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Pregnancy loss: A qualitative exploration of an experience stigmatized in the workplace☆

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ABSTRACT

Pregnancy loss is often stigmatized and is considered to be a taboo topic in the workplace, causing employees to suffer in silence. Yet, pregnancy loss is unequivocally a workplace issue – it can occur at work and influence work outcomes, such as performance, job attitudes, and employee wellbeing. Unfortunately, there is little research examining the intersection between work and pregnancy loss, leaving employers with little evidence-based guidance on how to support employees during and after pregnancy loss. The purpose of this qualitative study of working women ($N = 29$) is to provide insight into the ways by which work influences, and is influenced by, employees' physical and psychological experiences of loss. We utilized a phenomenological approach which revealed 12 themes that were temporal in nature and represented the interconnectedness of work and pregnancy loss. Themes related to the *pre-loss experience* (pregnancy experiences), *loss experience* (healthcare; physical health; psychological health; partner's experiences; loss disclosure; memorialization), *short-term post-loss experience* (work leave; workplace support; stigma), and *long-term post-loss experience* (return-to-work; shifts in perspective and identity). These results revealed that pregnancy loss experiences unfold over extended periods of time and across domains, involving the interaction between work, family, and healthcare systems. Findings are interpreted through the lens of bioecological systems theory and boundary theory, and illustrate the criticality of supportive workplace practices, such as return-to-work accommodations, bereavement support, and leave options, in supporting employee health and work outcomes.

> "It is not only the children that women have that affect their work lives, but also the children that they do not have, that they have desired and lost" (Hazen, 2006, p. 246).

Pregnancy disclosure in the workplace is often met with prejudice and even discrimination due to stereotypes of motherhood and perceptions of blurred boundaries between work and family life (Jones, 2017). Like other women's reproductive health issues (e.g.,

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pregnancy, menstruation, menopause), the subject of pregnancy loss is often considered "*taboo,*" particularly within workplace settings. Further, when employees experience pregnancy or pregnancy loss, they violate professional expectations of the "*ideal worker*," which are based on a masculine model wherein employees should be primarily dedicated to their work (Greenberg et al., 2009). These expectations are challenged when employees' bodily experiences merge with work responsibilities (e.g., Grandey et al., 2020). Pregnancy loss (i.e., loss of a pregnancy at any gestation such as through miscarriage or stillbirth) is a relatively common experience for working people, affecting 25 % of pregnancies (Ventura et al., 2012). Importantly, due to the overturn of Roe v. Wade in the United States in June 2022 (Durkee, 2022), the complex intersection between work and reproductive health is poignant. While many employers have scrambled to introduce policies specific to reproductive healthcare, mere policies are insufficient in protecting women's careers (see Grandey et al., 2020).

Due to the dearth of evidence surrounding employees' experiences of pregnancy loss, we use an inductive qualitative approach to explore the work-related experiences of women who have endured pregnancy loss. Given our inductive approach, the purpose is not to test any theoretical framework, but our methods are informed by theories of human-system interactions (bioecological systems theory; Bronfenbrenner, 1977) and of role transitions (boundary theory; Nippert-Eng, 1996).

The experience of pregnancy loss is complex and influenced by interacting individual and sociocultural factors. According to bioecological systems theory (Bronfenbrenner, 1977), individuals are influenced by a network of ecological subsystems (i.e., microsystems, mesosystems, exosystems, macrosystems, chronosystem). Individual biology is central to this model (e.g., pregnancy loss symptoms). Microsystems are most proximal to individuals and include the settings in which people interact directly (e.g., home, work, healthcare). Interactions between these settings occur within the mesosystem and influence individuals' thoughts, attitudes, and behaviors within and across settings (e.g., amount of work leave taken for pregnancy loss). Individuals are also influenced by events in settings in which they do not actively participate – the exosystem (e.g., legislation changes related to reproductive healthcare). The macrosystem includes the cultural, societal, and general belief systems that affect individuals' perceptions of themselves, others, and their environment. Finally, the chronosystem reflects how relationships among and between the network of systems fluctuate and unfold over time. Experiences are core components of this theory, which acknowledges that it is not merely objective events within an individual's ecological system that influence attitudes and behaviors over time and across settings, but that individuals' perceptions of these events also matter.

Boundary theory (Nippert-Eng, 1996) contends that people must navigate boundaries between domains (e.g., work-and non-work) by segmenting (separating) or integrating (blurring together) roles. Hall and Richter (1988, p. 215) describe permeability of boundaries as "the degree to which a person physically located in one domain may be psychologically or behaviourally concerned with the other" and flexibility as the "extent to which the physical time and location markers, such as working hours, may be changed" by the employee and/or the organization. In pregnancy loss, employees may adopt new roles (e.g., "expectant mother," "grieving mother") in addition to existing roles (e.g., "professional"). Roles (e.g., grieving mother) that involve physical or psychological symptoms of loss and/or recovery may be flexible (not constrained by physical or temporal boundaries) and permeable (may be experienced while engaged in a role in other domains, such as "employee"). Employees may experience high levels of permeability and flexibility if, for example, their grief-related thoughts interfere with work, or if work-related thoughts affect their healthcare decisions. In such scenarios, pregnancy loss is a "boundary violation event," whereby a life domain event affects (and is affected by) the work domain, thereby crossing the boundary between work and life (Hunter et al., 2019). As a stigmatized subject, pregnancy loss lacks norms or scripts for role transitions, often increasing uncertainty and distress (Quick, 2021).

1. Pregnancy in the workplace

Issues surrounding pregnancy and pregnancy loss sometimes overlap (Porschitz & Siler, 2017). Pregnant employees may face stereotypes, such as being perceived as irrational, overly emotional, and less competent, committed, and flexible (Hebl et al., 2007). The intersection of pregnancy and work often involves hardship for employees, including barriers to career advancement (Bernard & Correll, 2015), lower pay (Budig & England, 2001), and discriminatory performance evaluations or hiring practices (Hebl et al., 2007; Jones, 2017). Working women of childbearing age also tend to experience discrimination due to expectations that they may wish to become pregnant (Gloor et al., 2018). As many as 1 in 3 women conceal their pregnancies, do not ask for accommodation, or perform extra work to avoid negative consequences of pregnancy (Little et al., 2018). Due to these challenges, some women do not disclose that they are pregnant.

2. Pregnancy loss in the workplace

In her pioneering work in this area, Hazen (2003) described grief due to pregnancy loss as "*doubly disenfranchised*" - characterized by feelings of shame, guilt, failure, and shrouded by stigma, as well as physical and emotional trauma. She argued that work may contribute to healing or to further disenfranchising the grief experience. Significant to pregnancy loss experiences is "*silencing*" (i.e., quieting the voices of those suffering; Hazen, 2003). Although silence about pregnancy loss may protect employee privacy, it is also associated with depression, social exclusion, and 'career derailment' (Hazen, 2006; Porschitz & Siler, 2017) and may perpetuate the idea that pregnancy loss should be hidden (Brierley-Jones et al., 2014).

Pregnancy loss is also considered an ambiguous loss, or a loss that is difficult to validate, because the baby has not yet been born, is not known to others, and the bond created between parent and unborn baby is not well understood by others (Mcgee et al., 2018). For example, birth or death certificates are not issued for most pregnancy losses, and there are few common death or mourning rituals in Western society for pregnancy loss, which can feel delegitimizing (Brier, 2008). Additionally, collective agreements and benefit plans

are unlikely to extend bereavement leave benefits for pregnancy loss (Gagnon et al., 2014).

3. The current research

The scarce research on pregnancy loss and the workplace has provided little guidance for organizations. In 2021, Meunier et al. found that only 15 studies have addressed the work experiences of parents dealing with pregnancy loss. Of these, eight mentioned the workplace only tangentially, and five workplace-focused papers informed the current study. Four of these studies focused on stillbirth only (i.e., loss after 20 weeks' gestation). No studies used or suggested guiding theory (except for Goffman's theory of stigmatization, Goffman, 1963; see Brierley-Jones et al., 2014), limiting the theoretical implications of the work. It is unknown how workplace support or organizational policies related to pregnancy loss may influence employees' health and wellbeing or work attitudes and behaviors (Brier, 2008; Hazen, 2006; Meunier et al., 2021).

This study is guided by bioecological systems and boundary theories, but still takes an inductive, qualitative approach toward understanding pregnancy loss in the workplace. This approach aligns with Gagnon and Beaudry's (2013) argument that the complexity of these subjective experiences is best examined using qualitative methodology, wherein the viewpoint of the participant, rather than validating theory, is central. We operationalize pregnancy loss as the ending of a pregnancy at any gestation. Our research question asks: What are the intersections between work and non-work systems, including biological (i.e., physical, psychological) and social experiences, related to pregnancy loss experiences among working women?

4. Method

We used an interpretive phenomenological approach from a constructivist lens to identify elements constituting the nature of pregnancy loss and work experiences (Creswell & Poth, 2016). This method uses a double hermeneutic approach, wherein participants are asked to reconstruct and describe their lived experiences, and then researchers interpret their descriptions by examining underlying structures in the data whilst engaging in reflective analysis (Horrigan-Kelly et al., 2016; Moustakas, 1994; Smith & Osborn, 2003). Researchers using this approach attempt to set aside scientific preconceptions, such as hypotheses, and their own personal biases or assumptions, to instead focus on participants' "lived world" (Wertz, 2005, p. 169). As individuals' experiences are inseparable from, and intersect with, social contexts (in this study, the workplace as a social context is central; Heidegger, 1962), contextual information is gathered and considered in interpretation. Phenomenological research is appropriate when peoples' lived experiences could inform changes to practices or policies and develop a better understanding of the phenomenon (Lopez & Willis, 2004).

4.1. Role of the researchers

Interpretive phenomenology assumes that the researcher's first-hand and prior knowledge with the phenomenon may guide the researcher to consider a topic worth exploring and such experience can be useful to, but also influence, interpretation of data (Koch, 1995; Lopez & Willis, 2004). In this study, the first two authors experienced pregnancy loss, which guided this line of inquiry and, we believe, led to a deeper understanding of participants' experiences, which is critical to interpretative engagement (Eatough & Smith, 2017). While we expected to see some similarities across experiences, we also expected some experiences to differ from our own, and priority was given to participants' accounts rather than to our own experiences in our interpretations. Various methods were used to enhance trustworthiness and to limit the effects of researchers' preconceived biases within the research process, including fairness (i.e., capturing and honouring multiple constructions of the pregnancy loss experience), triangulation (i.e., participants had differing experiences from the researchers), dependability (i.e., following a systematic process of data collection and analysis), and dialogue between and among researchers to develop self-awareness about assumptions and biases and consider alternate interpretations (see Creswell & Poth, 2018; Lincoln & Guba, 1985; Morrow, 2005; Rennie, 2004). The lead author conducted all interviews, but coding, data analyses, and interpretations were conducted by all authors. The lead author engaged in reflexivity throughout the study via reflective field notes and dialogue with co-researchers. Participants were not informed of the interviewer's pregnancy loss so that they would not compare experiences and so that the conversation would remain focused on the participants' experience. For the sake of transparency, we share details about the researchers here that may have affected our interpretations of the data. All researchers were White, of middle class social status, within the ages of 22–36, one identifies as a man and the others as women. The first three authors hold PhDs, the third a master's degree, and the last an undergraduate degree. The first four authors received graduate level training in qualitative methods and the first two have published qualitative papers [citations removed for blind review]. The last two authors received training and were assigned readings by the other authors on interpretive phenomenology approaches and methods.

4.2. Participants

Participants were all women-identifying Canadians ($N = 29$), aged 26 to 49 ($M = 36.45$, $SD = 5.09$), who had experienced pregnancy loss and subsequently returned to full-time work within 5 years of this study. Most participants ($n = 28$) identified as White and one as mixed ethnicity; 28 were married or common law at the time of their loss, while one was single. Participants held bachelor's ($n = 13$), professional ($n = 3$), community college ($n = 4$) or graduate degrees ($n = 9$). Participants had one to six pregnancy losses ($M = 1.8$, $SD = 1.19$) and zero to three live births ($M = 0.93$, $SD = 0.91$). Most ($n = 54$) reported losses occurred before 20 weeks' gestation and 10 occurred after 20 weeks' gestation. One participant experienced loss due to termination for medical reasons. On average, organizational tenure was 4.25 years ($SD = 3.10$), ranging from two months to 10 years and 17 worked in large organizations (i.e., >

Table 1
Codes according to theme.

Theme	Theme Description	Subtheme	Prevalence[a]
Pregnancy Experiences	Participants' descriptions of their pregnancy experience, including medical complications, anxieties, and the nature of the pregnancy (i.e., if it was planned or not) and decisions to disclose their pregnancy at work are captured under this theme.	Experiences and challenges associated with pregnancy and becoming pregnant	Typical
		Motivation and decisions regarding disclosure of pregnancy at work	Typical
		Leader, coworkers, and organizational reactions and support following pregnancy disclosure	Variant
Healthcare	Participants' experiences within the healthcare system including interactions with doctors, nurses, and support services and medical interventions and recovery are included in this theme.	Systemic failures surrounding ambiguity, stress, and trauma due to medical care (access, diagnosis, and treatment)	Variant
		Physical, cognitive, and emotional experiences receiving medical confirmation of loss	Typical
		Post-confirmation medical care decisions and their relationship with work	Typical
Physical Health	Participants' physical experience of loss during and immediately following the loss of pregnancy is captured within this theme. Long-term health implications have been excluded.	Physical experience of pregnancy loss, including symptoms and setting	Typical
		Physical pain and ability/inability to work while losing the pregnancy	Variant
Psychological Health	Participants' emotional and psychological response to pregnancy loss is included under this theme both immediately following a loss and during the return-to-work period.	Sensemaking and explanation seeking, including blame (of self, body, work) and social comparison	Variant
		Triggers and experiences of grief in the workplace, including emotional labor and feelings of inefficacy	Typical
		Symptoms and manifestations of grief specific to pregnancy loss including negative emotions, ambiguity, disenfranchisement, and change in parental identity	Typical
Pregnancy Loss Disclosure	Participants' decisions to inform employers or coworkers about their loss are captured under this theme. Some participants did not disclose either their pregnancy, loss, or both; such cases are included here.	Normative influences of pregnancy disclosure, resulting in simultaneous disclosure of pregnancy and pregnancy loss at work	Variant
		Disclosure target (manager, coworker, HR) and actions taken to disclose the pregnancy loss	Variant
		Motivation and purpose to disclose/not to disclose the loss to work members (managers, coworkers, HR, clients/ customers)	Typical
Memorialization	Participants' grief, remembrance, triggers, and experiences with family following pregnancy loss have been included in this theme.	Methods of memorialization and emotional processing activities	Variant
		Normative influences and ambiguity surrounding the memorialization of pregnancy loss	Variant
		Sharing in the loss experience with, and receiving support from, non-work others	Variant
Partners' Experience	Participants' partners' experiences inextricably impact participants. Mentions of partners' experiences, particularly comparisons between partner's workplace responses and one's own as well as partner's grief are included in this theme.	Partner's emotional and behavioral responses to the loss (symptoms of grief, providing care to gestational partner)	Variant
		Partner's work experiences following loss (loss disclosure, support at work, leave from work) and crossover from partner's work experience	Variant
Work Leave	Participants' work leave, the type, duration, and influences on the leave.	Work leave policies, options/types, and duration	Typical
		Workplace barriers to taking leave from work (nonexistent or inadequate resources, poor manager support, stigma)	Typical
		Feelings (guilt, disappointment, shame, regret, pressure, fear) associated with leave-related decisions, experiences, and professional consequences	Variant
Workplace Support	Participants' mentions of workplace support are included under this theme. Participants recount their experiences receiving (or not) support, how it was perceived, and how it impacted participants. Codes for support include both instances where support was present and those where support was absent.	Clear communication, and provision of organizational resources (i.e., leave options, work accommodation, EAP, or counseling).	Typical
		Demoralizing, disenfranchising, and unsupportive workplace culture, experiences, and exchanges with others at work	Typical
		Workplace emotional support characterized by empathy, compassion, validation, positive relationships, and positive environments at work	General
Stigma	Participants' experiences of or fears associated with stigmatization including discrimination and inappropriate workplace behavior have been included under this theme.	Perceived vulnerability to stereotypes and others' perceptions and judgments at work	Typical
		Discrimination experiences (actual and feared) around pregnancy and loss, and its influences on disclosure and resource utilization at work	Variant
		Societal norms, opinions, and misconceptions around motherhood, grief, and pregnancy loss	Typical
Return-to-Work	Participants' experiences returning to work following loss leave are amalgamated under this theme.	Procedures and logistics of return-to-work planning, including work accommodations	Variant
		Readiness to return to work and feelings of professional efficacy/inefficacy	Typical

(*continued on next page*)

Table 1 (*continued*)

Theme	Theme Description	Subtheme	Prevalence[a]
		Psychosocial benefits and motivations associated with return-to-work and working	Typical
Shifts in Perspective and Identity	Participants described changing priorities, identities, or general perspectives following loss. These descriptions have been organized using this theme.	Health-related changes	Variant
		Changes in professional identity, priorities, career trajectories, and preferred job roles	Typical
		Changes in life perspectives and personal identity	Typical

[a] Prevalence: General (represented across all 29 cases), typical (represented in half to all of cases) and variant (represented by two to half of all cases) according to Hill and Knox's recommendations (2021).

500 employees), 8 in medium-sized organizations (i.e., 100–499 employees), and 3 in small businesses (i.e., < 99 employees). Participants took 0–85 days of work leave after loss, ($M = 22.08$ days, $SD = 28.42$) which was most often sick leave ($n = 21$), but was sometimes maternity leave ($n = 5$), short-term disability ($n = 4$), bereavement leave ($n = 3$), personal days ($n = 3$), or other time off ($n = 6$). Five women took no time off. Industries represented included business and administration ($n = 16$), healthcare ($n = 4$), education ($n = 3$), law ($n = 2$), or sales, social services, engineering, and non-profit ($n = 5$). Fifteen participants had an element of formal leadership in their jobs.

4.3. Procedure

Ethical clearance was granted by all the authors' institutions. Participants were recruited using convenience and snowball sampling, including the use of personal contacts, social media posts, and web-based and radio media exposure. Participants received a $25 (Canadian Dollars) gift card for their participation. At the end of the study, participants were referred to various mental health resources (e.g., employee assistance plans, clergy, publicly available services), both verbally and in a feedback form that they kept for their records, in case interviews evoked distress. They were also invited to reach out to the first author at any time following the interview if they needed help due to emotional distress. If ever participants experienced distress during the interview, they were offered a break or to finish the interview another time and reminded that they could skip any questions or stop the interview if needed.

McCracken's (1988) four-part method of inquiry was used to develop a semi-structured set of focused, open-ended questions and prompts. Based on this method, interviews began with two "*grand tour*" questions (i.e., general information about their job and their loss) followed by neutral, open-ended questions designed to address specific question categories. Question categories were identified based on literature review, the researchers' own experiences with pregnancy loss and work, and bioecological systems and boundary theories (i.e., asking about microsettings of the loss and work, meso-level intersections of these, *exo*- and macro-level policy questions, and more general questions allowing responses pertaining to broader spheres). Categories included workplace pregnancy loss disclosure, work leave, workplace support and accommodation(s), and work-related or personal change after loss (see Appendix A for interview questions). Sixty-minute phone or web-based interviews were conducted, transcripts were prepared, and participant identifying information was removed.

4.4. Data analysis

Transcripts were analyzed using an iterative coding process involving four of the study authors using Atlas.ti Web (Version 4.7.1;2022), a collaborative qualitative data analysis tool. In this program, all transcripts are accessible to coders and the codebook is updated in real time throughout the coding process. The first transcript was analyzed by all coders who, together as a group, developed and manually applied codes as we noticed "transitions in meaning" throughout the transcripts (Giorgi, 1979, p. 83). This process resulted in an initial codebook. Automatic coding functions were not used. Then, coders analyzed subsets of transcripts independently and new codes were added inductively to the codebook as they were identified within the data by tagging meaningful units of information with a descriptive name (code), resulting in 100 codes or subthemes (Miles et al., 2014). Ideas that were not new were tagged with existing codes. Coders met regularly throughout the process to refine codes and homogenize coding practices, which sometimes involved renaming, merging, or splitting codes to reduce redundancy and effectively represent the content. Finally, each researcher reviewed a subset of one another's coded transcripts, followed by further discussions about approach, further codebook refinement, and recoding of transcripts based on the final codebook. After this iterative process, the coders reviewed a subset of one another's coded transcripts and took note of cases where they disagreed with the original coder's analysis. Based on this process, coders together informally estimated their level of agreement to be approximately 85 %. The final subthemes were uploaded onto a digital workspace, where similar codes were grouped together into themes by all coders as a team. Any disagreements were resolved in group discussions. This process resulted in 12 themes (Miles et al., 2014). Table 1 provides a map of themes and their respective subthemes, including their prevalence in the data, represented as general (emerged in all cases), typical (emerged in over half of cases), or variant (emerged in two to half of all cases; see Hill & Knox, 2021). This information gives a sense of the degree of convergence and divergence of experiences in our sample, a critical element of interpretive phenomenology (Eatough & Smith, 2017).

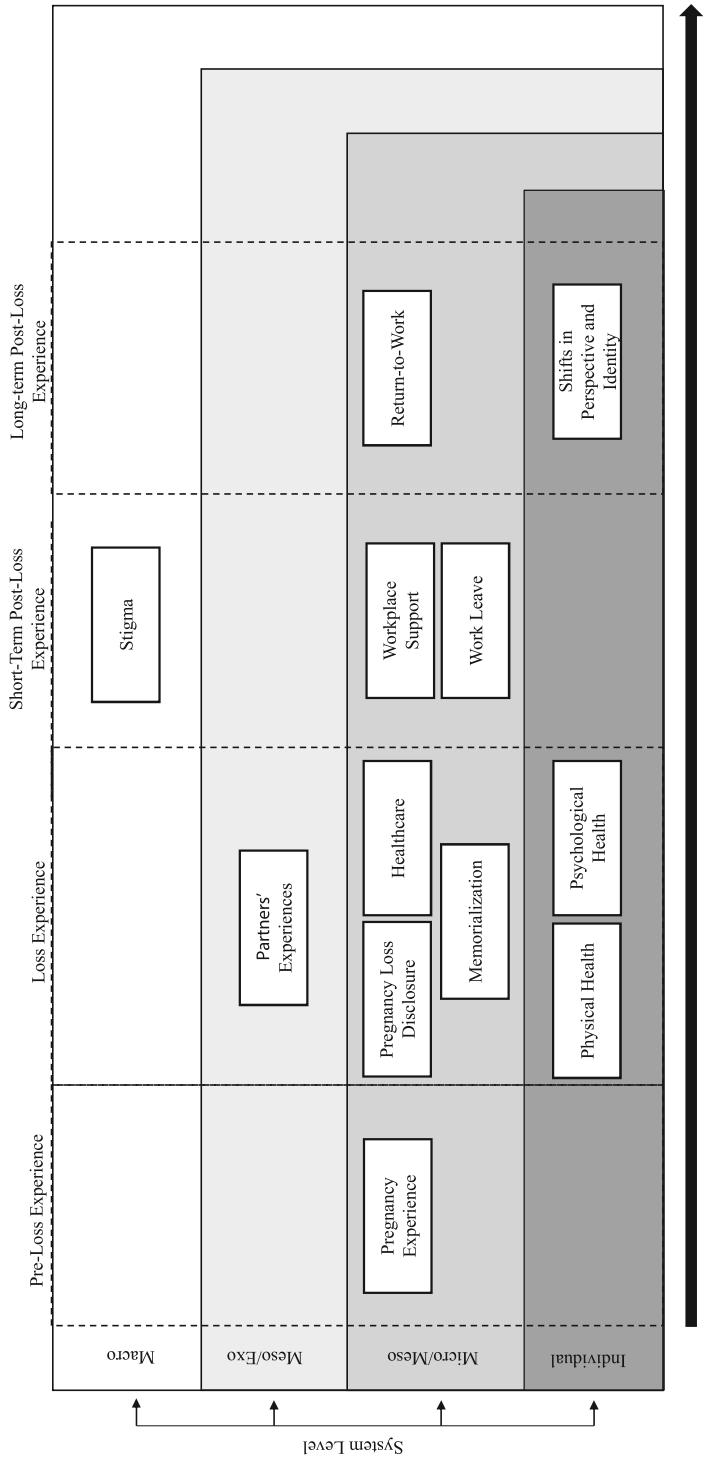

Fig. 1. Model of Pregnancy Loss Themes. This figure displays themes according to when they occur within the pregnancy loss timeline.

5. Results

Twelve themes were developed from the data representing critical elements of the pregnancy loss experience for working women. Many themes were experienced across work and non-work domains, and were temporal in nature. Fig. 1 depicts the themes, their temporal orientation, and bioecological systems level. *Pre-loss experiences* were characterized by (a) pregnancy. *Loss experience* themes related to (b) healthcare, (c) physical health, (d) psychological health, (e) pregnancy loss disclosure, (f) memorialization, and (g) partners' experiences. *Short-term post-loss* themes were: (h) work leave, (i) workplace support, and (j) stigma. The long-term *post-loss* stage was developed as two themes: (k) return-to-work, and (l) shifts in perspective and identity.

5.1. Pre-loss experience

5.1.1. Theme #1: pregnancy experiences

Pregnancy experiences preceded and influenced pregnancy loss experiences. Within this theme, three subthemes reflected the nature of the pregnancy experience. First, *participants' experiences and challenges associated with pregnancy and becoming pregnant* involve the process of trying to conceive, their reactions to (e.g., shock, excitement, happiness) to becoming pregnant, working while pregnant, or pregnancy symptoms. Amy[1] described how the challenges of pregnancy impacted her work performance: "*The first trimester with the morning sickness and all of that, it's not easy…. As it was, I could not work at full capacity. I was still working and everything, but not my best."* Participants like Amy took work leave or used other accommodation (e.g., less work travel; flextime) to manage symptoms or attend prenatal appointments. Some participants, like Brook, noted the stress of pregnancy at work: "*It was a rollercoaster…having to leave and go for the blood work and not wanting to tell anyone where I was going and why. You know on top of the wanting to throw up every day, all day.*" Stressful circumstances involved having to hide pregnancy symptoms, appointments, or a growing belly.

The second subtheme reflected participants' *motivation and decisions regarding disclosure of pregnancy at work*. Many participants who did not disclose their pregnancy at work were following the societal norm of waiting until 12 weeks gestation in case of miscarriage. Others, like Emma, chose not to disclose their pregnancy for professional reasons:

> I had found out I was pregnant 10 days after I joined the company…I didn't want them to think … [that] I hadn't disclosed something to them. I also didn't want [it]…to affect the future for me. There could be potential salary increases on the line, and I just didn't want every conversation…to involve whether or not I might be off on maternity leave.

Emma worried that her pregnancy may have implications for her career advancement, project assignments, or others' opinions of her. Some participants in more precarious positions noted that disclosure had the potential to lead to job insecurity. Some participants, like Una, disclosed because of a need for accommodation and/or leave time: "*I had told [my boss] fairly early because I needed her to know if I needed to run to the bathroom or something."* Participants who disclosed during early pregnancy often did so due to debilitating symptoms or safety concerns (e.g., handling chemicals) that they feared could lead to perceptions of poor work performance.

The final subtheme pertained to *leader, coworkers, and organizational reactions and support following pregnancy disclosure*. Some participants experienced positive work reactions to their pregnancy disclosure, such as Mia: "*Everyone would frequently say, 'Oh, how are you doing? How's the baby doing? You guys excited?'"* These check-ins felt supportive to participants. Others had difficulty asking for or receiving pregnancy accommodation or faced hardships, including discrimination, like Poppy: "*…as my pregnancy progressed, I was really, really sick… I was missing some time because of that, …then, probably about when I was four months pregnant, [my boss] tried to fire me because he wasn't happy with my performance*." Poppy had difficulty advocating for herself in this situation while experiencing severe pregnancy symptoms. Some noted that since they had already taken leave during pregnancy, they didn't feel entitled to request leave for their pregnancy loss. Together, the nature of the pregnancy, including symptoms, gestational stage, and work factors (e.g., supportiveness and job security) influenced pregnancy experiences at work and pregnancy disclosure decisions.

5.2. Loss experience

5.2.1. Theme #2: the healthcare experience

Most participants sought care through the healthcare system as medical attention is often required during and/or after pregnancy loss. Most participants went into detail about their healthcare experience despite not specifically being asked about it. The first of three subthemes, *systemic failures surrounding ambiguity, stress, and trauma due to medical care (access, diagnosis, and treatment),* describes how healthcare experiences for pregnancy loss were often negative, stressful, and associated with ambiguity and trauma. Some participants experienced hassles with hospital bureaucracy, uncertainty around where to receive treatment, or had to advocate for themselves to receive treatment. Many participants who had miscarriages received care in chaotic emergency rooms (ERs), where wait times could be lengthy. After a traumatic ER experience, Tara observed that *"healthcare is not very well equipped to handle us [who are going through pregnancy loss]."* Another participant miscarried in an ER bathroom while waiting for care. Ada felt like she was *"seeing everybody in the hospital"* while receiving inconsistent care from numerous practitioners. Further, medical interventions for loss are often painful and stressful, as described by Anna:

[1] All participant names have been changed to protect confidentiality.

> Two days [after taking medication to induce miscarriage], I started having really, really heavy cramping and super heavy bleeding. I went through a pad every half an hour… So we had to go back into the emergency department. Arg, it was the worst day [crying]…they did a pelvic exam….they removed some things; it was incredibly painful.

Anna and others were often sent home by their providers to miscarry on their own with no information about what to expect. Further, the cause of many participants' losses was unknown, leading to unanswered questions, as was the case for Josie: "*[The cause of my loss was] officially inconclusive, which is frustrating…but on the other hand, me and my partner have come to terms with that conclusion, because somehow, it's nice to have nothing to be mad at…"* Many participants felt that they experienced unnecessary stress due to inefficiencies and lack of training and resources related to pregnancy loss in the healthcare system.

The second subtheme pertained to *physical, cognitive, and emotional experiences receiving medical confirmation of loss*, which participants often remembered vividly. Beth recalled learning that her twins had died: "*The doctor called me and said, are you sitting down? So…I knew it wasn't going to be good…and she said…I'm really sorry, but there were no heartbeats."* As Beth experienced, there was often a stressful waiting period after testing and before medical confirmation. Despite her own background as a nurse and the physical signs that something could be wrong, Sam felt shocked: "*I just really didn't think this was going to happen to me… It was a big shock, and I knew what was happening because I had had some spotting and I'd had a few things here and there."* Most losses were unexpected, even when symptoms like bleeding arose, because many participants held out hope that everything would be okay.

The third subtheme surrounded *post-confirmation medical care decisions and their relationship with work*. Most participants had choices around managing their loss (e.g., waiting for a miscarriage to occur naturally, taking medication to induce labor, having a surgical dilation and curettage [D&C]). Options were often provided in tandem with confirmation of the loss itself, which could be overwhelming. Women often factored work into their decisions, like Bea: "*the obstetrician…presented me with different options… I opted for medication…that way I was able to pass it at home over that weekend and I went back to work on Monday."* Pregnancy loss sometimes also requires follow-up medical appointments, making work flexibility instrumental, as it was for Josie: "*…I'd still been going to lots of doctors appointments and stuff because they were…still testing me for things. So physically, if…I had to go into the office, I probably would not have been ready."* Healthcare experiences were often depleting, characterized by pain, shock, distress, and ambiguity, which affected many participants' ability to work effectively afterwards.

5.2.2. Theme #3: physical health

The physical experience of losing the pregnancy (i.e., miscarriage, medication-induced miscarriage, D&C procedure, or vaginal or cesarean delivery) and subsequent physical recovery from the pregnancy and loss was described by two subthemes. The first subtheme surrounded the *physical experience of pregnancy loss, including symptoms and setting*. Participants described a wide variety of physical symptoms (e.g., cramping, bleeding, pain, fatigue, reduced fetal movements, premature labor, placental abruption), as well as the setting (e.g., work, home, hospital) in which they lost their pregnancies. Two participants described actively miscarrying in the workplace with little to no privacy or comfort. Poppy recalled: "*… I was almost crying because… every time I'd go to the bathroom [at work], I'm like, 'That's my baby.'…I just want[ed] to crawl in my bed and cry."* These participants struggled to continue to work and act normally as if nothing were happening. Participants whose losses occurred at home also dealt with the uncertainty of miscarrying without medical care or proper instruction. Lea described: "*I lost the pregnancy myself at home after going through what I consider a labor… without knowing what to expect, because I still hadn't gotten a call from the [medical] clinic."* Many participants felt unprepared to miscarry at home or work and some still required subsequent medical support, such as for retained tissue.

The second subtheme under physical experiences pertained to participants' *physical pain and ability/inability to work while losing the pregnancy*. Symptoms such as blood clots, cramping, surgery, labor, and delivery, for many, necessitated at least some time off from work. Faye noted that her symptoms would have impeded her ability to focus on work and move around comfortably: "*The actual passing of the tissue, it's very painful. I remember thinking the night before that if this pain didn't pass, there's no way I could have gone to work the next day."* Lily noted her postpartum bodily changes after pregnancy loss that could affect work:

> You leave the hospital without your baby and then all of a sudden your milk comes in…or you don't have a baby around so you forget that you're not supposed to be lifting things…But I think we really need…the same type of care that people with babies get, because… our bodies went through the same thing emotionally and physically.

Evidently, postpartum recovery may require accommodation after pregnancy loss just as it would for any pregnancy. Beth needed time off work when she was treated at home with a medication that induces miscarriage and can result in painful cramping and contractions:

> I did take some time off when I got the [medication] because I knew from the previous loss that this was going to be really painful. And…I did not feel prepared for how traumatic that would be…oh my goodness, it was like being in labor.

Her previous pregnancy loss still did not prepare her for the pain she endured. Lucy, who had seven pregnancy losses, took two weeks off work for each loss: "*I use the [medication] process every time. So you're basically home for two days, expelling all the tissue…and then the additional time off was just spent getting rest."* Lucy came to know what to expect from a miscarriage and that she needed time for physical recovery. The physical effects of pregnancy loss highlight that a physical recovery is needed to perform normally at work.

5.2.3. Theme #4: psychological health

In addition to physical recovery, psychological symptoms and recovery were inherent in the pregnancy loss experience. First, women engaged in *sensemaking and explanation seeking, including blame (of self, body, work) and social comparison* as they sought reasons

for their loss. Self-questioning about whether they or the stress of their work could have been to blame for the loss was common, as Jana describes: "*I start to blame myself and I almost start to blame my career and the pressure I put on trying to be successful in my career.*" Besides work stress, many wondered if forgetting to take prenatal vitamins, flying in airplanes, or some other factor could have caused their loss. Some, like Poppy, compared themselves to mothers with living babies:

> "When I would see somebody with a baby, it's like, 'Well, why did they get to have one and I didn't?...What did they do that I didn't? What did I do?' I was going through everything in my head...Was it flying? Was it taking the bus? Is the bus too bumpy? I was just trying to figure out. Because without a reason, your head just spins."

Women would wonder why others had living babies and they did not, and this caused them a great deal of distress. Many sought explanations for their losses, trying to make sense of their experience and/or aiming to prevent something similar from happening again.

The second subtheme involved *triggers and experiences of grief in the workplace, including emotional labor and feelings of inefficacy*. Grief triggers that brought up memories of their loss at work were challenging for many. Sam, a teacher, described a student asking upon her return to work: "*'Where were you? Ah, I bet I know. It had something to do with your baby, didn't it?'*" Sam had to breathe and "bite her tongue" while answering the difficult question. Some participants had feelings of incompetence at work due to their psychological symptoms, including poor concentration, fatigue, and disorganized thoughts. Brook, a pharmacist, felt concerned about making prescription errors due to her "brain fog" after loss. Some participants engaged in exhausting emotional labor at work to hide their grief, like Mia: "*[It was] emotionally exhausting just to pull myself together. Honestly, I was faking everything because I was in such an emotional turmoil… And throwing myself into my job because I felt like that's what I should be doing.*" The experience of "*faking*" was shared by many participants, who felt it was necessary to mask their grief at work. Eve, a manager, noted: "*I don't know how fair it was to the workplace because I was not in a position to not react really emotionally to things. I would just remember thinking like, 'I shouldn't be here.' That felt a little bit untethered.*" For many, performing normally at work after loss was difficult due to emotional distress.

The third subtheme was about participants' *symptoms and manifestations of grief specific to pregnancy loss, including negative emotions, ambiguity, disenfranchisement, and change in parental identity*. This theme described negative emotions (e.g., anger) and psychological and cognitive manifestations (e.g., shock, confusion, denial) of grief due to pregnancy loss. Brook described her state of mind after loss: "*Emotionally, I was a disaster…And therefore mentally also a disaster. It was a fine line for me between staying at home and festering on my thoughts all day…So that's why I went back to work. As a distraction.*" For Brook, work provided welcome opportunities to detach from grief. Eve struggled with depression and complex emotions after loss: "*I wasn't really prepared for the depression that followed because I… had some mixed emotions and some ambivalence around the pregnancy in the first place.*" Other participants, like Beth, reported longer-lasting negative mood and emotions, including anxiety.

Denial of the loss was common, as Poppy experienced: "*I just was, I guess, in a weird denial of it, like just sort of in shock that everything seemed normal and why is this happening.*" Generally, most participants found it very difficult to accept their loss initially. Most participants experienced common grief symptoms including psychological distress, sadness, depression, difficulty concentrating, resentment, anger, feelings of hopelessness, becoming easily agitated, emotional exhaustion, emotional triggers, or memory problems, as noted by Sara: "*It's all kind of a blur…And I think that's something that people don't really realize is that because it's a trauma…It has an effect on your mental capacity. For me, it's memory and things like that.*" This quotation highlights the lack of understanding by others about grief symptoms, which can serve to disenfranchise grief. Many participants noted that their loss felt traumatic and that they experienced grief triggers such as seeing babies or children. Lily noted: "*certain things became absolutely debilitating…even going for a walk…brought on a lot of grief because I didn't have my baby to push in a carriage.*" Overall, participants' psychological response to loss included negative emotions, sensemaking, and grief symptoms at work and generally.

5.2.4. Theme #5: pregnancy loss disclosure

Pregnancy loss disclosure included three subthemes that described participants' decisions about whether and how to inform others at work about their loss. The first subtheme was *normative influences of pregnancy disclosure, resulting in simultaneous disclosure of both pregnancy and pregnancy loss at work*. Participants who had not disclosed their pregnancies had often been waiting to do so until around 12 weeks' gestation, when the risk of pregnancy loss declines (Scotchie & Fritz, 2006). Many of these participants, like Faye, disclosed their pregnancy and loss simultaneously at work: "*[I had to tell] my very new boss…that I, (a) was pregnant, and (b), something was wrong with the pregnancy, and I was in no state [to work] because…I'd had a bad ultrasound.*" Such conversations often felt emotional and vulnerable.

The second subtheme was about the *disclosure target (*e.g.*, manager, coworker, HR) and actions taken to disclose the pregnancy loss*. For Skye and others, their manager was one of their first loss disclosure targets because they were unable to return to work:

> Believe it or not, my direct manager was the first person that I called when we found out there was no heartbeat. Because I was supposed to be going back to work later that day. I had called her right away in tears.

Some participants, like Sam, asked a close coworker to share the news on their behalf at work: "*My friend…knew what was happening… and she had shared it with a couple of coworkers. It's a very delicate, difficult conversation.*" Doing so spared her from having those vulnerable conversations herself. Other participants like Josie, shared the news themselves at work: "*I tried to be proactive about that…I said, 'My baby died, and it's really hard. But we're doing okay, and I'm glad to be back to work,' basically showing them that I was okay to talk about it.*" Some participants, like Aly, also shared about their loss on social media, which was visible to some co-workers: "*I did put a post up on social media about it…because people are so unaware…I needed to get the information out and tell people that it is okay to talk about their own experiences. It helped me a lot.*" Disclosing their losses in whatever way was comfortable for them helped others understand

their experience and facilitated support.

The final subtheme pertained to participants' *motivation and purpose to disclose/not to disclose the loss to work members (*e.g.*, managers, coworkers, HR, clients/customers)*. Some participants did not disclose their loss at work due to fears about job security, advancement, being overlooked for project assignments, or potential discrimination. Dana noted:

> I was in a contract position, and I had the opportunity to be permanent and those are really rare and so I…didn't want to signal like, 'Hey, I'm actually trying to start a family and there's a chance that I could be leaving you in however many months' time.' …[I knew that] if I were to disclose, it would not be met with compassion and understanding, it would be awkward and weird and potentially…used against me in decisions about my career and my advancement

This participant had a fear of negative interactions and even potential discrimination and received no accommodations or support at work for her loss because of not disclosing. Others in precarious roles at work or who wanted to advance were also less likely to disclose their loss. Others disclosed their loss because they needed time off, needed paperwork to apply for federal leave programs, because others at work knew they had been pregnant, because they knew their performance would be affected, or to receive instrumental or emotional support at work.

5.2.5. Theme #6: memorialization

Memorialization involved means of remembrance that helped participants process their losses. The first subtheme in this category was participants' *methods of memorialization and emotional processing activities*. Funerals and memorial services were less common for pregnancy loss, and particularly early losses, and participants often found other means of remembrance. Some, like Sam, found that having time alone to process was important:

> It was extremely therapeutic, just to have time to think and go for walks. I journaled a little bit…There were things that I wanted to put to paper because I didn't want to forget them. I'm really, really glad I did that.

Participants memorialized their losses in different ways, such as journaling, holding memorial services, memorial gardening, naming the baby, memorial tattoos, or sharing about the baby.

The second subtheme pertained to the *normative influences and ambiguity surrounding the memorialization of pregnancy loss* wherein there are no clear rituals or processes for memorializing pregnancy loss. Poppy described the ambiguous nature of this loss:

> There was no physical being, [so] it's like how do I mourn that?... When someone dies, you have the funeral. You have the ceremony and this process that you go through to wrap your head around it. But when you lose a baby, there's no steps...when you lose a baby, it's like, "I have no roadmap of where to put my emotions or how to express." Do I do a little ceremony? Do I do something to make it normal?

Due to the lack of norms for these losses, participants found various ways to memorialize their losses, but often did so more privately than would be typical for less ambiguous losses.

The third subtheme involved *sharing in the loss experience with, and receiving support from, non-work others*. Sharing about their loss with close family and friends often led to receiving emotional support and to sharing of similar experiences. For example, Sam was surprised when her husband's aunt shared in a sympathy card to her that she had had a stillbirth herself. Many participants reported that people shared their loss experiences with them, which reduced their isolation and helped them feel understood. For most people, engaging in memorialization alongside friends and family felt supportive to participants.

5.2.6. Theme #7: partners' experiences

Many participants discussed how their partners coped with the loss and how their partners' support from outside of their relationship was relevant to their own loss experience. The first subtheme involved the *partner's emotional and behavioral responses to the loss (*e.g.*, symptoms of grief, providing care to the gestational partner)*. Many women noted that their partners felt the need to support them, to appear strong, and sometimes stifled their own grief. Lea's husband was concerned for the wellbeing of both her and their older child:

> It's hard on the dads too... [My husband was just] like, "My wife's in a lot of pain. She's passing a lot of blood. What's going on here?" And trying to keep things normal for the two-year-old, because they're very perceptive at that age and they notice everything.

Some participants noted that their partners were uncertain about how to offer support, were overwhelmed, or felt helpless about what was happening to their partner.

The second subtheme involved the *partner's work experiences following loss (loss disclosure, support at work, leave from work) and crossover from partner's work experience*. Reports of partners' work experiences, particularly comparisons with partner's workplace responses, partners' access to work leave, and disclosure of the loss at work are included in this theme. Partners typically received less leave time than participants, but when both partners could take time off together, this enabled them to memorialize the loss, care for and support one another, and grieve together. Josie experienced stress when her husband's workplace did not acknowledge their stillbirth, which made him angry and led to him quitting his job. In other cases, partner's workplaces were very supportive, as Aly mentioned: "*My partner's co-workers would check in with him on a daily video meeting. They would always check in on how I'm feeling and how he's feeling. They sent flowers. It was really sweet.*" In this case, she appreciated the support for both herself and her partner by his coworkers.

5.3. Short-term post-loss experiences

5.3.1. Theme #8: work leave

The nature of work leave varied across participants and played a large role in most participants' experiences. The first subtheme involved *work leave policies, options/types, and duration*. Many participants needed to urgently take leave from work to receive medical care for their loss, their manager was often among the first points of contact upon confirmation of the loss. Due to the urgency, lack of complete information about leave options, and the fact that organizational policies rarely accommodated pregnancy loss, participants most often used sick days rather than other options such as bereavement leave. For instance, Poppy stated: "*They had zero policies at the time. They still don't…you get three sick days a year and that was it and your vacation. So either I could have used vacation or sick days."* Poppy opted to take sick days. Sometimes, participants received inaccurate, incomplete, or ambiguous information from work about leave options. For example, most of our participants would have had access to federal employment insurance programs after their losses, but many were unaware of their eligibility. Most participants also felt ambiguity around what was an acceptable amount of time to take, and often felt pressure to return even if they still had leave time available. Although most participants took some time off, five participants took no time off at all because they did not disclose their loss at work and/or they felt pressure to continue working.

The second subtheme was *workplace barriers to taking leave from work (nonexistent or inadequate resources, poor manager support, stigma)*. Bea returned to work before she was ready due to workload pressure and the administrative burden of seeking additional time: "*It seemed like so much more mental effort really, to try to figure out if I could take more time, especially more time without needing to worry about my work because at the time I was the only person doing my specific tasks."* When pregnancy losses happen suddenly, planning, finding a replacement, or delegating tasks prior to taking leave may be impossible. Some participants were supported in taking time off, particularly when they had compassionate supervisors or an organizational representative who worked with them to meet their needs, when their work was delegated out to others, and their leave options were reviewed. Zoe felt supported at work in taking time off: *"I had a lot of encouragement from work to stay home. Because that's the type of job that I work, you can't help people when you're in 'the other place.'"* Her supervisor knew that she would be less effective in her role while in emotional distress. Being able to take leave without pressure and without having to worry about work was very helpful to these participants.

The third subtheme involved participants' *feelings (guilt, disappointment, shame, regret, pressure, fear) associated with leave-related decisions, experiences, and professional consequences*. Poppy felt guilty asking for leave time from her two bosses:

> Neither one of [my bosses] offered any time off, and I said, "Could I just have off till Thursday, like four days?" [My boss] was like, "Yeah, I guess." That was his response…as if it was too much to ask…It just seemed weird to me at the time that I had to ask and that I felt guilty for asking.

This unsupportive response left Poppy feeling ashamed and like she was asking for too much. Beth felt guilty about her colleagues taking on her workload while she was on leave, and so she returned before she was ready: "*I felt that I needed to return quickly, partly because I knew that it was a pretty short staff. And so, I felt my absence would be really felt by my colleagues."* Aly described the guilt she felt about "doing nothing" while on leave which led her to return to work: *"I think it was more pressure that I put on myself. It was like an internal guilt for just sitting around even though I was still recovering mentally and physically. I just didn't want them to think I was lazy or something."* Participants who returned to work early due to workload pressure, guilt, lack of support, or other factors often wished they'd had more time off. Adequate leave time allowed participants to grieve, physically recover, and engage in self-care.

5.3.2. Theme #9: workplace support

The nature of participants' workplace support or lack thereof, and how it impacted them are included under this theme. The first subtheme involved *clear communication, and provision of organizational resources (*i.e.*, leave options, work accommodation, EAP, or counseling)* and related to instrumental support. Josie's supervisor supported her by "*acknowledging that we went through this horrible thing. And they told me, 'Take all the time you need.' They were just extremely supportive."* Providing leave and reducing pressure to return soon meant she could return when she felt more ready. Lexi was also encouraged to take time off and was referred to the employee assistance plan: "*[My supervisor] was incredible…she told me to take all the time I needed and she even reminded me of the employee assistance program."* Utilizing these programs may promote grief recovery for both employees and their families who use them. Lea noted that although her boss meant well, she didn't provide any helpful accommodation: "*My supervisor at the time…was wonderful, but maybe she just didn't think of what I actually needed and…couldn't really relate."* Lea noted that her boss had no personal experience with pregnancy or pregnancy loss and was probably unaware of the challenges. Poppy received accommodation at work during pregnancy for prenatal care, but not after her miscarriage: "*It seemed like, 'Okay, well, now that you're not pregnant, let's just continue on like normal,' like things just should go back to the way they were."* Such lack of support may stem from a lack of awareness of the pregnancy loss experience and needs people may have after such loss.

The second subtheme involved *demoralizing, disenfranchising, and unsupportive workplace culture, experiences, and exchanges with others at work*. When participants' losses went unacknowledged, it often felt strange, painful, and awkward, as if nothing significant had happened at all, as described by Mia: "*After we lost the baby, less than half of [my coworkers] commented or acknowledged…it's really unfortunate when people don't acknowledge such a large moment in your life."* Lily's loss also went unacknowledged by her coworkers, and she noted: "*I was surprised by some of [my coworkers] not saying anything, but I think that's just how people react to grief. They don't know what to say, they don't say anything at all."* Others at work may not acknowledge pregnancy loss because they do not know what to say, but this left many participants feeling dismissed, unsupported, and invalidated.

Workplace emotional support characterized by empathy, compassion, validation, positive relationships, and positive environments at work was the third subtheme. Emotional support (i.e., affirming one's value and social acceptance despite any difficulties; Cohen & Wills,

1985) came from coworkers, managers, or the organization. Participants remembered receiving cards, gifts, food, or flowers after their losses, and they were grateful when others at work acknowledged their loss through simple acts that validated their pain. In some cases, co-workers or managers shared their own loss experiences, which sometimes led to closer relationships, a phenomenon Eve described as the "old girls' club." Some participants also talked about the importance of a healthy work environment that prioritized mental health, like Lily: "*[My employers] are very focused on mental health and I think it's just part of their core value to treat their employees this way."* Generally, a positive and healthy workplace was related to greater emotional and instrumental support, a sense of safety at work, and promoted loss disclosure.

5.3.3. Theme #10: stigma

Participants' experiences of or fears associated with stigmatization including discrimination due to pregnancy and pregnancy loss have been included under this theme. The first subtheme involved *perceived vulnerability to stereotypes and others' perceptions and judgments at work*. Participants were often highly aware of how uncomfortable others at work were about broaching the subject of pregnancy loss. This led some participants to experience fear and discomfort about interacting with others at work, as detailed by Zoe: "*Going back to work is really, really, really hard…people look at you different. I mean, maybe they want to talk, but they don't want to ask questions…Then you just, you kind of feel like the elephant in the room."* That feeling of awkwardness was shared by many participants. Others, like Jana, elaborated on how silence about pregnancy loss contributes to shame and lack of understanding: *Lots of people have had losses, but we still don't talk about it…Why should I be ashamed about it? But I'm still nervous in the workplace."* As she notes, the taboo nature of pregnancy loss conversations are highly salient in the workplace, making returning to work especially difficult for sufferers.

Discrimination experiences (actual and feared) around pregnancy and loss, and its influences on disclosure and resource utilization at work characterized the second subtheme. A few women noted feeling vulnerable to workplace discrimination such as being passed over for work opportunities or experiencing job loss. Poppy was let go from her job unexpectedly while she was on leave after her loss: "*I emailed [my boss] and said, "Hey, can we talk about when I'm going to come back and…what are the options?' He's like, 'Yeah, there's no position for you.'…So I filed complaints against him."* She was the only participant to experience such overt discrimination, but others feared discrimination during their pregnancy and/or loss especially if they were in more vulnerable work roles. Dana, who was a very ambitious employee who had already had difficulty advancing in her organization, said: "*I feared that it would contribute to decisions about my career trajectory*." She chose not to disclose her loss out of such fear.

The third subtheme involved *societal norms, opinions, and misconceptions around motherhood, grief, and pregnancy loss*. Participants discussed that, while fertility and motherhood is celebrated, the subject of pregnancy loss is stigmatized, brings discomfort and awkwardness, and that women are sometimes blamed for pregnancy loss. To address misconceptions about grief and loss, some participants like Faye, guided others in how to respond to them about their losses:

> I did all of the work of emailing everybody who knew and actually telling them how to react to me…My experience, in general, was not so much that there aren't workplace systems in place for miscarriage. It's that there aren't really very good workplace systems in place for just grief in general, right? Certainly, in this case where there's also physical stuff going on with it. I did have to tell everyone how to react to me because I didn't want people to ignore it obviously, but I also did not want everyone trying to feel my feelings.

In contrast, Kate, who went back to work before she felt ready due to pressure, anticipated awkward social interactions upon returning and did not want to talk openly about it at work. She told her boss: *"'Okay, well, if I'm going to go back to work right away,' I said, 'You need to ask everyone else that we work with to not ask any questions about what happened', because I wasn't ready to talk to other people about it."* Not all participants were so proactive in managing social interactions, but these two reactions highlight the variability in preferences for interactions with others. Participants also recognized that the stigma and ambiguity surrounding pregnancy loss may differ depending on when the pregnancy loss occurred, signaling that some pregnancy losses are perceived as more "legitimate" than others. About her full-term stillbirth, Josie said:

> In terms of…women who have earlier pregnancy loss and people saying horrible things about how it wasn't a person yet or you shouldn't grieve for it, there was certainly none of that gray area with my situation…He was a completely full-term baby. And so we… were spared some of the judgment in that way because there's no doubt that it was a baby.

In a stillbirth, loss may be less ambiguous than miscarriage in the sense that it is clearer that a baby was born and lost. Josie acknowledged, however, that assumptions about a 'hierarchy of loss' where early losses are perceived as less significant can be painful and delegitimizing.

5.4. Long-term post-loss experience

5.4.1. Theme #11: the return-to-work experience

Return-to-work experiences were salient parts of the pregnancy loss experience, as it marked a transition back into society for many. The first subtheme was *procedures and logistics of return-to-work planning, including work accommodations*. Accommodations included more flexible work, working from home, fewer hours, less work travel, extra breaks, or reduced workload. Some participants had positive experiences with working from home initially or easing gradually back into the workplace, as was the case for Nora:

> I did have a gradual return to work schedule…over two weeks…it was really helpful because…I just didn't want to break down and cry at work all day…I just had to hold it together for a couple hours, and then I could go home, and cry.

These arrangements minimized work demands at the height of emotional distress.

The second subtheme involved *readiness to return to work and feelings of professional efficacy/inefficacy*. Some participants went back to work before they were able to perform normally. Faye, a manager, informed her direct reports upon returning to work: *"I have to be at work…but I'm probably 70% of my normal effectiveness right now, just because I cannot concentrate."* Josie maintained lower confidence at work after loss: *"My self-confidence is a lot lower. For work…when I'm doing a task… I'm like, "Am I doing this right?" I'm worried…I'm doing everything wrong."* Feelings of inefficacy may result from grief symptoms and a general lack of confidence in ones' body and oneself that is typical after pregnancy loss.

The third subtheme was *psychosocial benefits and motivations associated with return-to-work and working.* Some participants, such as Josie, benefited from work itself which provided structure and a distraction from grief: "*I definitely felt like I needed a bit of a distraction or something else to occupy my mind. So I was ready and very much looking forward to getting back to work by the end of that three months."* Participants benefited from going back to work more often when they had a positive, healthy, or supportive work environment and when they had access to, and support for utilizing, instrumental resources. Such was the case for Lexi, who was able to attend therapy during the workday: "*I started private therapy with a therapist and [my work was] very good about knowing that I would need to take time during the workday away from my training to do [that]."* Her emotional and instrumental support and ongoing accommodation to receive therapy facilitated her recovery and mental health.

5.4.2. Theme #12: shifts in perspective of life, work, and identity

Participants sometimes described their loss as a "*rude awakening,*" a "*shock*," as "*lighting a fire,*" or as "*opening a window onto the human experience*" that caused them to think differently about their life, health, professional identity, and work. The first subtheme involved *health-related changes*. Poppy described how she changed her lifestyle due to her loss: "*I was thinking, obviously, my body did something [to lose] this pregnancy, so I should maybe eat healthier, drink less coffee."* She adopted more healthy habits in case that would improve the outcome of a future pregnancy. Other participants noticed a decline in their mental health and began treatments including therapy or medication. These shifts may have been due to the role that women's bodies play in such loss (e.g., feeling that their bodies had failed them), and the psychological stress involved, which could lead to mental health issues.

The second subtheme was *changes in professional identity, priorities, career trajectories, and preferred job roles*. Jana questioned her beliefs and life priorities after loss:

> I'm just not as married to work now as I was. I have a totally different outlook on what's important…if I get pregnant again I'm not going to stress about where that leaves my employer. I big time see my work differently now. Loss totally shifts your world. I find I'm less motivated these days. I just don't feel like work takes care of me as much as I thought I needed it to. So why am I changing my life around for work?

Her poor work experiences following her loss led to reduced commitment and engagement at work. Nora, Dana, and Lucy were also unsupported at work following their losses. Nora had felt pressure from her supervisor to make up for her time off and remembered thinking: *"I have to do more, because I don't want to be seen as a bad employee, because I took this time off for this personal thing."* Dana and Lucy later opted to transfer to different departments, which Dana said offered her a "*fresh start*". Many participants considered job changes such as job advancement, changing to safer roles (e.g., not front-line), or jobs with more security and flexibility.

Other participants, like Lily, who were treated well at work following their loss had a renewed sense of appreciation for their workplaces: *"I always knew it was a really great organization…they've really stood up to everything that they say which is nice. So I really respect where I work."* The support that Lily received reinforced her positive job attitudes.

The third subtheme involved *changes in life perspectives and personal identity*. Some participants became less concerned about small stressors and reported that they were more empathetic, compassionate, self-aware, grateful, and less judgmental. Mia described her loss as: *"Such an emotional experience that completely changed me as a person…I'm much more emotionally self-aware."* Others, like Beth, felt less naive: *"I think there was a loss of innocence, I guess, a loss of a naivete about how terrible the world can be."* Some participants noted negative changes like having lower confidence, both generally and in their bodies, and more pessimism; Josie noted: "*I definitely have a more pessimistic outlook on life than I did before. And I definitely feel like I'm more of a hypochondriac."* Specific to pregnancy loss was the loss of parental identity that had been developing during their pregnancy, as described by Poppy:

> My reality is that I'm not going to be having a baby in nine months. Everything in my head that I had planned…being like, 'Okay, if it's a girl, we could do this. If it's a boy…' All those things that you had thought in your head were going to happen aren't.

Some participants had to make the difficult decision to stop trying to get pregnant, like Sam: *"It was hard to let go of that I wasn't going to be able to have another baby."* These women had to let go of possible identities as a parent to a new child. Some participants realized after loss how resilient and strong they were. Poppy remembered saying that she *"would never recover"* if she were to ever have a loss, but now views herself as, *"a very strong individual."* Pregnancy loss led to both positive and negative changes in life perspectives for many participants.

6. Discussion

This study answers a call by scholars for more research on pregnancy loss in the workplace (e.g., Ladge et al., 2012; Meunier et al., 2021). Twelve domain-spanning themes were developed based on the data. The themes of our study can be interpreted through the lens of bioecological systems (Bronfenbrenner, 1977) and boundary theories (Nippert-Eng, 1996), which illustrate the

interconnectedness and influence of life domains that affect individuals' experiences. Our findings address our research questions by identifying how work, healthcare, family, and broader sociocultural systems influence, and are influenced by, the biological experiences of employees following pregnancy loss. The results provide insight into how pregnancy loss experiences (a) are characterized by multi-level system interactions, (b) can be understood as boundary violating events that increase permeability across roles, and (c) unfold over time. This study demonstrates that pregnancy loss is not solely a personal issue; it can have far-reaching short-and long-term implications for workers and their workplaces, and that organizations play a role in employees' experiences and outcomes.

6.1. System-spanning nature of pregnancy loss

Consistent with the bioecological model, interactions between systems were implicit to the pregnancy loss experience, and previously segmentable domains became more inextricable (e.g., work influencing healthcare decisions). Boundary theory contends that people manage boundaries between work and their personal lives through 'segmenting' (separating roles with clear boundaries) and 'integrating' (interfacing between roles with unclear boundaries) domains (Quick, 2021). Boundaries that are more flexible (i.e., can be temporarily relaxed to meet the demands of another domain; Ashforth et al., 2000; Clark, 2000) and less permeable (i.e., elements from one domain interrupt another domain; Ashforth et al., 2000; Clark, 2000) are related to less work and non-work conflict (Bulger et al., 2007). However, even when barriers between work and home are flexible, health issues may result in unwanted permeability between microsettings, a problem exacerbated by higher role identification (e.g., as a bereaved parent). Our findings suggest that pregnancy loss is a 'boundary violating event' that affects individuals across domains, wherein work becomes personal and the personal 'goes to work'.

Participants shared experiences illustrating system intersections between *physical, psychological,* and *healthcare experiences* and the workplace (i.e., *return to work*), and the criticality of *workplace support* in terms of responses and policies (i.e., inclusive leave options, work accommodations, supportive work environments). The intersection of personal experiences (e.g., *physical bodily changes*) and work life (e.g., *pregnancy loss disclosure* at work) was reported by all participants, with work often influencing personal outcomes and vice versa. Although *healthcare* experiences are often considered 'private,' receiving healthcare for pregnancy loss is often distressing and can have short- and long-term implications for participants' well-being, mental health, and ability to work (Freeman et al., 2021; Hazen, 2003, 2006), illustrating the permeability of the boundaries between work and health microsystems. When *healthcare experiences* were especially challenging, participants struggled more with negative subsequent workplace experiences, perhaps due to psychological depletion upon *return-to-work* (see ego-depletion theory; Baumeister et al., 2007). Similarly, participants reported profound changes in their *physical* (e.g., abdominal cramping, bleeding, fatigue; Quenby et al., 2021) and *psychological* health (e.g., sadness, anxiety, depression, lack of focus; Quenby et al., 2021) that were beyond their control and that manifested at work and home.

An individual's experience was often influenced by their partners' work experiences, representing the exosystem (i.e., a sphere that participants are not directly involved in, but that influences them). Many participants felt angry or resentful when their partners were unsupported at work after loss. Similarly, if their partner's workplace was supportive and their own employer was not, participants reported feeling less interested in their work or returning to work. Partners' workplace experiences may increase the salience and valence of one's own work-related support experiences due to comparisons made between the two experiences (Thompson et al., 2021).

6.1.1. Stigma

Stigma surrounding the subject of pregnancy loss was another cross-domain theme with far-reaching influences on employee wellbeing, reflecting the influence of the macrosystem – sociocultural ideologies, beliefs, and norms surrounding *pregnancy* and pregnancy loss. As argued by Wilkinson (2022, p. 8), "capitalism, gender orders, and ableism… position maternal and 'ill' bodies as 'problematic' in the…workplace–contrasted to the 'ideal worker' who can work full time, long hours, unencumbered and constantly visible." Experiencing *physical* and *psychological* symptoms of pregnancy loss at work, or taking *work leave* due to such symptoms, misaligns with the notion of the "*ideal worker*" and can lead to *stigma*.

Stigmatizing attitudes deriving from macro- and exo-level systems influence individuals' experiences within their microsettings (Follmer & Jones, 2021). Elements of pregnancy loss that are stigmatized subjects of conversation included grief (Gilbert & Kelloway, 2021; Gilbert et al., 2021), bodily changes, and the ambiguous nature of pregnancy loss (Hazen, 2003, 2006; Mcgee et al., 2018), which led many participants to feel isolated and their grief disenfranchised (Hazen, 2003, 2006). According to Jones et al.'s (1984) stigma theory, pregnancy loss may be stigmatized due to its concealability, disruptiveness, displeasing aesthetics, and because of perceptions that women are to blame for loss (Brier, 2008). Negative stereotypes surrounding women's reproductive health experiences (i.e., menstruation, menopause, and maternity) impact work outcomes more negatively than the health experience itself (Grandey et al., 2020). For example, the fear of discrimination or negative stereotypes can prevent employees from seeking and receiving *workplace support* or *disclosing their pregnancy loss* at all (Hackney et al., 2021; Jones, 2017).

6.1.2. Disclosure

When employees do not *disclose their pregnancy loss,* they may risk *returning to work* before they are physically or psychologically ready. Often, employees avoided disclosure due to inflexible boundaries even though they often feared that permeability would lead to perceptions of unprofessionalism (e.g., if they cried at work). Consistent with other *stigmatized* health issues (e.g., mental illness), they may feel like they must act normally by working as usual or maintaining secrecy about the loss (Dimoff & Kelloway, 2019). Porschitz and Siler (2017) refer to such secrecy and 'faking' as "violent acts against the self" (p. 571) which forgo immediate physical and emotional needs to remain "*professional,*" leading to exhaustion. Further, the emotional labour (i.e., emotional control exerted to

suppress undesired emotions at work; Hochschild, 1983) of concealing their feelings at work was depleting. Feelings of fear were often exacerbated by guilt (i.e., feeling responsible for the loss) and shame (i.e., feeling inferior because of the loss; Barr, 2004) that often accompany ambiguous losses (Mcgee et al., 2018). When employees felt safe enough to *disclose their pregnancy losses*, they could receive *workplace support,* and have more positive subsequent job attitudes (i.e., *shifts in perspective in life, work, and identity*). This aligns with boundary theory which suggests that increased flexibility, particularly when combined with social support, can benefit employees and work outcomes when permeability is unavoidable (Quick, 2021).

6.1.3. Cross-domain identity shifts

Pregnancy loss was, for many, a transformative experience that altered participants' *perspectives of work, life, and identity,* a common phenomenon after life-altering events (Ashforth, 2001; Ladge et al., 2012). Some participants reported shifts in identity (i.e., a description of the self answering the question, "Who am I?;" Ashforth et al., 2008), related to their self, work, and work role. Thus, pregnancy loss may elicit a cross-domain identity transition (i.e., when an individual's work identity must be adapted to integrate with a change in a non-work identity; Ladge et al., 2012), as was evident in many themes (e.g., *pregnancy* as a transition to parenthood, loss as a transition to *bereaved parent*, *memorialization* as representative of bereaved parenthood). In *pregnancy,* women may produce mental images of their future selves to integrate and segment their existing identities (e.g., as a professional) with their new or emerging mother identity (Jones et al., 2016; Ladge et al., 2012). After loss, some participants experienced renewed commitment at work, especially if they felt *supported there* (Hazen, 2003) in negotiating their new identities. Other participants' professional identities became less prominent, leading to lower work engagement, withdrawal from the workforce, or job-seeking behaviors. In bioecological systems theory, such shifts are important to human development, defined as "lasting change in the way a person perceives and deals with [their] environment" (Bronfenbrenner, 2005, p. 50). As individuals' environments change, so do their self-perceptions that are dictated by norms and rules stemming from meso- and macro-level systems that shape emotion and cognition over time (Bronfenbrenner, 2005). Thus, engagement in new microsettings (e.g., *healthcare*) or the construction of a new role (e.g., bereaved parent) within an existing microsetting, may lead to *identity shifts*.

6.2. Temporal nature of pregnancy loss

Pregnancy loss is not just an acute *healthcare experience* but may be represented by stages of struggle that unfold over time. These stages were affected by work (i.e., work leave) and non-work (e.g., healthcare setting) microsystem, mesosystem (e.g., work-home spillover), macrosystem (e.g., *stigma*), and exosystem (e.g., their *partner's workplace support*) factors. This is consistent with bioecological systems theory, which examines change in human development as a process that takes place over time (i.e., in the chronosystem) as the individual interacts with spheres of their environment (Bronfenbrenner & Morris, 1998). Also embedded into this theory is the acknowledgement of the physical being and biological factors. Pregnancy and pregnancy loss involve bodily changes that affect women in different ways over time. Some employees experienced *physical* and *psychological* symptoms of loss and/or required multiple absences over time, to receive *healthcare* (e.g., doctor's appointments, surgeries), and/or *memorialize their loss* (e.g., funeral or memorial service). We found that the *physical* experience of loss was associated with *disclosure*-related decisions, *work leave* and *return-to-work plans*, *workplace support,* experiences of *stigma*, and *shifts in perspective surrounding work and professional identity*. Symptoms and severity often impact a woman's ability to do her job, and remain in work or *return-to-work* over time (see Wilkinson, 2022). As such, it is critical to acknowledge the biological element of pregnancy loss for gestational parents.

Due to the highly salient and emotional nature of pregnancy loss (Porschitz & Siler, 2017), its implications extend beyond the immediate *physical* loss, relate to pre-loss experiences (e.g., *pregnancy disclosure*), and affect long-term outcomes (e.g., *shifts in perspective and identity*). For example, employees' treatment prior to and during the early stages of loss (e.g., work *leave* options, *workplace support*) were related to employees' *physical* and *psychological health* experiences and tended to influence *return-to-work* motivations, and their general feelings about work (Hazen, 2003; Meunier et al., 2021), illustrating the chronosystem of employee experiences over time. The interaction between systems across time can influence employees' work-related attitudes and behaviors prior to, during, and following pregnancy loss, rendering the pregnancy loss experience an ongoing boundary violation event that affects, and is affected by, both work and life microsettings (Hunter et al., 2019).

6.3. Practical implications

Findings from this study have implications for working women experiencing pregnancy loss, their managers and coworkers, organizations, and policymakers. For women experiencing pregnancy loss, these findings highlight the breadth of experiences that they may have, the range of responses others may have toward them (from sharing of similar experiences to lack of acknowledgement), and how contextual factors, such as the nature of their work and the healthcare they receive, may influence their individual work experiences and well-being. These findings may help to validate elements of their experience and help them to feel less isolated – an important implication given the stigma surrounding pregnancy loss. Although pregnancy loss experiences are highly individual, this study may inform people about what they might expect related to the intersections between their physical and psychological symptoms, healthcare experiences, and their workplace and the factors that may influence their decision-making. For example, healthcare decisions may be affected by work leave time availability and workplace loss disclosure decisions may be affected by psychological safety or leader support. Work leave decisions may be affected by work factors (e.g., adequacy of staffing, leave policies) or physical symptoms (e.g., need for treatment, recovery needs). Women may also benefit by considering some of the various coping strategies highlighted in our study, such as leaning on close co-workers for support, requesting accommodation or adequate time off, coaching

others in how to talk to them about their loss, memorializing their loss in various ways, and sharing about or disclosing their loss to access support (if it feels safe to do so). Further, our findings may benefit women by highlighting some of the possibilities for leave options beyond sick leave (e.g., federal sickness or maternity leave benefits), work accommodations, and other forms of support at work (e.g., counseling through an EAP program) that they may consider and try to access.

For managers, study findings may highlight the important role that they play as an intermediary between the employee and the organization in facilitating access to supportive resources, accommodation, and work leave. By illuminating some of the needs that working women may have related to accessing healthcare, postpartum recovery, bereavement, and work accommodation following pregnancy loss, findings from this study may help improve managers' awareness of the contextual factors that constrain or facilitate pregnancy loss disclosure and influence the pregnancy loss experience. Through greater awareness of these factors, managers and coworkers may be better able to act as allies (i.e., individuals who engage in behaviors that support an individual who is experiencing stigma or belongs to a stigmatized group; see Sabat et al., 2013) of their employees' work-and health-related needs following pregnancy loss.

By creating a supportive, respectful work environment that promotes well-being and destigmatizes health challenges, including pregnancy loss, managers can help foster psychologically safe work environments (see Edmondson, 2018) for all employees, where individuals are more willing to seek out and receive support. Organizations that offer inclusive health resources, such as a variety of paid leave options (e.g., sick leave, bereavement leave, pregnancy leave, parental leave), a wide-range of accommodation options, and family-friendly policies (e.g., flexible work arrangements), may help to foster work environments that destigmatize health issues and promote positive job attitudes and retention. Best practices from other areas of the occupational health literature that address stigmatized health issues (e.g., mental illness; cancer) suggest that (a) providing training for managers and HR personnel on how to support employees, (b) offering resources specific to pregnancy loss (e.g., EAP programs with access to perinatal loss counselors), and (c) implementing leave policies and return-to-work plans related to pregnancy loss can improve employees well-being and their perceptions of support (see Dimoff & Kelloway, 2019). Institutional and legislative policy implications of our findings include a need to expand paid and unpaid leave options and accommodations related to childbirth to include pregnancy loss. Since men also suffer after pregnancy loss and often provide critical support to their partners (Due et al., 2017), leave options and accommodations should also be available to men.

6.4. Limitations and future directions

The homogeneity of our sample (primarily White, Canadian, highly educated, heterosexual, and cis-gender women in mainly white-collar jobs) limits the generalizability of findings. Specifically, our participants might have more control, access to benefits, and other support in their work environment than other employee groups. Future studies should examine the interconnectedness of work and pregnancy loss in more diverse samples including blue collar occupations and in different genders and sexualities, which may face greater systemic inequalities and reduced access to support (Silver-Greenberg & Kitroeff, 2018). Non-gestational partners should also be a focus of future work that examines their unique experiences of work after pregnancy loss, crossover effects of partners' experiences on one another, or effects of pregnancy loss on the nature of the relationship between partners.

Few of our participants utilized government-sponsored leave programs for their loss(es) due to lack of awareness of such programs and/or their eligibility. Future research should aim to explore the benefits and limitations of such programs, and the barriers to program utilization. Future work could examine cross-cultural and cross-national differences in pregnancy loss experiences, as government programs and sociocultural norms may be influential. Future qualitative or quantitative research may more deeply explore the themes identified in this study. For example, survey research may examine how stigma surrounding pregnancy loss conversations affects the careers and identities of working people over time. Research could also identify barriers and facilitators to accommodation or resource use after pregnancy loss.

7. Conclusion

This study addresses the dearth of literature on pregnancy loss as a "taboo" topic in the workplace (Meunier et al., 2021). Findings suggest a timeline of pregnancy loss for gestational parents, inclusive of the pregnancy, the immediate loss experience, and its aftermath, as well as the long-term work outcomes and finds 12 intersecting elements that characterize the experience. Pregnancy loss is a transformative experience for employees, propelling them toward domain-spanning shifts in perspectives, priorities, and even identity. Our findings highlight the criticality of compassionate and supportive workplace responses and policies that protect employee wellbeing and promote positive work and health outcomes.

CRediT authorship contribution statement

Stephanie L. Gilbert: Conceptualization, Methodology, Validation, Investigation, Resources, Writing – original draft, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Jennifer K. Dimoff:** Conceptualization, Methodology, Resources, Writing – original draft, Writing – review & editing. **Jacquelyn M. Brady:** Formal analysis, Data curation, Validation, Writing - original draft, Writing - review & editing. **Roderick Macleod:** Formal analysis, Validation, Data curation, Visualization, Writing - original draft. **Taegen McPhee:** Formal analysis, Validation, Data curation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

Appendix A

A.1. Interview questions

1. To start, can you describe your workplace, your job title, and responsibilities at work?
2. Can you talk a little about the pregnancy loss/losses that you experienced, and how you learned about the/each loss?
3. Did you share your loss with anyone in your workplace? Why or why not? Who did you share with and how long after your loss did you share? How did they react?
4. Did you receive or take any form of leave or time off following your loss?
   a. [If yes]: Do you remember what type of leave it was (e.g., maternity leave, sick leave, or bereavement leave)? If you did take leave, how much did you take, and what factors influenced your decision to return to work when you did? How did you feel physically, mentally, and emotionally about returning to work at that point?
   b. [If no]: Why didn't you take leave, and what factors played a role in this decision? How did you feel physically, mentally, and emotionally about working following your loss?
5. What support or accommodation was offered to you by your manager, co-workers, HR, or others at work that were helpful at work following your loss?
6. What difficulties, if any, did you encounter with your manager, co-workers, HR, or others at work that were unhelpful at work following your loss?
7. Was anything you experienced in the workplace after your loss/losses surprising or unexpected to you?
8. Have there been any changes in how you see yourself, your work, or the world in general after your loss?
9. Looking back, what could your manager, coworkers, organization, or others at work (e.g., clients) have done to support you following pregnancy loss more effectively?
10. Looking back, would you do anything differently with respect to work and working following your loss/losses?
11. What advice would you give to policymakers/legislators to help improve the experiences of people coping with pregnancy loss?

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