Pregnancy loss in lesbian and bisexual women: an online survey of experiences

This item was submitted to Loughborough University’s Institutional Repository by the/an author.


Additional Information:

- This is an Open Access Article. It is published by OUP under the Creative Commons Attribution 2.5 Unported Licence (CC BY-NC). Full details of this licence are available at: http://creativecommons.org/licenses/by-nc/2.5/

Metadata Record: https://dspace.lboro.ac.uk/2134/21015

Version: Published

Publisher: © The Author. Published by OUP

Rights: This work is made available according to the conditions of the Creative Commons Attribution-NonCommercial2.5 Unported (CC BY-NC 2.5) licence. Full details of this licence are available at: http://creativecommons.org/licenses/by-nc/2.5/

Please cite the published version.
Psychology and counselling

Pregnancy loss in lesbian and bisexual women: an online survey of experiences

Elizabeth Peel

Senior Lecturer in Psychology, School of Life & Health Sciences, Aston University, Birmingham B4 7ET, UK

Correspondence address. Tel: +44-121-2044074, E-mail e.a.peel@aston.ac.uk

BACKGROUND: Although pregnancy loss is a distressing health event for many women, research typically equates women’s experiences of pregnancy loss to ‘married heterosexual women’s experiences of pregnancy loss’. The objective of this study was to explore lesbian and bisexual women’s experiences of miscarriage, stillbirth and neonatal death.

METHODS: This study analysed predominantly qualitative online survey data from 60 non-heterosexual, mostly lesbian, women from the UK, USA, Canada and Australia. All but one of the pregnancies was planned. Most respondents had physically experienced one early miscarriage during their first pregnancy, although a third had experienced multiple losses.

RESULTS: The analysis highlights three themes: processes and practices for conception; amplification of loss; and health care and heterosexism. Of the respondents, 84% conceived using donor sperm; most used various resources to plan conception and engaged in preconception health care. The experience of loss was amplified due to contextual factors and the investment respondents reported making in impending motherhood. Most felt that their loss(es) had made a ‘significant’/‘very significant’ impact on their lives. Many respondents experienced health care during their loss. Although the majority rated the overall standard of care as ‘good’/‘very good’/‘outstanding’, a minority reported experiencing heterosexism from health professionals.

CONCLUSIONS: The implications for policy and practice are outlined. The main limitation was that the inflexibility of the methodology did not allow the specificities of women’s experiences to be probed further. It is suggested that both coupled and single non-heterosexual women should be made more visible in reproductive health and pregnancy loss research.

Key words: miscarriage / pregnancy loss / lesbian and bisexual women / heterosexism / online survey

Introduction

Pregnancy loss is an important issue that affects family planning and childbearing, yet it is often overlooked in reproductive health research, and is shrouded in cultural silence (Layne, 2003). Fetal mortality has also been described as ‘a major...public health problem’ (MacDorman and Kirmeyer, 2009a: 1). Pregnancy loss, especially early miscarriage, is extremely common and estimated to occur in between 12 and 31% of confirmed pregnancies, and up to as many as half of all pregnancies (Cramer and Wise, 2000; Cosgrove, 2004; Renner et al., 2000; Speroff et al., 1999). Epidemiological evidence from the USA indicates that risk of pregnancy loss is increased for a number of groups of women, including non-white women ‘teenagers, women aged 35 years and over, unmarried women and multiple deliveries’ (MacDorman and Kirmeyer, 2009b: 1). Within the ‘unmarried women’ category it is not possible, however, to discern the sexuality of these women. Furthermore, in many Western jurisdictions marriage, or ‘marriage-like’ legal frameworks, are now available to same-sex couples (Harding, 2006; Peel and Harding, 2008).

The normative Western narrative of pregnancy is continually reproduced across medical, literary and mass-media resources. It involves a missed period, a positive home pregnancy test and a medically managed pregnancy that entails visits to view the developing ‘baby’ via ultrasound (Davis-Floyd and Dumit, 1998; Harpel, 2008). According to Layne (2003: 27), pregnancy loss at any gestational stage ‘does not conform to the norm’ of joyful pregnancy and childbirth and therefore represents ‘an incomplete rite of passage’ for women in the normative route to motherhood. It also fails to conform to medical norms of correct reproductive embodiment, since it exposes and disrupts the myth of continuous, linear ‘biomedical progress’ (p. 176) implicit in dominant Western ‘technobirthing’ discourses that make pregnancy and child rearing the object of rationalizing medical management (Davis-Floyd, 1998). Therefore, the multiple ‘failures’ that pregnancy loss represents encourage a general socio-cultural avoidance of this issue.
Pregnancy loss is a physically and psychologically distressing event for many women—a form of (often socially unrecognized) bereavement, trauma, significant loss and grief (Renner et al., 2000; Swanson, 2000; Frost et al., 2007; Brier, 2008). Furthermore, when non-normative relational contexts, such as lesbian couples, are considered, the phenomenon becomes even more complex. The narrative of ‘normal’ pregnancy begins with ‘natural’ conception, in the context of a heterosexual relationship, usually marriage. Lesbian motherhood is less common than heterosexual motherhood, and lesbian routes to conception are, by definition, non-(hetero)normative and prone to classification as ‘artificial’ (Mamo, 2007), even when medical assistance to conceive is not sought (Ferrara et al., 2000). Nevertheless, estimates suggest that there are between 1 and 5 million lesbian mothers in the USA (Patterson and Redding, 1996), and that about a third of British lesbians are mothers (Golombok et al., 2003). Sixteen percent of married and co-habiting lesbian couples in Canada have children living with them (Statistics Canada, 2009), and according to the 2001 Australian census 19% of female same-sex couples have children (Australian Bureau of Statistics, 2005). As Bos et al. (2003: 2216) acknowledge ‘in most Western industrialized countries the total number of lesbians who have given birth to a child within a lesbian relationship amounts to several thousands; however, this is an estimate’. Despite these significant numbers of lesbian women (and other women in same-sex relationships) becoming parents, very little is known about the incidence or psychosocial repercussions of pregnancy loss for non-heterosexual women.

Research suggests that ‘around one quarter of lesbian-mother families, in the UK at least, are created’ through assisted conception services (Golombok et al., 2003: 31). Many non-heterosexual women also utilize assisted reproduction technologies and services in creating their families (Mamo, 2007). The regulation of, and access to, fertility clinics for non-heterosexual couples and single women, however, varies widely across different countries and jurisdictions (Gunning and Szoke, 2003). A comparative study of intrauterine insemination (IUI) with frozen donor sperm (based on 122 single heterosexual women and 35 lesbian couples attending a fertility clinic in London) found that in 63 pregnancies the miscarriage rate was 15% for lesbians and 35% for single heterosexual women (Ferrara et al., 2000). The authors suggest that the difference in miscarriage rates between the two groups may be due to the heterosexual single women in their study being older and having failed to conceive for some time prior to clinic referral. Lesbian and bisexual women are all but invisible in the generic literatures on pregnancy and pregnancy loss (Peel and Cain, 2008). The ‘heterosexist monopoly of reproduction’ is invidiously pervasive (Trettin et al., 2006; Wojnar and Swanson, 2006: 5). As Cosgrove (2004) emphasizes in her critique of the pregnancy loss literature:

Assumptions about compulsory heterosexuality inform research agendas and conclusions. Despite awareness that technological advances have allowed many women to get pregnant who previously would not have been able to, the voices of single or lesbian mothers and nontraditional couples are nowhere to be found in the research literature … [this] must be addressed so that ‘women’s responses’ to pregnancy loss are not conflated with ‘married heterosexual women’s responses to pregnancy loss. (pp. 113–114)

The only empirical study, to date, that has specifically focused on lesbians’ experiences is a small-scale qualitative study based on interviews with 10 white USA lesbian couples (Wojnar, 2007). The participants had all experienced miscarriage as a couple within the previous 2 years; five couples had used identified sperm donors and five had used anonymously donated sperm. Gestational age at miscarriage ranged from 1 to 20 weeks and conception had taken from 1 to 5 years. A central theme of ‘we are not in control’ was identified in these women’s accounts, alongside ‘we work so hard to get a baby’ and ‘it hurts so bad: the sorrow of miscarriage’. Wojnar found that birth (biological) mothers typically grieved their loss openly whereas social (non-biological) mothers kept their sadness more private and felt that they needed to be strong for their partners. She concluded that:

In contrast with heterosexuals whose unintended pregnancy rates linger at about 50%, lesbian pregnancies are generally planned and wanted . . . regardless of how long it took couples to conceive, the ‘typical’ stressful process of becoming pregnant for lesbians was similar to the ‘atypical’ experience of the subset of heterosexual women who experience infertility . . . Because the stakes of pregnancy were extremely high for these lesbian couples, their experience of pregnancy was a time of intense joy and preparations for upcoming motherhood. In contrast to the conclusions of other investigators that the bonding process during pregnancy may take from weeks to months, all birth mothers in this study developed an emotional bond with their unborn child quite early in the pregnancy (p. 483)

In order to develop the limited literature in this area, the current study aimed to: (i) find out how birth mothers and social mothers experience pregnancy loss; and (ii) gain lesbians’ and bisexual women’s views about health care provision, attitudes and behaviour of health professionals and support provided by health professionals.

Materials and Methods

Study design

An online survey methodology was chosen in order to maximize the geographical spread of respondents, speed of data collection and anonymity of participants (Harding and Peel, 2007; Peel, 2009) and because online methods are well utilized with lesbian, gay, bisexual and trans (LGBT) populations (Ellis et al., 2003). The survey was designed using SurveyMonkey.com and contained six sections: demographic information; conception and pregnancy; experience of pregnancy loss; health professionals; sources of support and; after your loss(es). The questions were developed based on key issues in the academic and lay literatures and experiential knowledge. Questions included: ‘How did you conceive?’, ‘During your/your partner’s pregnancy, how did you feel?’, ‘What, if any, preparations did you make for the baby?’, ‘How did you first realize that you were likely to lose your baby/ies/fetus(uses)/embryo(ies)?’ and ‘Please tell the story of how you lost your baby(ies)/fetus(es)/embryo(s)?’ Write as much or as little as you wish. For example, you could include how, where and when the loss(es) happened; how you felt at the time and afterwards; what health professionals said and did; how/when you told others of your loss(es). It was stated in the introductory information that the study’s focus excluded heterosexual women and fathers. It also stated that ‘you will remain anonymous and any identifiable information you provide will be changed. Information you provide will be held on Survey Monkey’s server, however, Survey Monkey guarantee that the data will be kept private and confidential’. The researcher’s contact information was provided for respondents to ask any questions about the study before deciding whether to take part, and information about further sources of support and information were provided. Respondents were free to exit the survey...
at any point without giving reason and a response was not mandatory for most questions. Respondents were asked to provide a unique identifier at the start of the survey so, if they wished, they could contact the researcher to withdraw their data retrospectively. No respondents chose to withdraw their data. British Psychology Society ethical guidelines were adhered to and Aston University Ethics Committee granted ethical approval. The survey was piloted and refined before going live.

Recruitment and data collection
Respondents were recruited using strategic opportunistic sampling. Twelve recruitment emails were sent to LGBT email lists, e-newsletters and personal contacts (e.g. Diva magazine, Pink Therapy newsletter, University and Colleges Union LGBT email list, Psychology of Women Section listserv, Lesbian and Gay Psychology listserv, British Sociological Association Human Reproduction Study Group, American Anthropological Association Council on the Anthropology of Reproduction). The study was also published through community organization websites in the UK, USA and Canada. Invitations to assist with recruitment were also sent to mainstream miscarriage, stillbirth and neonatal death organizations, but these organizations declined to publicize the study. Data were collected between November 2008 and March 2009, with the majority of responses (40) occurring within the first 2 weeks of the study being publicized.

Respondents
The 60 women who responded to the survey came from four countries: the UK (43.3%, 26), the USA (28.3%, 17), Canada (18.3%, 11) and Australia (10.0%, 6). Of the respondents, 39 (65%) fully completed the survey. All respondents are included in the analysis because answering most questions was optional, and valuable qualitative data were gained from incomplete surveys: numbers do not necessarily add to 60 because some respondents did not answer all questions and some provided multiple responses (if, for example, they had experienced multiple losses or could choose a number of responses to a fixed choice question). The majority defined their sexuality as lesbian (76.6%, 46); the remainder as bisexual (15.0%, 9) or ‘other’ (8.3%, 5). The mean age of respondents was 35 years (range 22–55 years). Most respondents identified as white (92%, 55), middle class (78%, 47) and as not having a disability (95%, 57). Just over half the respondents had children (55%, 33) whose mean age was 3.5 years (range 4 days–17 years). The majority (82%, 49) were in relationships with women [45% (22) of which were legally recognized] 8% (5) were single, 5% (3) were in polyamorous relationships, 3% (2) were married to men and one respondent was in a relationship with a trans man. Most were in the same relationship context when they experienced pregnancy loss (90%, 54).

In terms of the ‘type’ of loss respondents experienced, as would be expected, the majority were early miscarriages (up to 13 weeks, 76%, 32); some of which were biochemical pregnancy losses (i.e. initial positive pregnancy test result, but HCG levels do not rise at the appropriate rate and a gestational sac is not visible during ultrasound). Others experienced late miscarriage (14–24 weeks, 12%, 5), stillbirth (24 weeks+, 10%, 4) or neonatal death of their baby (5%, 2). One respondent reported experiencing an ectopic pregnancy; and another respondent reported a blighted ovum. Most respondents (78%, 47) had physically experienced their loss(es) (i.e. carried the pregnancy), but 13 (22%) respondents had experienced loss as the social mother (i.e. the partner of the women who carried the pregnancy). The majority had experienced one loss (67%, 40), although 27% (16) had experienced two losses, 5% (3) had experienced three losses and one respondent had experienced four or more losses. The majority had experienced loss during their first pregnancy (58%, 35) and had lost their pregnancy recently: 45% (27) in 2008/2009 and 38% (23) within the previous 5 years.

Analysis
Survey Monkey collated the descriptive data from the fixed choice questions and thematic analysis was used to analyse the open-ended qualitative responses (Braun and Clarke, 2006). The closed (fixed choice) questions were in various formats, including: Likert rating scales (outstanding–extremely poor); ‘yes’/’no’ questions; and selecting from a range of options. For example, ‘early miscarriage (up to 13 weeks)’, ‘late miscarriage (14–24 weeks)’, ‘stillbirth 24 weeks+’, ‘neonatal death (up to 4 weeks after birth)’ were the options available for the question ‘what type of pregnancy loss(es) did you experience?’. The closed questions were analysed using descriptive statistics. This analysis takes a critical realist epistemological standpoint, treating respondents’ accounts as indicative of their lived ‘reality’ although recognizing that the meanings attached to experiences are mediated by socio-cultural contexts (Willig, 1999). Responses to the qualitative questions were repeatedly, and systematically, read by the author and organized into the most prevalent themes (Braun and Clarke, 2006); processes and practices for conception; amplification of loss; and health care and heterosexism. In the following analysis, quotes are tagged with respondent number and country of residence. Data extracts have been edited to remove typographical errors.

Results
Processes and practices for conception
The majority of respondents (84%, 36) reported conceiving using donated sperm: 42% (18) used ‘anonymous donor insemination at a clinic’, 28% (12) used ‘known donor insemination not at a clinic’, 7% (3) used IVF with anonymously donated sperm and one experienced IUI with identified donated sperm. Of the remainder, 14% (6) conceived ‘through sexual intercourse with a male partner’ and one conceived ‘through sexual intercourse with a man who was not your partner’. These respondents used many different resources to help plan conception—on average 2.8 different resources each (Table I). In addition to those most commonly reported ‘ferring’ (i.e. examining saliva or cervical mucus under a microscope, 7%, 3), cycle monitoring at a clinic (7%, 3), fertility hormones (e.g. HCG trigger, clomid, 7%, 3), lesbian parenting group (2%, 1) and position and texture of cervix (2%, 1) were also used to facilitate conception. Four women did not indicate using resources to plan conception: all these women conceived through heterosex. Only one pregnancy

<table>
<thead>
<tr>
<th>Table I</th>
<th>Resources used to help plan conception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovulation tests</td>
<td>61% (26)</td>
</tr>
<tr>
<td>Lesbian parenting books/information</td>
<td>49% (21)</td>
</tr>
<tr>
<td>Calculating cycle length and likely fertile ‘window’</td>
<td>49% (21)</td>
</tr>
<tr>
<td>Fertile mucus</td>
<td>40% (17)</td>
</tr>
<tr>
<td>Basal body temperature charting</td>
<td>28% (12)</td>
</tr>
<tr>
<td>Blood tests at clinic</td>
<td>14% (6)</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>12% (5)</td>
</tr>
<tr>
<td>None</td>
<td>9% (4)</td>
</tr>
</tbody>
</table>
was explicitly tied to their desire and endeavors to get pregnant, as
process’ (R53, UK), and the significance of their experience of loss
investment in achieving pregnancy was evident in these women’s
difficulties conceiving’ (p. 480). Similarly, a high degree of effort and
effort and lesbians’ experience of miscarrying without understanding their
highlighted that ‘the experiences of miscarriage and conception
of which was miscarriage or multiple miscarriage (42%, 18) and toys (33%, 14). Some undertook more major prep-
the case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
ing perinatal loss involve heightened anxiety relative to first pregnan-
cancer, and the emotional and material investment these women
made in impending motherhood, the experience of loss is amplified
issues that may enhance non-heterosexual women’s concern. In the
case of those respondents who were describing emotions about a
pregnancy after prior loss, evidence suggests that ‘pregnancies follow-
...
women were in a medical setting (hospital, doctor’s office, clinic). Indeed, 60% (25) of these respondents indicated they were involved in the pregnancy loss for the health professionals. Health care and heterosexism can exacerbate the emotional impact of loss, with some respondents describing feelings of ‘emptiness’ (64.3%, 27) and ‘numbness’ (35.7%, 15). Other emotions reported included ‘disbelief’ (57.1%, 24), ‘emptiness’ (64.3%, 27), and ‘disbelief’ (57.1%, 24). The experiences of heterosexism in respondents’ accounts ranged from the ‘mundane’ (Peel, 2001) or diffuse (e.g., ‘my partner was asked to leave during several exams, and was not allowed to answer questions regarding the autopsy or funeral arrangements after stillbirth’, R46, USA) to the extreme (e.g., ‘the assumption that I am straight and advice that seems patronizing’, R60, USA) or ‘heterosexism being ‘pretty much ignored’ (R1, UK) or likewise treated problematically (R41, UK) and same-sex partners were ‘more cautious’ (R33). For example:

We were very excited going for an ultrasound at our obstetrician’s office - so far the pregnancy seemed to be going well - I was having symptoms but none of them were too extreme. My wife Emma was a medical student so she was a little more cautious than me knowing that many things can go wrong this early in a pregnancy - I really expected any kind of pregnancy loss to be symptomatic and since I hadn’t had any cramping or bleeding at all I didn’t expect there to be any problems … Emma started crying and I just felt really numb. (R33, USA)

Another respondent recounted two losses revealed through sonogram:

I went for a 12 week scan with my partner. When they did the ultrasound they couldn’t find the heartbeat … There was a horrible disjunction between what I’d been expecting to see on the scan (12 week fetus, humanlike) and what was there (7 week blob, no arms/legs/head) … I felt really numb … I was absolutely devastated this [second] time - it was just past the due date for the first pregnancy. And also I had been much more confident about this pregnancy. So it was enormously, terribly distressing to have that happen again. (R19, UK)

Numbness, shock, distress and devastation were the overriding emotions conveyed by those respondents who had their loss revealed to them in this way: ‘it was a total shock. We were devastated’ (R27, USA). Moreover, the medical technologies aroused strong emotions in some respondents: ‘I get very angry that people see this [ultrasound] as an opportunity to put the first photo in the album not as a serious medical procedure with potentially disastrous news’ (R4, UK). The experience of pregnancy loss has changed me (64.1, 25). Indeed, 60% (25) of these respondents indicated they were involved in the pregnancy loss for the health professionals. Health care and heterosexism can exacerbate the emotional impact of loss, with some respondents describing feelings of ‘emptiness’ (64.3%, 27) and ‘numbness’ (35.7%, 15). Other emotions reported included ‘disbelief’ (57.1%, 24), ‘emptiness’ (64.3%, 27), and ‘disbelief’ (57.1%, 24). The experiences of heterosexism in respondents’ accounts ranged from the ‘mundane’ (Peel, 2001) or diffuse (e.g., ‘my partner was asked to leave during several exams, and was not allowed to answer questions regarding the autopsy or funeral arrangements after stillbirth’, R46, USA) to the extreme (e.g., ‘my partner was asked to leave during several exams, and was not allowed to answer questions regarding the autopsy or funeral arrangements after stillbirth’, R46, USA). There were two key issues in these accounts: ‘the heterosexism of the clinic structures and approach’ (R41, UK) and same-sex partners being ‘pretty much ignored’ (R1, UK) or likewise treated problematically. The first issue is exemplified in R60’s comment that: ‘the intake

### Table III Reactions to loss

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Percentage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>83.3% (35)</td>
<td></td>
</tr>
<tr>
<td>Grief</td>
<td>81.0% (34)</td>
<td></td>
</tr>
<tr>
<td>Tears/criing</td>
<td>73.8% (31)</td>
<td></td>
</tr>
<tr>
<td>Shock</td>
<td>66.7% (28)</td>
<td></td>
</tr>
<tr>
<td>Emptiness</td>
<td>64.3% (27)</td>
<td></td>
</tr>
<tr>
<td>Disbelief</td>
<td>57.1% (24)</td>
<td></td>
</tr>
<tr>
<td>Felt out of control</td>
<td>38.1% (16)</td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td>35.7% (15)</td>
<td></td>
</tr>
<tr>
<td>Numbness</td>
<td>35.7% (15)</td>
<td></td>
</tr>
<tr>
<td>Worry</td>
<td>33.3% (14)</td>
<td></td>
</tr>
<tr>
<td>Loneliness</td>
<td>28.6% (12)</td>
<td></td>
</tr>
<tr>
<td>Nervousness</td>
<td>19.0% (8)</td>
<td></td>
</tr>
<tr>
<td>Uncertainty</td>
<td>9.5% (4)</td>
<td></td>
</tr>
<tr>
<td>Relief</td>
<td>7.1% (3)</td>
<td></td>
</tr>
<tr>
<td>Ambivalence</td>
<td>2.4% (1)</td>
<td></td>
</tr>
</tbody>
</table>

*Responses to the question ‘have you recovered emotionally from the loss(es)?’.

### Table IV Emotional Recovery from Loss(es)*

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The experience of pregnancy loss has changed me</td>
<td>64.1% (25)</td>
<td></td>
</tr>
<tr>
<td>I will always grieve the loss of my baby</td>
<td>33.3% (13)</td>
<td></td>
</tr>
<tr>
<td>I doubt I’ll ever ‘get over’ the loss</td>
<td>30.8% (12)</td>
<td></td>
</tr>
<tr>
<td>No, I haven’t</td>
<td>23.1% (9)</td>
<td></td>
</tr>
<tr>
<td>When I/we conceived again</td>
<td>17.9% (7)</td>
<td></td>
</tr>
<tr>
<td>After a month or two</td>
<td>7.7% (3)</td>
<td></td>
</tr>
<tr>
<td>I recovered from the experience very quickly</td>
<td>7.7% (3)</td>
<td></td>
</tr>
<tr>
<td>After a year</td>
<td>2.6% (1)</td>
<td></td>
</tr>
</tbody>
</table>

*Responses to the question ‘have you recovered emotionally from the loss(es)?’.
forms at our clinic were extremely heterosexist, even though they have many lesbian clients and advertise that they accept lesbian clients. It seems like such a little thing to change!’ (R60, Canada).

The second issue of respondents’ partners or relationships being dealt with problematically was manifest in various ways, including ‘confusion’ (R8), exclusion and lack of acknowledgement of the social/non-birth mother’s ‘distress’ (R45).

...Some health professionals seemed unable to understand my partner’s distress at losing her child … I don’t think they understood what it meant for my partner, that she was a parent and she had lost her baby too. (R45, UK).

The experience, or expectation, of heterosexism was also apparent in the relief and gratitude (‘a huge blessing’) expressed in respondents’ accounts when they were treated appropriately: ‘the doctors and nurses were great—no homophobia, no problem at all with us. They automatically gave my girlfriend the consent form to sign (or whatever it was—I don’t know)—they just treated her as my partner, no questions or issues which was a huge blessing in those circumstances’ (R41, UK). Despite the reported high levels of satisfaction with health care, respondents’ wanted health professionals to ‘realize how hard getting pregnant is for any lesbian and then especially for someone who has dealt with infertility (R30, USA); and ‘get some training in how to deal with people and understanding about how devastating pregnancy loss is’ (R18, UK).

**Discussion**

This study has highlighted three themes in non-heterosexual women’s experiences of pregnancy loss, namely ‘processes and practices for conception’, ‘amplification of loss’ and ‘health care and heterosexism’. General population statistics indicate that around 50% of pregnancies are unintended (Finer and Henshaw, 2006; Keith et al., 2006), whereas 98.3% (59) of the pregnancies in this study were intended and planned. Although ‘preconception care is recognized as a critical component of health care for women of reproductive age’ (Johnson et al., 2006), research suggests that (assumed-to-be heterosexual) women tend not to undertake preconception health care (Holing et al., 1998; Mathews et al., 1998; Keith et al., 2006; Parrott et al., 2009).

In contrast, the non-heterosexual women in this study reported engaging in preconception planning and health care behaviours. Of the respondents, 74% took folic acid before conception compared with rates of 31.5% (Mathews et al., 1998) and 47% (Parrott et al., 2009) reported in the literature on heterosexual women, and 90.7% used various resources to plan conception. In line with previous research (Wojnar, 2007), the findings indicated that the resources (psychological, interpersonal and material) invested in achieving pregnancy shaped, and indeed amplified, the subsequent loss. It is well established that the grief caused by pregnancy loss is not linked to gestational age of the pregnancy (Swanson et al., 2007). For the women in this study, however, the intensity and significance of the loss was evident even in biochemical pregnancy losses experienced just days after a positive home pregnancy test.

Although this was not a comparative study, previous research has highlighted that the desire and motivation for lesbian parents to have children is much stronger than for fertile heterosexual parents (Bos et al., 2003). Bos et al.’s (2003) comparative study of 100 lesbian two-mother families and 100 heterosexual families with no history of fertility problems did, however, draw parallels between the experiences of lesbian and infertile heterosexual couples: ‘lesbian couples, like infertile heterosexual couples, have to go through a long and difficult process before they finally have a child’ (p. 2222). Future comparative research could examine the pregnancy loss experiences of same-sex couples and different-sex couples with a history of infertility. A strength of this study is that it significantly extends current knowledge of non-heterosexual women’s experiences of pregnancy loss, and does so across a number of different (Western) countries. A limitation was that the inflexibility of the methodology did not allow the specificities of women’s experiences to be probed further, and in-depth; semi-structured interviews could be utilized in future research.

**Implications for policy and practice**

The findings of this study suggest a number of policy and practical recommendations for improving lesbian and bisexual women’s experience of pregnancy loss. Health professionals should not de facto assume patients are heterosexual, they should demonstrate awareness and sensitivity to women’s relational contexts, and ensure that same-sex partners are acknowledged and actively included. More procedural changes include the alteration of forms in clinics and maternity services so that the gender of partner is neutral rather than male (e.g. ‘Do you have a partner? If so, what is their gender?’). The sexual orientation of patients attending clinics and maternity services could also be routinely collected alongside other demographic characteristics such as age and ethnicity. As non-heterosexual women’s pregnancies are more likely than heterosexual women’s to have involved lengthy planning and resources and be wanted, health professionals should be especially empathetic and supportive, even in the case of early miscarriage or biochemical pregnancy loss. As one respondent commented: ‘for them, it was just another miscarriage. For us, it was the end of the world’ (R8, Australia). Given the medicalization of pregnancy and pregnancy loss, information that ultrasound could reveal a loss should be provided in preparatory materials given to women. This may alleviate some of the ‘shock’ associated with asymptomatic loss. Finally, lesbian couples, single lesbians and other single and coupled non-heterosexual women should be made more visible in both the academic and lay literatures on reproductive health and pregnancy loss, and their experiences should be disaggregated from implicit or explicit ‘married heterosexual women’s responses to pregnancy loss’ (Cosgrove, 2004: 114).

**Acknowledgements**

With thanks to the women who took part in this study and Rosie Harding, Damien Riggs and Ruth Cain.
References


Bos HMW, van Balen F, van den Boom DC. Planned lesbian families: their desire and motivation to have a child. Hum Reprod 2003;18:2216–2224.


Peel E. Online survey research about lesbian and bisexual women’s experiences of pregnancy loss: positives and pitfalls. In: British Psychological Society Division of Health Psychology Conference, 9–11 September, 2009. Aston University, Birmingham, UK.


Submitted on August 12, 2009; resubmitted on November 18, 2009; accepted on November 20, 2009.