researcher.

How long will be information gathered in the study be retained?

The audio-recordings of the interviews will be deleted following transcription. All other information will be retained for 6 years (in accordance with guidance in the Bishop Grosseteste university Code of conduct for Doctoral Research Policy, 2017), before being destroyed either by shredding (for paper data), or the deleting of electronic files.

How will be information gathered in the study be used and who will see it?

The information from this study will be used to produce my PhD thesis. The people who are likely to read the thesis in an official capacity are the supervisors named above, and the independent examiners selected to examine this work.

Will any action be taken as a result of me taking part in this research?

The researcher is unable to change any service provision as a result of the findings from this study. However, it is intended that the findings from this research will be published in relevant journals and disseminated at conferences both nationally and internationally.

Will the information from the study be published?

There may be a number of articles published as a result of this study. The results may also be presented at various relevant conferences both within the United Kingdom and Internationally. All identifiable information gathered from you will be anonymised prior to this happening to ensure that your identity is protected.

How will you try to make my contribution is anonymous?

All the information you give me will be treated with the utmost respect and be kept confidential. This means that your name will not be used in the interview transcripts, nor will you be identifiable in any of the publications or conference presentations relating to this project.

How do I make a complaint about this study, or anyone involved in this study?

If you wish to make a complaint relating to this study, or anyone involved in this study, please initially contact the Director of Research, Dr Andrew Jackson, who will investigate your concerns.

Email: andrew.jackson@bishopg.ac.uk

Tel: 01522-527347

Please note that your confidentiality and anonymity cannot be assured if, during the research, it comes to light you are involved in illegal or harmful behaviours which I may disclose to the appropriate authorities.

Suggested support individuals and organisations.

<u>National organisations</u>

Stillbirth and Neonatal death charity (Sands)

Website: www.uk.sands.org

Email: helpline@sands.org.uk

Tel: 0808 164 3332

Bliss – for babies born premature or sick.

Website: www.bliss.org.uk

Email: ask@bliss.org.uk

Tel: 020 7378 1122

Miscarriage Association

Website: www.miscarriageassociation.org.uk

Email: info@miscarriageassocation.org.uk

Tel: 01924 200799

Local support/organisations/groups

Contact your own GP to access support. This may be emotional support from the GP, medication, referral to NHS mental health services such as Cognitive Behavioural Therapy or Counselling, or a combination of these as your GP deems appropriate.

Lincolnshire Partnership NHS Foundation Trust

Website: www.lptf.nhs.uk

Tel: 0303 123 4000

Private Counsellors

If you wish to access private counsellors, the counselling directory website provides a list of approved counsellors in your local area. Follow the directions on the website to find individual counsellors contact details. http://www.counselling-directory.org.uk/

Appendix C – Research consent form

BISHOP
GROSSETESTE
UNIVERSITY

RESEARCH CONSENT FORM

Title of Project: Women’s lived experiences of pregnancy after loss: A Heideggerian perspective.

Name of Researcher: Teresa Garrod

IRAS ID: 232475

Participant identification number for this research:

Please initial box

1. I confirm that I have read the information sheet dated December 2017 version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that relevant sections of my medical notes may be looked at by individuals. from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐

5. I agree to being audio-recorded during the interviews. ☐

6. I agree to the researcher using direct quotations from the interviews providing that any quotations are anonymised. ☐

7. I understand that in the unlikely event that I lose capacity to give consent (as defined in the Mental Capacity Act, 2005) during the study I will not be able to continue to take part, and that any information gathered from me until that point will still be able to be used by the researcher in the ways outlined in the Information sheet. ☐

8. I agree to an identified third-party having access to my contact information as outlined in the Information sheet for the above research project. ☐

9. I understand that any information gathered about me for this research will be retained and stored securely to comply with the recommendations of the Data Protection Act (1998). ☐

10. I agree to take part in this research study. ☐

______________________	______________________	______________________
Name of Participant	Date	Signature
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

Appendix D – Excerpts from transcribed interviews

Excerpt one – Jules, interview one

Int Thanks very much for saying that you'll do this for me.

Jules No problem

Int So, like I said to you earlier em, I want to ask you about your pregnancies because this current one is your fifth pregnancy isn't it.

Jules Yep

Int You've had four other ones.

Jules Yep

Int Can you tell me a bit about your previous ones?

Jules Em, first one IVF

Int Um

Jules I tried for 5 years…

Int Oh gosh.

Jules Before I went for the IVF…em I had clomid, tamoxifen, I had bad reactions, I had to lose near enough 8 stone.

Int Oh gosh.

Jules to be able to go for it em… and it worked first time. I ended up with early onset pre-eclampsia from 16 weeks… and ignored my instincts… the day before my glucose test, and the next day he was gone.

Int Oh gosh.

Jules So…… yes

Int …so that was how long ago?

Jules Em… 5 years. He was born on the 8th of January 2013…

Int And how many weeks was he…

Jules **Em 25 and 5…**

Int Okay. And he was called…

Jules **XXXXX**

Int He was called XXXXX

Jules **XXXXX XXXXXXXXXXX …Yes… (Pause)**

Int So, lets wind back a little bit first, so tell me about…. Coz the IVf process is, can be quite tough,

Jules **It is tough yes…**

Int So, tell me about that…

Jules **Lots of testing, lots of bloods, lots of injections you have to give yourself…em the, eh retrieval of the eggs was the worst part, they sedate you for it. But they pop a catheter in…but you have to go so every other day to be scanned, to see whether your eggs are ready to be collected, and it was in XXXXXXXXX so travelling from XXXXXXXX to XXXXXXXXXX every other day and working full time at the same time was really hard. Em, but they pop a catheter in, pop a needle through and out, they pierce the side of your uterus, and into the ovary and they drain the eggs out into a test tube...**

Int Oh

Jules **Which is where test tube babies come from**

Int Right... yea

Jules **And we had the ixxy, where they fertilise the sperm straight into the egg, because he had a low sperm count, em then they cook it until it's ready… out of 10 eggs I had 7 that were of grade A quality…so…**

Int That's excellent…so

Jules **They'd only put one back at a time….**

Int So, tell me about the emotional impact of going through all of that…

Jules **The only thing that bothered me was the self-injecting…. coz I'm petrified of needles…. that's the only thing that bothered me about the IVF process….as hard as it was at the time…. I thought that that was the only way I could have**

a baby, and that was all I wanted, so you just tend to shut up and put up. But the people at XXXX at XXXXXXXXXX are fantastic, lovely, really nice clinic…

Int That’s the organisation that….

Jules Yea, they are brilliant……I’ve actually sent a few people, through recommendations, to them…. em one couple, they’ve got twins, and another couple, a lesbian couple, they’ve got twins…

Int Wow….

Jules And another one, she’s just had a little boy, so…

Int So, do you all meet up?

Jules Ah no, no……they’re all in XXXXXXXX, and since moving to XXXXXXX with XXXXX…I don’t get home very often, and work full-time, so…

Int So, you said that that one worked first time when they implanted…

Jules Yep, yea…em I had my other eggs frozen….it was about a year after I lost XXXXX that we went back, and I had another egg put in, eh got a positive test, phoned the clinic, booked in for my scan, a couple of days before my scan I started bleeding and passed…

Int Oh

Jules Lots of clots, things like that...

Int Eh, how many weeks were you....

Jules I only must have been about 8…

Int Right okay…

Jules Then my sister got married in about July…2014, so I had 2 in a year….one at the beginning of January 2013 and one in the middle of January 2014, and then the last one was 2017… so there was a bit of a gap...

Int Yea, so…. tell me a bit more about the pregnancy with XXXXX, so em…the implant with XXXXX was fine?...

Jules Yea, yea …I had my 2-week rest, I went for my scans…everything was fine. My 8 weeks scan I had at the clinic was normal, you could see his heartbeat, you could see him. Then I had my booking in appointment with the midwife, everything was fine, my blood pressure was a little bit high, sorry, it’s such a

long time ago now (laughs), then my 12-week scan perfectly normal, then my 20-week scan perfectly normal. Mm I went for my 16-week check and I'd been having bad headaches, I was a bit puffy, em I'd got like loss of vision, so say I was sat here talking to you one minute I wouldn't be able to see out of one of my eyes, I'd have flashing lights and sort of rainbows coming over.

Int Mmm, Mmm

Jules Em, and that was constant.

Int Em, right, so it didn't just come on, it was there….

Jules Yea, quite early, it was 16 weeks, I mentioned it to the midwife, blood pressure, it was still in the normal range, but right at the very top range. I think I went to the assessment unit a few times about it…but then it would ease off, but there was nothing in my urine, or anything like that at the time. Em, because my dad's diabetic I had to have a glucose test.

Int Yea

Jules Em, and I was going in on the 7th January, on that Monday for my glucose test…and I was at pathology, the woman was taking my bloods, and the woman just went "I don't like the look of you" (laughs), I said Cheers, thanks for that – I was pale, I was puffy, I had a few stomach pains, I didn't look very well at all. So, she rang down to maternity, they got all my bloods and my glucose done…. I didn't have gestational diabetes, em probably the only thing, em and it took, there was only one midwife on, and I sat there for nearly 5 hours.

<u>Excerpt two – Hayley, interview two</u>

Int: it's so good to see you and the end result bless him. We'll talk about your labour and delivery in a minute, but can you tell me a bit about your care in this pregnancy overall. You know I'm looking at womens experiences of care after they've had a previous loss, tell me overall about things that stood out as good and not so good.

Par: I think the thing that stood out as good were the people that recognised us and knew and understood the full story. We were assigned to a consultant but she wasn't always there on our check-ups so we had the head midwife or whatever you call her doing those appointments when she wasn't there and she would always greet us as if we saw her every day, and it was the little things like that that always made a difference, coz then you felt that you could approach her with more questions if you had questions in your mind

Int: so, she was approachable, and you felt like you didn’t have to repeat anything that had happened with XXXXXX I suppose
Par: yea it was like an unspoken thing that she knew the full story without having to refer to the notes, or me having to refer to a specific letter that we'd copied and pasted into the notes book, because each time that you bring it up it can bring up all those sad emotions depending on how you are feeling each day, when you're just trying to check that this pregnancy is ok.

Int: so familiar faces were a good thing, did that happen all the way through your pregnancy then.

Par: yea pretty much, depending on the time in the pregnancy we had appointments every 2 weeks or every 4 weeks, because they were checking for my infection levels and things like that so they would see us at least once a month. and it was a friendly atmosphere as well rather than just a clinical check-up. But that was also one of the negative things because when we saw the consultant she would be more so straight to the point, more like a doctor, more clinical and she didn't give any full explanations she would just say no you don’t need to do this but wouldn’t explain why. she would only just smile like she only just recognised us, but then we had one doctor that came in when she was away because I was having a high vaginal swab and they had to have a doctor do them rather than a midwife and she was like oh I remember you from last year, little things like that stand out, so it might have just been that consultant and

Appendix E – Excerpts from crafted stories

Crafted story one – Jules

My first pregnancy was IVF. I tried for 5 years before I went for the IVF. I had Clomid and Tamoxifen, but I had bad reactions to them. I had to lose nearly 5 stone to be able to go for it, and it worked first time. I ended up with early onset pre-eclampsia from 16 weeks….and ignored my instincts…. it happened the day before my glucose test, and the next day he was gone. He was born on the 8th of January 2013 at 25 +5, we called him XXXXX, XXXXX XXXXXXXXXXX. The IVF process was tough, there was lots of testing, lots of bloods, lots of injections I had to give myself. The only thing that bothered me about the process was the self-injecting because I'm petrified of needles. The retrieval of the eggs was the worst part. I was sedated for it. Before that I had to go to the clinic every other day to be scanned to see if the eggs are ready to be collected. We had to travel from XXXXXXXX to XXXXXXXXXX every other day, whilst working full-time at the same time. It was really hard. To collect the eggs, they pop a catheter in, pop a needle through and out, they pierce the side of your uterus, and into the ovary and they drain the eggs out into a test tube. We had ICSI where they fertilise the sperm straight into the egg because he had a low sperm count. Then they 'cook' it until it's ready. Out of 10 eggs I had 7 that were grade A quality. They only put one back at a time. It was hard at the time, but I thought that that was the only way that I could have a baby, and that was all I wanted, so I just shut up and put up. The people at XXXX at XXXXXXXXXX are fantastic, brilliant. I've actually sent a few people to them through recommendation (two couples have had twins and one has just had a little boy). I had my other eggs frozen. After the implant with my first pregnancy (James) I had my 2-week rest, I went for my scans, everything was fine. My 8-week scan I had at the clinic was normal, we could see his heartbeat, we could see him. Then I had my booking in appointment with the midwife and everything was fine except that my blood pressure was a little bit high. My 12-week scan was perfectly normal. When I went for my 16-week check I'd been having bad headaches, I was a bit puffy, I'd had loss of vision. I wouldn't be able to see out of my eyes and I'd have flashing lights and sort of rainbows coming over. I mentioned it to the midwife, but my blood pressure was in the normal range although right at the top of that range, and there was nothing in my urine or anything like that at the time. I think I went to the assessment unit with it a few times, but it would ease off. My 20-week scan was normal. Because my dad is diabetic, I was booked in to have a glucose test on 7th January. I was at pathology on that day having my bloods taken, and the woman who was taking my bloods said, "I don't like the look of you". I said, "thanks for that". I was pale, I was puffy, and I had a few stomach pains. I didn't look well at all. So, they took all my bloods, and she rang down to maternity. When I got there, I had to wait for nearly 5 hours before they got around to seeing me because there was only one midwife on her own in clinic that day.

Crafted story two – Hayley

With this pregnancy I think the thing that stood out for me as good care was when there were people that recognised us and understood the full story. We were assigned to a consultant, but she wasn't always there at our check-ups, so we had the head midwife (or whatever you call her) doing those appointments when the consultant wasn't there. She would always greet us as if she saw us every day. It was the little things like that that made the difference, I felt like I could ask her questions if I had anything on my mind. She knew the full story without having to refer to the notes. Each time I had to explain the full story to someone new it brought up all those sad emotions, when all I want to do is check that this pregnancy is going ok. We had appointments every 2 or 4 weeks depending on where we were in the pregnancy because they were checking my infection levels and things like that, so we got seen regularly. It was a friendly atmosphere, not just a clinical check-up. But this could also be negative, because when we saw the consultant, she would be more clinical and straight to the point. She didn't give full explanations; would just say no I didn't need to do this but wouldn't explain why. She would smile like she only just recognised us. We had one doctor that came in while she (consultant) was away because I was having a high vaginal swab and a doctor needed to do that rather than a midwife. She said she recognised us from last year – it was little things like that that stand out. The consultant's care wasn't bad, it was perfect, but it was just the way she came across.