

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

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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 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/fetus/embryo?’ 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 publicized 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 chose 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 4.5 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 'ferning' (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 I Resources used to help plan conception

Ovulation tests	61% (26)
Lesbian parenting books/information	49% (21)
Calculating cycle length and likely fertile 'window'	49% (21)
Fertile mucus	40% (17)
Basal body temperature charting	28% (12)
Blood tests at clinic	14% (6)
Ultrasound	12% (5)
None	9% (4)

Table II Lifestyle or behaviour changes before conception

Took a folic acid supplement	74% (32)
Stopped or reduced alcohol consumption	63% (27)
Took general vitamin supplements	60% (26)
Stopped or reduced caffeine consumption (e.g. coffee)	56% (24)
Increased amount of fruit/vegetables in diet	40% (17)
Increased level of physical activity/exercise	30% (13)
Did relaxation exercises or classes	21% (9)
Quit smoking	19% (8)
Lost weight	16% (7)
Decreased level of physical activity/exercise	7% (3)
Gained weight	5% (2)

within these data were unplanned; this respondent 'was a teenager, and got pregnant accidentally' (R14, UK).

Another indicator of the effort these women underwent to achieve pregnancy was the number (mean 4.1) and variety of lifestyle or behaviour changes they reported making before trying to conceive (Table II). For 37% (16) of respondents, the first change made was taking folic acid supplements. As one respondent commented: 'we did about a year of 'preconception planning' before our first insemination' (R27, USA). Others remarked that they 'tracked cycles for 6 months prior to trying to conceive. I went on a diet and exercised to lose weight also 6 months before' (R31, USA), 'stopped eating blue cheese and pre-prepared salads' (R4, UK) or 'ate fish and bacon after being a vegetarian for 20 years' (R45, UK). In addition to relaxation exercises respondents also commented that they had undertaken acupuncture, reflexology, homeopathy and yoga.

The majority (88%, 38) conceived within months of actively trying (mean 9.2 months, range 1 month–10 years) and indicated that the process was 'hard' or 'very hard' (58%, 25). Some, however, did indicate that getting pregnant was 'easy' or 'very easy' (28%, 12). Just over half (58%, 25) reported that they had experienced fertility problems, the most common of which was miscarriage or multiple miscarriage (28%, 7), followed by polycystic ovarian syndrome (24%, 6). Wojnar (2007) highlighted that 'the experiences of miscarriage and conception for lesbian couples were so intertwined that one cannot fully comprehend lesbians' experience of miscarrying without understanding their difficulties conceiving' (p. 480). Similarly, a high degree of effort and investment in achieving pregnancy was evident in these women's stories of conception. For many 'trying to conceive was a long process' (R53, UK), and the significance of their experience of loss was explicitly tied to their desire and endeavors to get pregnant, as illustrated by the account below:

From what I have read and from women who I have talked to, it seems that most women experience miscarriages as traumatic and upsetting. I know that my devastation when we lost our baby was a lot to do with the context - i.e. wanting one for a long time and feeling very powerless in the process. All the time I was wanting to be pregnant, there was no possibility of being pregnant. I couldn't just hope for an 'accident' or 'forget' to take contraceptive pills. I had to be totally proactive in order to even get to the point where a pregnancy might be possible... I often think that when lesbians get as far as getting an appointment with

the GP [family physician] to be referred to a clinic or decide that they are definitely going to try to find a donor, they should get a congratulations card!! It's the equivalent of many heterosexuals giving birth or at least getting pregnant! It's usually the result of years of talking and planning and working out how to do it. (R41, UK)

Another respondent emphasized that: 'it has been a very long and distressing journey of over 8 years, and I look back on it as a time of waiting—waiting for appointments with clinics, waiting to hear the answer from their ethics committee, waiting for a friend to say yes [to donating his sperm], waiting for ovulation, waiting for a period, waiting... ' (R8, Australia).

The most commonly reported emotional reactions to the news that they were pregnant and emotions during the pregnancy were 'excited' (77%, 33), 'thrilled' (74%, 32) and 'happy' (70%, 30). However, 'nervous' (56%, 24) and 'anxious' (56%, 24) were also reported with respect to the news of the pregnancy, and the frequency of the reporting of these emotions increased during the pregnancy ('anxious', 77%, 33; 'nervous', 63%, 27). A number of explanations for the high reported levels of anxiety and nervousness in these data are plausible, not least because of socio-cultural and biographical 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 following perinatal loss involve heightened anxiety relative to first pregnancies' (Geller *et al.*, 2004: 40) and a risk that a subsequent loss may be higher (Cramer and Wise, 2000).

Amplification of loss

Pregnancy loss, in heterosexual women, has been dubbed 'the loss of possibility' (Frost *et al.*, 2007), a loss of 'hopes, and desired future' (Swanson *et al.*, 2007: 2). This resonates in non-heterosexual women's accounts. However, based both on the complex processes, practices and often lengthy time period involved in achieving pregnancy, and the emotional and material investment these women made in impending motherhood, the experience of loss is amplified for lesbian and bisexual women. For instance, 'it was only 12 days but it seemed like we reorganized our lives—we made so many plans, got so excited, felt so happy. It's hard to believe your life, and the way you look at your life, can change so much in just 12 days' (R60, Canada). Only three respondents did not make any preparations for the baby: they experienced early biochemical pregnancy losses. Most read pregnancy books (84%, 38) and bought clothes (42%, 18) and toys (33%, 14). Some undertook more major preparations, such as moving house (19%, 8), changing their car (12%, 5) or organizing a nursery (19%, 8). As Table III shows, most respondents (both women who carried the pregnancy and those who did not) chose the responses 'sadness', 'grief', 'tears/crying', 'shock', 'emptiness' and 'disbelief' in reaction to their loss.

Many respondents signalled the profundity of the experience through statements such as 'utter devastation' (R30, USA), feeling 'suddenly that the world had ended' (R6, UK) and 'hollowed out and dead' (R8, Australia). Most felt that their loss(es) had made a 'significant' or 'very significant' 85% (33) impact on their lives and the majority felt that the experience of loss had changed them (Table IV).

As Table IV indicates, only three respondents reported that they had emotionally recovered from their loss 'very quickly' or 'after a month or two' and some indicated that they would 'always grieve

Table III Reactions to loss

Sadness	83.3% (35)
Grief	81.0% (34)
Tears/crying	73.8% (31)
Shock	66.7% (28)
Emptiness	64.3% (27)
Disbelief	57.1% (24)
Felt out of control	38.1% (16)
Fear	35.7% (15)
Numbness	35.7% (15)
Worry	33.3% (14)
Loneliness	28.6% (12)
Nervousness	19.0% (8)
Uncertainty	9.5% (4)
Relief	7.1% (3)
Ambivalence	2.4% (1)

Table IV Emotional Recovery from Loss(es)*

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

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

the loss' of their baby (Ross, 2005). As respondents highlighted: 'it affected me and my partner hugely and for a long time afterwards' (R41, UK); 'there is a part of it that will stay with me forever, but I don't think it's quite 'grief' maybe sadness is a better term' (R33, USA); and 'I will always feel it but a few months later the deep crisis pain gets a bit easier' (R30, USA). Although the impact of loss for these respondents generally corresponds to findings from the literature on heterosexual women (Geller *et al.*, 2004; Swanson *et al.*, 2007; Brier, 2008), there do appear to be differences (Ross *et al.*, 2007). Reviews of the literature indicate that anxiety symptoms typically continue 'until approximately 4 months after the loss event' (Geller *et al.*, 2004: 42) and that grief reactions are 'significantly less intense by about 6 months' (Brier, 2008: 451). However, for these women, the loss seem to have a longer lasting impact: '[I] started to feel less raw after 18 months, but it'll never completely go away' (R53, UK).

Health care and heterosexism

Health professionals were involved in the pregnancy loss for the majority of respondents (86%, 36). Indeed 60% (25) of these women were in a medical setting (hospital, doctor's office, clinic)

when they realized that they were losing their embryo/fetus/baby. Half of the women (50%, 21) initially found out through ultrasound (36%, 15) or other clinical investigation. Respondents also listed 'spotting' 45% (17), 'cramps' (26%, 11) and 'heavy bleeding' (19%, 8) as signs of impending loss. Sonographic visualization techniques have been critiqued 'for their role in the construction of fetal personhood at the expense of maternal personhood' (Petchesky, 1987; Layne, 2003: 100). Ultrasound plays a role in anxiety about fetal health, even in circumstances when it transpires that the fetus is healthy (Harpel, 2008). Rather than 'fear of the unknown' despite subsequent 'visual evidence of the fetus' health' (Harpel, 2008: 303), these women reported being 'very excited' (R33) and 'confident' (R19) about their scan. They did not anticipate problems ('we had no idea', R27), even if 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 disjuncture 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).

Most respondents (71%, 25) rated the overall standard of care they received from health professionals as 'good', 'very good' or 'outstanding'; and of these, 31% (11) rated overall standard of care as 'outstanding'. Only six (17%) rated their care as 'poor', 'very poor' or 'extremely poor'. Nevertheless, in response to the question 'did you experience any heterosexism, homophobia or prejudice from health professionals?', 26.8% (10) indicated 'yes' and a further 8.6% (3) were 'unsure'. The experiences of heterosexism in respondents' accounts ranged from the 'mundane' (Peel, 2001) or diffuse (e.g. 'the assumption that I am straight and advice that seems patronizing', R27, USA; 'general unfriendliness and lack of eye contact', R41, UK) 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

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).

I recall there being a lot of confusion as to the relationship between me and my partner. They did not seem able/willing to accept our relationship. One doctor even said 'you listen to your mum, now'. Which was blatantly ludicrous given we are the same age and [were] openly behaving intimately. (R8, Australia)

In one hospital, my partner was not allowed into the ultrasound room because she was not legally a family member. It was awful because I was all alone in there with the technician. (R29, USA)

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).

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