Co-Ownership of Private Information in the Miscarriage Context

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Abstract

Pregnancy loss due to miscarriage is a pervasive health issue. Although talking about the miscarriage experience with friends and family members has been linked to better adjustment, revealing this loss can be difficult because discussing a miscarriage often makes people uncomfortable. Moreover, couples often manage this information jointly as they decide whether to share the miscarriage with people outside the dyad. We conducted in-depth interviews with couples to explore the nature of co-ownership in the miscarriage context and to identify the privacy rules that couples develop to manage this information. We found that couples frame miscarriage as a shared but distinct experience and that both members exert rights of ownership over the information. Couples' privacy rules centered on issues of social support and others' need to know about the loss. Even though couples described their privacy rules as implicitly understood, they also recalled having explicit conversations to develop rules. We discuss how the management of co-owned information can improve communication and maintain relationships.

Keywords: miscarriage, co-ownership, Communication Privacy Management, privacy rules

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Miscarriage, the spontaneous loss of a fetus before the 20th week of pregnancy, is a pervasive health issue in the United States; as many as 25% of known pregnancies end in miscarriage (American Pregnancy Association, 2011). Miscarriage can be a traumatic experience for both women and men, linked to negative outcomes like depression and anxiety (Swanson, 2000). A miscarriage is typically a shocking and unexpected event (Maker & Ogden, 2003), as most couples anticipate a healthy pregnancy (Rinehart & Kiselica, 2010).

Despite how common miscarriage is, it remains a taboo topic, all-too-often shrouded in silence and hidden from public view (Frost, Bradley, Levitas, Smith, & Garcia, 2007). As Brann (2011) noted, "It is the overwhelming silence society has placed on this topic that keeps many individuals from knowing, understanding, sharing, and being comforted during such a tragic event" (p. 22). This taboo nature has important implications for how people manage private information (Petronio, 2002) about their experience. Moreover, the fact that miscarriage is often experienced by a couple adds another layer of complexity to talking about miscarriage. Communicative dilemmas arise for couples who must navigate not only personal desires about discussing or avoiding the topic but also their partner's wishes.

Although the experience of a miscarriage is often a communal stressor, particularly for committed couples actively trying to build a family, the literature examining miscarriage as a couple-level experience is small in both size and scope. Our goal in this study was to draw on assumptions of Petronio's communication privacy management theory (CPM) to explore the couple experience of miscarriage from a communicative perspective. We sought to build on existing communication theory to understand whether and how couples co-own and co-manage private information about miscarriage.

The Importance of Talking about Miscarriage

The loss of a pregnancy, particularly a desired one, has been connected to negative outcomes for individuals and couples. Most of what we know about the psychological toll and social impact of miscarriage privileges the voices and experiences of women (van den Akker, 2011) and perhaps rightly so, as miscarriage is a widespread health issue for women who still struggle to have this loss recognized as "real" by the medical community and society as a whole (Cosgrove, 2004). Women have reported feeling completely unprepared for the intense physical pain, deep emotional toll, and profound social strain that accompany the loss of a pregnancy (Maker & Ogden, 2003). At the same time, scholars have noted that both women and men may endure the psychosocial consequences of miscarriage and have called for greater attention to the experiences of men (e.g., Rinehart & Kiselica, 2010) and couples (van den Akker, 2011). For instance, both women and men experience grief following a miscarriage, a grief that has has been compared to that felt in response to other significant losses (Brier, 2008). Although evidence suggests that women's grief might be more profound than men's (Brier, 2008), other studies have found that women and men report similar levels of grief but that men tend to grieve less openly than women (Rinehart & Kiselica, 2010). Women might feel guilty about the loss (Brier, 2008), whereas men report a need to be strong for their partners while engaging in their own coping (Rinehart & Kiselica, 2010).

One explanation for the powerful toll of a miscarriage is that it poses a "unique form of loss" (Frost et al., 2007, p. 1003). A miscarriage involves multiple losses: the loss of identity as a pregnant woman or couple; the lost potential for becoming parents; the loss of a future child; and the loss of future hopes, plans, and expectations (Brier, 2008). These losses and the ability to cope with and talk about them are complicated by the ambiguity surrounding miscarriage,

such as the inability to pinpoint a definitive cause for the loss. Moreover, couples sometimes discover the miscarriage during a routine ultrasound or medical appointment, and thus the precise moment of loss can remain unknown (Frost et al., 2007).

The sparse research exploring miscarriage as a couple-level experience suggests mixed effects on couples. Some women have reported growing closer to their partners, but others have reported tension in their marital relationships (Swanson, Karmali, Powell, & Pulvermakher, 2003). However, when partners engage in mutual sharing about the miscarriage, they report greater feelings of closeness (Swanson et al., 2003).

Disclosing the loss is a key turning point in coping with a miscarriage (Wojnar, Swanson, & Adolsson, 2011). Women have reported that talking to others, including partners, health care providers, and other supporters, about the miscarriage is an important part of their adjustment (Maker & Ogden, 2003), and a lack of social support has been associated with increased psychological distress, including depressive symptoms in women (Swanson, 2000). For men, too, support from their partners is of paramount importance, and men have also reported a lack of support from people outside the couple (Rinehart & Kiselica, 2010). Frost et al. (2007) noted that it can be difficult for couples to grieve when they feel that their pain must remain unexpressed. However, allowing couples to share their experiences and communicating support has numerous beneficial outcomes such as effective coping and psychological well-being (Jeong, Lim, Lee, Kim, Jung, & Joe, 2013). Studies with women highlight their desire for social support after the revelation of their miscarriage (Brann, 2014; Geller, Psaros, & Kornfield, 2010). It is clear, then, that talking about the miscarriage can be associated with positive effects, not only when talk occurs between partners but also when partners feel they can share the information with others. Yet, for both women and men, talking to friends and family can be uncomfortable because of the

taboo nature of miscarriage.

Scholars have suggested that the social stigma of miscarriage has an overwhelming impact on women, who might blame themselves or perceive that others blame them for the loss (Brier, 2008). Women must also contend with the identity threat of pronatalist social norms that view motherhood and womanhood as inextricably linked (Bute, 2009). In addition, both partners might feel reluctant to broach a topic so closely associated with other taboo topics like death, bodily functions, and abortion (Frost et al. 2007). To better understand how couples manage this tricky territory, we sought to uncover how they make decisions about whether and how to tell people about their miscarriage. Because miscarriage is a pervasive health issue that can have substantial psychosocial effects, and because discussing the miscarriage experience is linked to better adjustment, it is critical to improve our knowledge of how couples make decisions about discussing this topic.

Theoretical Framework

We drew on theoretical insights from CPM (Petronio, 2002) to better understand possible co-ownership of miscarriage information. CPM employs a boundary metaphor to understand how individuals, groups, and dyads control private information by creating boundaries around the information that vary in permeability level. Thinner boundaries indicate somewhat ready access to the information, while thicker boundaries indicate that access is highly restricted. Boundaries are managed through the creation of privacy rules. CPM posits that people feel a strong sense of ownership over information that they consider to be private because the revelation of private information involves some measure of vulnerability for the owner(s) of the information. This perception of vulnerability might be amplified in situations involving management of stigmatized information. Recent models of disclosure of health information

(Greene, 2009) emphasize the role of stigma, among other factors, in guiding disclosure decisions. Steuber and Solomon (2012) suggested that tenets of CPM are particularly relevant when examining "information that is perceived as sensitive and perhaps stigmatizing" (p. 20).

Although private and sensitive information is often owned by one person, in many cases it is owned by multiple individuals. Co-owners emerge when multiple people claim control over a common issue, particularly when the parties are highly invested in the issue (Petronio, 2002). Although linkage of privacy boundaries can occur when one person discloses private information to another, co-ownership also emerges in the case of shared experiences (Steuber & Solomon, 2012), meaning that multiple parties share responsibility for boundary management. This is likely the case in the context of a committed couple coping with miscarriage, as both partners experienced the loss.

Although theoretical insights provide tools for understanding dyadic ownership, little research exists examining the complexities of co-ownership (Steuber & Solomon, 2012). Even recently tested models of disclosure decisions about health-related information tend to emphasize decision-making by individuals (e.g., Greene 2009; Greene Magsamen-Conrad, Venetis, Checkton, Bagdasarov, & Benjeree, 2012). Communication scholars have made explicit calls for exploring how couples manage private information. As Steuber and Solomon (2010) indicated, "A large majority of extant research focuses on how *individuals* manage privacy. Future research studying information within the marital context should consider the processes at work as *couples* decide, together, how to supervise their private information" (p. 319). In response to this call, we aimed not only to explore miscarriage as a couple-level experience but also to make a contribution to existing communication research by studying the issue of co-ownership in a context that involves a communal stressor. Our first research question addressed this issue:

RQ1: To what extent do couples co-own private information about a miscarriage?

Past research on privacy management in the broader context of infertility has suggested that couples might have differing views on managing private information. Steuber and Solomon (2011) found that couples sometimes disclose at discrepant levels (e.g., wives reveal more than husbands), which could be a sign of disagreement. But it is also possible that couples discuss mutually agreed upon privacy rules that allow for these sorts of discrepancies. Such a conclusion is mere speculation, however. Current research does not tell us to what extent couples discuss privacy management rules when encountering fertility struggles like miscarriage. Our second and third research questions explored this issue by asking:

RQ2: What rules do couples develop to guide control of private information about a miscarriage?

RQ3: How do couples develop these privacy rules?

Methods

We conducted semi-structured interviews with 20 couples (40 total participants) to discover how they managed private information after a miscarriage. We drew on interpretive approaches to qualitative research, as defined by Tracy (2013), and were committed to allowing couples to express in their own words how they managed private information about this extremely delicate topic. At the same time, we acknowledged the theoretical concepts from CPM that drove our research questions and analysis process (MacFarlane & O'Reilly-deBrún, 2012).

Participants

The sample included committed adult couples who had experienced a miscarriage in the previous three years. We wanted the experience of the miscarriage to be relatively recent to maximize the likelihood that couples would recall conversations. Because research has

demonstrated that early pregnancy loss is a unique form of ambiguous loss, our sample included only couples who had suffered pregnancy loss prior to 20 weeks of gestation.

We recruited participants by visiting local support groups focused on infant and pregnancy loss, infertility, or adoption. We also posted announcements via social media sites, including the Facebook page, website, and electronic newsletter of a local nonprofit group with services for people coping with infertility. We posted advertisements in an e-mail newsletter distributed to faculty and staff and an e-mail distribution list for women's studies programs on the authors' campus. Finally, we used snowball sampling such that couples who volunteered for the study shared information about the research with others who had a miscarriage.

Although our advertisements did not explicitly recruit heterosexual couples, our final sample consisted of 20 married heterosexual couples. The average age of wives in the sample was 33.4 years (range 28-40), and the average age of husbands was 34.5 years (range 27-52). Couples had been married for an average of 6.3 years (range 2-19). All but one person in the sample described herself/himself as White/Caucasian, one person described herself as Chinese. The sample was highly educated, with 13 of the 40 participants reporting that they had completed a college degree, and 22 reporting they had completed at least some graduate school. Eight of the couples had suffered one miscarriage, and the remaining 12 reported suffering multiple miscarriages (range 2-6). The average gestation at the time of the most recent miscarriage was approximately 7.7 weeks, with one couple reporting the gestational age as unknown. The average time couples reported since their most recent miscarriage was 17 months.

Interviewing Procedures

Because we were interested in the communal experience of miscarriage, couples participated together in the interviews. In-depth interviews are an appropriate method for

studying privacy management, especially when practical and ethical considerations impede direct observation or recording of naturally occurring conversations (Bute & Vik, 2010). Moreover, participants can benefit from catharsis during the interview. Women who have had a miscarriage reported valuing the chance to "vent" to someone neutral during a research interview (Frost et al., 2007), and several couples in the present study expressed their gratitude that we were studying this topic.

Interested parties contacted the first author to schedule a time for the couple to participate. Face-to-face interviews were held in a private and convenient location. Because we advertised the study through social media sites and employed snowball sampling techniques, we received requests to participate from volunteers across the country. Although we had intended for all interviews to occur face-to-face, we did not want to deny couples the opportunity to tell their stories and agreed to conduct some interviews via telephone. We wanted to be conscious that the information we gathered via telephone interviews did not differ substantially from what we learned in face-to-face interviews. The first author, who conducted all 20 interviews, noted any observed differences between phone and in-person interviews. Likewise, both authors were cognizant of differences during the data analysis process but did not find any noticeable differences between phone and in-person interviews. Of the 20 interviews, 8 were conducted in a conference room on campus, 4 were conducted in the couples' home, and 8 were conducted via telephone. All couples received a $50 gift card for a retail store. Although we noticed recurring patterns in how couples told their stories and described their privacy management after the 13th interview, we continued conducting interviews because so many couples had volunteered to share their intimate experiences and because our grant funding allowed us to pay for 20 interviews. We wanted to honor the voices of as many couples as possible.

Prior to the interview, couples completed a demographic questionnaire to collect personal information and information about their relationship and the miscarriage. Interview questions focused on (a) to whom the couple had disclosed their miscarriage, (b) factors the couple considered when deciding whether to disclose, (c) details of disclosure and avoidance interactions, and (d) discussions couples had with each other about whether and how to disclose. The semi-structured nature of the interview allowed discussion of these topics while enabling the interviewer to make adjustments for the couple to elaborate on issues. Interviews lasted between 50 minutes and two hours, with an average length of 86 minutes. We audio-recorded each interview and used a transcription service to transcribe each session near-verbatim (i.e., transcripts did not include notes on pitch, intonation, etc. but did include vocal fillers, laughter, and crying). We then conducted a check of the transcripts against the original recordings to ensure that the transcripts were accurate and to allow the authors to benefit from hearing the recordings. We also removed identifying information from the transcripts.

Data Analysis Procedures

We followed an iterative approach to data analysis that involved several rounds of analysis guided by concepts from CPM. As such, rather than devising analytic codes that employ theoretical concepts near the end of our process (Tracy, 2013), we entered the analysis for this manuscript with concepts like ownership and privacy rules in mind. After each interview, the first author wrote detailed field notes to record theoretical reflections and methodological adjustments. Throughout the interviewing phase, the investigators corresponded regularly to discuss emergent themes and refine the interview protocol as necessary. During this process, we maintained theoretical and methodological memos to identify and organize concepts and serve as an audit trail for data verification (Corbin & Strauss, 2008).

As interview transcripts were completed, both researchers completed an initial reading of the transcripts to gain a holistic sense of the data. Based on our sense of the entire set of transcripts and field notes, we developed a set of CPM-based questions centered on ownership, control, and privacy rules to guide a more in-depth coding of the transcripts. Next, we used the CPM-based questions to guide our reading of a single transcript. We each read that transcript independently and then met to compare notes. During our discussion, we agreed on the CPM themes most prevalent in that transcript (privacy rules and ownership) and decided to read an additional three transcripts to develop codes for these concepts. After meeting to compare notes on the four transcripts, we refined our coding to a set of common themes related to co-ownership and privacy rules. We then each coded eight of the remaining transcripts, exchanged our coding notes, and resolved any areas of concern.

Results

Couples openly shared their stories of their miscarriage with us. It was through their narratives that we were able to ascertain levels of ownership and privacy rules used to communicate with others about their experiences.

Shared yet Different Experiences: Evidence of Co-Ownership

In each interview, partners co-narrated stories of the miscarriage affecting their relationships with each other and with others. Through their dialogue, it was apparent that a miscarriage is something both partners endure, albeit in unique ways. As one person took the lead in telling their story, their partner would follow-up, fill in gaps, or share individual incidents making it clear that both partners experienced the miscarriage, and therefore, both partners owned the information about that shared experience. Couples recognized that the emotional turmoil was a common experience, but the bodily event, and the immense physical pain that

often resulted, belonged solely to the woman. Hence, both partners co-owned the information, but women embodied the ownership through their physical experience of losing a child. This physical embodiment made women the primary owners of the information, yet couples clearly treated the information as jointly owned.

Communicating shared information. Many times couples talked as a unified unit, not only literally, but also in their language use. Couples frequently used the collective "we" to describe what they were experiencing. Beth[1] described how they "both lost something … we went through it together," and Carol said, "We have been through so much." Thus, couples recognized that the loss was shared, and in some instances, so was the communication about the miscarriage. Beth also shared, "We talk enough with each other about the loss … to say the same thing, or be on the same page at least." Thus, they shared communication about the miscarriage and how they would disclose that information to others as well as the actual disclosure.

Although a minority, some couples described their communication with others as a joint venture, further symbolizing that both parties co-owned the information to share. Wanda said, "I know [with] people at church, we talked together about it." This collaborative sharing was often done with mutual friends or family. Carol stated, "We decided to go ahead and tell my family" illustrating the mutual decision and communication of that decision. However, all of the couples also had stories of times they individually told people about the miscarriage. This individual action provides support that the information is co-owned if the person felt comfortable communicating about the miscarriage without the partner present (e.g., ownership) but wanting, or needing, to "check in" with the partner regarding the disclosure (e.g., co-ownership). As Miles noted, "we're a couple and it was both of ours baby, but since it's such a personal experience for the two of us, I wanted to make sure that was alright to talk about that."

[1]All names are pseudonyms.

In many instances, partners discussed outside disclosures with each other before doing it to make sure it was okay (e.g., Vera said, “I’ve asked him before I told something, like ‘Is this okay?’”) or after to let the other person know the information had been shared and then they were able to process the interaction together. For example, a couple shared:

> Seth: I mean I think Sally usually knew when I spoke to somebody about it because they would usually say, “Tell Sally she’s in our prayers” or “We hope she’s feeling better.”
>
> Sally: And yeah, I’d usually tell him, “I talked to so and so today and told them about the miscarriage.”

Partners wanted each other to know about their disclosures because of the shared experience. Both spouses “checked in” with the other person, recognizing that the information was jointly owned, which provides support for co-ownership.

Embodied ownership. Although couples shared the emotional experience of losing a child together, both partners emphasized and honored the fact that only women suffer the physical toll of a miscarriage. The physical experience can mean coping with frightening and ambiguous symptoms like pain or bleeding that signify the beginning of loss, enduring surgical procedures and the subsequent recovery process, and even seeking emergency medical care when blood loss or pain become unbearable or potentially life-threating. Couples were quick to acknowledge the immense impact of this bodily experience which, in turn, affected much of the communication both within and outside the couple. For example, Maggie shared, “One thing we did talk about … making the decision of what to do. This is my body, but our baby.” Although it was her body, they recognized the shared experience of loss. Similarly, Beth said, “We’re still experiencing the same thing. He’s the only other one who had the emotional attachment like I did.” Couples recognized that although a woman is the one who physically loses a child, both

partners share in the loss and together should discuss how to cope with that loss.

Still, couples stressed that women's physical embodiment of the loss privileged the woman in making privacy management decisions. Many of the men relied on their wives to grant permission to communicate about the miscarriage because they felt like her physical and emotional health was paramount to disclosing this information to other people. Amy shared a conversation she had with her husband:

> So I was like, "Well, if you want to tell your parents, go for it." Because I always thought he was worried because I was so private that he had to protect me. I was just telling him it's okay to let them know.

Men would also often turn to the woman to know when and what was appropriate to communicate. Many of the husbands discussed deferring to the wife. Oscar said, "I was really taking Olivia's lead of who I would be authorized to tell and when." Not only were some of the men letting their wives decide when and how to communicate, but they were also allowing them to do the communicating. For example, when talking with his wife about communicating about the miscarriage, Miles said, "I was letting you take the lead on it for the talking about it … It happened to us as a couple, but more on your end."

Couples often argued that the woman's collective experience (i.e., physical and emotional) almost trumped the emotional involvement of the men, and therefore, the woman had more freedom to disclose information. Karen shared, "If it got shared at all, it was me who did the sharing. And we didn't talk about why that was so, but hearing Kent talk about it – that makes perfect sense … it hadn't happened to him."

Couples clearly shared the emotional experience, but they could never share the physical experience. Because of this, internal communication between the couple was essential to

determine levels of ownership and what could be communicated. Although there were examples of individual disclosures, or non-disclosures, based on the physical embodiment of the miscarriage, most couples recognized the co-ownership of the information.

Rules about Communicating Private Information

As the couples shared their experience with communicating about the miscarriage, it was clear that rules existed regarding the disclosure of their private information. Four privacy rules related to the miscarriage as well as a privacy rule about pregnancy in general emerged in our data. Although most couples argued that they "just knew" how and to whom to communicate (i.e., implicit rule), examples abounded in their narratives of explicit conversations in which they developed boundaries around private information. The rules surrounding the disclosure of miscarriage information described in this study could be characterized as rules about who to tell. The privacy rule about pregnancy in general was related to the timing of the disclosure.

Disclose to someone who miscarried. One privacy rule revolved around disclosing information to others who had a similar experience. A couple may disclose they had a miscarriage after learning that someone else had a miscarriage or, if they did not know anyone in their social network, by attending support groups for parents who miscarried. For example, Larry discussed how his wife made a profound statement during a counseling session when "she said that she was given these issues [multiple miscarriages] as an opportunity to be able to share her experiences with other people. When someone says, 'Oh, I've had one miscarriage,' and she can say, 'Well, so have I.'" When someone disclosed about a miscarriage, it provided an opportunity for couples to feel validated and share their experience.

Men also valued being able to discuss the experience with others, especially other men, in similar situations. Miles shared a conversation from a support group:

> Him and his wife had experienced a miscarriage at seven months. So he talked to me about it, and it was very honest because he said to me, there was support there, but he said, “It’s gonna suck. There’s no way around it.”

These outlets provided couples with an opportunity to communicate shared experiences. As some couples expressed, “you’re a member of the club now,” even if it is a club to which you do not want to belong. Although this club is very large because of the commonality of miscarriage, people are unaware because of the stigma society places on communicating about miscarriage. Eugene stated,

> It absolutely is taboo. People don’t talk about it, and people don’t want to hear about it. It’s just one of those things you’re supposed to keep behind closed doors. There’s no real way to talk about it. I mean if there was a way to talk about it, if it was acceptable in society, there’d be a Hallmark card: “Sorry you lost your child.” And there’s not, and that right there tells you it’s not socially acceptable to talk about because there’s a Hallmark card for pretty much everything else.

Because of the stigma of miscarriage, couples learned that finding and communicating with others who shared the experience were usually most helpful.

Disclose to someone who initiates topic. The second common privacy rule was disclosing information about miscarriage to others who brought up the subject first. If someone else began a conversation about miscarriage, infertility, or family planning in general, couples were more likely to disclose their miscarriage experience than bringing up the topic themselves. As Jessica stated,

> I don’t usually, I guess, bring it up unless somebody brings it up to me, or if I hear, like if somebody says, you know, “So-and-so lost a child” then I will start talking. But I guess I

don't bring it up unless there is a topic.

Additionally, if someone explicitly asks the couple about their experience (e.g., Colin said, "If they ask, I'll tell them, but I'm not going to volunteer the information proactively") or if they ask about their plans for a family then they may also be more willing to disclose about their miscarriage. Couples noted that when people questioned them about their plans to have children, it provided an opportunity to share their experience. Hank said,

> You get these awkward questions about "Oh, are you gonna have more children?" Sometimes I'll say no or "Probably not and these are the reasons why." That's actually opened doors for me to have conversations with people I work with who have been through infertility problems themselves and have children through IVF [*in vitro* fertilization] or that they've had loss themselves. So I've been able to have conversations with people and share experiences in that way.

Although someone else bringing up the topic does not guarantee that the couple will disclose, it is important to note that a primary reason couples gave for not revealing miscarriage is because people did not ask about it (e.g., Lisa said, "If they ask, I tell 'em. If they don't, I don't").

Disclose to someone who needs to know. A third privacy rule involved communicating with individuals who needed to know the information. This was most often discussed as information employers or co-workers needed because of absences or mental distraction from work tasks. Women discussed telling their employers because the physical nature of the miscarriage required them to take time off of work. For example, Amy said, "When I had the miscarriage, I just had to tell everybody at work because I was missing so much work." Some men continued going to work but were not as productive as they once were. Colin shared, "I felt like my performance at work was already suffering somewhat, and I felt like I needed to let him

[employer] know what was happening."

This rule also included telling people who knew about the pregnancy, a common reason shared among the couples. Carol stated, "We had already told everyone under the sun about our pregnancy and so when we lost the baby, we had to tell everyone." This type of disclosure prevented future inquiries about the pregnancy. For example, Vince shared that it was important to communicate with everyone who knew about the pregnancy because he did not want to have to tell everyone months later when the baby was expected to arrive:

> The thing that was really concerning me was that phone call eight months later in February, like "how is the baby?" So I guess I really wanted to make sure that we contacted everybody so we wouldn't get those phone calls.

The couples explained that the pain never completely disappears but does lessen with time. Still, they did not want to relive the experiences when asked about the child. Nor did they want other people to feel uncomfortable communicating with them. Flora shared the story of when she told her cousin about the miscarriage: "She e-mailed me later and said she didn't mean to not follow up, and she wasn't sure how to have a conversation about it … she felt uncomfortable." Flora disclosed to her cousin because her cousin already knew she was pregnant.

Disclose to someone who provides support. The final couple-level privacy rule focused on communicating with people who will provide needed support. Couples need different types of support and often share their experience when seeking that support. For example, couples disclose their loss when they need emotional (e.g, comfort, reassurance), informational (e.g., advice, feedback), or even instrumental (e.g., meals, transportation) support (Brann, in press). Women, in particular, discussed confiding in their friends because they wanted to have someone listen to them. As Denise described, "I would reach out to my friends to talk to them about it

because it was something that I was really sad about and needed to work through." It was important to the couples to communicate with the people who they thought would understand and provide them with the support they needed, even if that meant telling them what it was they needed. Carol shared the couple's story of communicating with a church group:

> We were in the emergency room Friday night and on Saturday I sent an e-mail to the group that we sang with at church … I remember saying, "Please give us a few days. We kind of feel the need to cocoon a little bit right now," but I think within three days they were over bringing meals and making sure we had everything we needed.

Another common type of instrumental support desired was having someone else disclose the loss to others who needed to know. This actually was a helpful way for parents to provide support to their children who were experiencing a miscarriage, especially if the parents did not have any prior involvement with miscarriage. Couples recalled telling their parents to share the information with other family members, and many assumed they would do so without prompting. Denise said, "I think I said [to her parents], you know, 'tell everybody,' and I think that they assumed that they would be doing that anyway."

Finally worth noting, the lack of inquiry is not the only reason couples avoid talking about their miscarriage with others. Another reason why people do not divulge their miscarriage is because of uncertainty about anticipated responses (Greene, 2009). If a couple is unsure if they will receive support, they are less likely to share information about their miscarriage. Jeff stated, "Even though people, family and friends, know about it and maybe know that you're going through it, they don't know what to say, and so even when they do say something, it's usually the wrong thing to say." This uncertainty of responses often led to the formation of new privacy rules. For example, when discussing how her stepmother violated her trust by sharing

information about the couple's miscarriage – a response she did not expect – Lisa shared, "When the next one did come up, I didn't tell her."

In addition, when couples received dissatisfying responses, or even lack of responses, they changed rules about who would make a worthy confidant. This reformulation of rules usually occurred when they received insensitive comments. For example, Larry said he would not disclose private information about future pregnancies, miscarriages, or infertility issues with his mother after her response. He shared, "After the miscarriages, she pretty much told us we didn't need to have any more kids and we were – ridiculous that we were gonna try again." People's dearth of comments and recognition of the experience was another hurtful response illustrating the lack of expected support that dictated who would be privy to future information. Having others recognize the loss and the need to grieve was important for couples and often a source of contention when people did not respond in the supportive way that couples needed.

Disclose when the pregnancy is "safe". Many couples recognized the societal "rule" of not revealing a pregnancy until after the first trimester (e.g., Peter noted, "The magic 12 weeks"), which can make the disclosure awkward because people were not even aware of the pregnancy. For example, Sally shared the confusion that can surround this approach:

> I didn't tell them [friends] that I was pregnant. They didn't know. So for those 10 weeks, I was keeping it a secret because I wanted to wait to tell them until at least 12 weeks, and so then when I had miscarried, it was like they didn't know that whole part of me that had been going on for the last 10 weeks. And so I did end up sharing it with a couple of them just because I felt like that was something that I was so looking forward to sharing with them in just a few weeks, and I think that was harder. None of them knew what I was going through. I couldn't share that – or not that I couldn't, but I had chosen not to share

> that. So then when the miscarriage happened, it was like, "Now do I tell them I had a miscarriage or even that I was pregnant?" That was a weird thing for me to deal with.

Many people had not followed the 12-week rule until they had suffered a miscarriage and then that led to the creation of a new rule for them. This affected the communication of subsequent pregnancies until after the pregnancy was deemed "safe": either because of time (after the first trimester) or a viable fetus shown on an ultrasound. However, even these times are ambiguous as many of the couples had a miscarriage after seeing or hearing the baby's heartbeat, and some were after the first trimester. Oscar shared:

> We've come to realize that yes, a lot can happen in the first couple of weeks. So, at what point do you feel comfortable telling others knowing that you might have to retract it a month later? I think that sort of played into when we plan to announce any sort of pregnancy at this point.

The effects that pregnancy and miscarriage, and the rules formulated around both, have on each other speaks to interrelated webs of privacy boundaries. For those who subscribed to the societal norm of not disclosing a pregnancy until it was deemed as safe, once the miscarriage occurred, the couple had to decide whether to keep their information private or develop a new privacy rule to disclose their information that violated the original privacy rule of waiting 12 weeks. Alternatively, for those who had already shared the news of their pregnancy, after the miscarriage occurred, many couples developed new privacy rules of (a) talking about the taboo topic of miscarriage because they felt forced to share their private information in light of the previous disclosure of a pregnancy and (b) restricting communication about subsequent pregnancies until a safe time had been reached in future pregnancies. Developing privacy rules

around miscarriage and pregnancy information illustrates the complexity and interrelatedness of privacy rules in this context.

Formation of Privacy Rules

The couples stated that they did not usually have explicit conversations regarding with whom and what they would communicate about the miscarriage. However, through the interviews, it became evident that these conversations did occur, though the couples did not always label them as explicit conversations related to privacy rules. Nearly everyone stated that they did not discuss who they would talk to or what they would say. The sentiment expressed by virtually all of the couples was "it was just understood." They trusted each other, and most believed that they could decide on their own who to communicate with about the miscarriage. They felt that the partner would be respectful of their shared experience. However, the stories they shared about their conversations surrounding the miscarriage clearly illustrated that they were communicating desired privacy rules.

Those who recognized their explicit conversations often deferred to the wishes of the woman because of her embodied ownership of the information. However, additional decision-making conversations emerged during the couple's narratives. Larry said, "We had major discussions after each [loss]." In some instances, couples described how they decided together who they would tell and who would tell those people. For example, Patsy explained that after their second miscarriage "we had had the conversations again of like, 'Okay, what do we do on the telling people?'" and Colin shared that it was important to make sure that they were in agreement by simply asking, "Are we on the same page about when and who to tell?" There were conversations detailing that each partner should tell her/his respective families and friends.

The new privacy rules couples formed after unexpected responses or when planning for

future families involved explicit conversations. Couples talked with each other to determine if they would share additional information with others about miscarriage, pregnancy, infertility, or even family planning. The miscarriage prompted communication between the couple about what rules they wanted around their fertility experiences. For example, a couple shared that they were negotiating what information to disclose to others: “Just recently we had a discussion about when to tell or how to tell or if to tell Colin’s family that we’re doing treatments because they know about our losses but not about the IUIs [intrauterine insemination] and IVFs.”

Much of the communication between the couple occurred after the miscarriage and after the disclosure of the miscarriage. Partners would verify that their disclosure was acceptable and that would lead to a discussion of what should be disclosed, how it should be done, and who should receive the information. These discussions are examples of privacy rule negotiations.

Discussion

Couples in our sample coping with miscarriage clearly share the emotional experience of the loss and jointly own the information about the miscarriage. However, their reflections on their journeys and their management of private information are also distinct largely due to women’s embodiment of the experience. Because the information is co-owned, couples must negotiate privacy rules to satisfy both co-owners. In this sample, couples’ privacy rules reflected to whom they would communicate. Ultimately, communication with each other and with people outside the couple influenced subsequent disclosures.

Theoretical Implications

This study answers calls for more research about co-ownership of private information in romantic relationships (Steuber & Solomon, 2010; 2012), examines a new context in which CPM can be applied, and extends our knowledge of CPM’s privacy rule formation, or in many cases,

re-formation. Because women endure the bodily trauma of losing a child, they are often designated as the primary owners of the shared information. We propose that this sort of ownership is a distinct form of "embodied ownership," which illustrates the ways that co-owners of private information defer to the owner who embodied the experience central to the private information at hand. In our data, both partners expressed deep emotional pain and grieved the loss of a desired pregnancy. Both partners described a need to talk to others to seek support; keep friends and relatives updated; and express their sadness, frustration, and anger. Yet, both communicated that the woman's embodiment, the fact that she had felt the physical pain of a miscarriage, entitled her to determine many of the privacy rules surrounding the information.

This designation of women as primary owners of information provides empirical evidence for CPM's contention that co-ownership does not necessarily mean equal ownership. In other words, deferring to one partner's preferences or designating one partner as primarily responsible for disclosing to the social network can be an agreed-upon strategy for privacy management, a form of collectively managing the information. The patterns found in our study are similar to disclosure discrepancy patterns revealed in infertility studies (Steuber & Solomon, 2012). Coordination and co-ownership do not necessarily mean that everyone follows the same rules, but rather that the rules are agreed-upon by the relevant parties. As Steuber and Solomon (2012) suggested, couples might benefit from specifying different but agreed-upon rules "that are consistent with the comfort level of each spouse" (p. 21).

Even in situations in which information is defined as belonging primarily to one partner, in our case to wives who lived the physical experience, "there is a collective responsibility of both parties for that personal information, making it dyadic" (Petronio, 2002, p. 136). Perhaps ownership in the case of miscarriage (in the context of a committed relationship in which

pregnancy is desired) can be characterized as both a personally owned event and a collectively owned event in which both personal and dyadic privacy control are at play. For women, only they possess the intimate bodily knowledge of what the loss felt like, a loss characterized by emotional and physical pain that prompts not only fear and anxiety but mourning for what might have been. Men, too, own the emotional toll of miscarriage, marked not only by grieving the loss but also by a sense of helplessness as they watch their wives embody the loss. For both partners, they likely share the aspects of miscarriage that mark it as a truly communal event. For instance, often both parties share knowledge about the details of the event itself (e.g., hospital visits, interactions with health care providers), their future childbearing plans, their decision to announce another pregnancy, and so on.

Couples provided examples of explicit conversations detailing negotiation about privacy rules and the relational benefits of communicating about privacy management. This was especially evident when new privacy rules were formed, often after the miscarriage or the disclosure of the event. Even when couples were confident in their management of private information in their relationship, the unique context of miscarriage challenged privacy rule assumptions and forced the creation of new rules. Miscarriage is a new circumstance that emerges in the midst of a pre-existing dyadic privacy boundary in which couples likely operate under previously established rules and patterns for handling private information (Petronio, 2002).

Couples' experiences within a quickly evolving situation marked with joy and tragedy make privacy management in this setting unique. For example, couples begin to share an initially private occasion of being pregnant only to have it taken from them and replaced with the experience of loss. This makes a miscarriage unlike anything else a couple shares and a unique context for observing the ebb and flow of privacy rule formation and re-formation. Couples must

develop rules for multiple intertwined experiences (i.e., pregnancy, miscarriage, subsequent pregnancies) by relying on contextual criteria. Contextual criteria illustrate how rules "emerge and are modified" in response to shifting circumstances (Petronio, 2002, p. 57). In the miscarriage context, the contextual criteria that prompt privacy rule formation and modification for both joyous and tragic events are intermingled. Temporality is an especially important, though ambiguous, criterion. Couples recalled using temporal markers, such as waiting for a pregnancy to progress past the first trimester, as the basis for privacy rules, though these temporal markers are nebulous. As many couples can attest, progressing beyond the first trimester does not guarantee the birth of a healthy child. Yet, these time-oriented markers seemed to give couples one concrete criterion for privacy rule development in the midst of a chaotic and unpredictable situation. By highlighting the way that privacy management shifts over time (Bute & Vik, 2010) and drawing attention to the role of temporality, this study contributes to continuing scholarly conversations that frame privacy management as an ongoing, ever-shifting process rather than a one-time event (e.g., Caughlin, Bute, Donovan-Kicken, Kosenko, Ramey, & Brashers, 2009).

Practical Implications

Our conversations with couples offer insights for practitioners providing therapeutic resources and designing interventions for dealing with miscarriage. For instance, Wojnar et al.'s (2011) recently proposed model of miscarriage for use in clinical practice urges health care providers and mental health professionals to view miscarriage as a multifaceted process marked by critical turning points, including "going public" with the loss. However, the model offers no guidance on *how* to go public. Moreover, the model is drawn entirely from interviews with women, with little acknowledgment of the communal nature of miscarriage and co-ownership of

private information. Our study demonstrates that couples view the information as jointly owned. Health professionals should encourage couples to discuss their preferences for handling the information by metacommunicating. Designating a primary owner of the information could be a useful approach, and professionals could assist by guiding couples through this process. The pattern of designating the wife as the primary owner of the information worked for most couples in our study but merits greater discussion and exploration in other couples, especially in cases where men feel that their voices are neglected in the coping process (Rinehart & Kiselica, 2010).

Most couples in our study explained that they did not have explicit conversations about managing their shared information; they claimed to "just know" what was appropriate for their partner. Yet, our data suggest that explicit conversations did occur, and even couples who insisted that they did not recall talking about privacy rules went on to describe examples of explicit discussions about handling the private information. It could be that because the couples in our sample value communication, this type of talk is a common pattern in their relationships; therefore, they did not recognize the explicitness of these conversations. This self-disclosive openness about relationship and communication expectations is effective for maintaining relationships (Canary & Stafford, 1994); thus, it seems important to enact such patterns when faced with potential relationship-damaging consequences in the midst of tragedy. Practitioners counseling couples should identify those couples who do not have existing patterns of healthy and supportive communication and encourage them to talk explicitly about privacy rules.

Finally, professionals aiding couples coping with miscarriage could encourage them to contemplate how potential recipients will respond to the disclosure and to consider seeking support from others who have suffered miscarriage. Couples in our study sometimes anticipated how confidants would react and developed privacy rules accordingly, a practice consistent with

work by Greene and colleagues (2009, 2012) that points to the ways that anticipated reactions shape disclosure decisions. Some couples in our sample developed privacy rules centered on disclosing to people who had a miscarriage themselves, which mitigated the risk of receiving insensitive and hurtful comments and diffused some of the anxiety associated with going public (Wojnar et al., 2011). Couples found support from others bereaved by miscarriage more helpful than support from those who could not fully understand the extent and nature of the grief prompted by pregnancy loss. This finding is consistent with research suggesting that people who have had direct, or even indirect, experience with miscarriage might provide higher quality social support (MacGeorge & Wilkum, 2012) and a greater sense of validation than those who do not (Gold, Boggs, Mugisha, & Palladino, 2012). Seeking support from similar others could also mitigate feelings of social stigma and help couples feel more confident about divulging a taboo topic like miscarriage (Greene, 2009). Thus, practitioners should encourage couples to communicate with others who have similar experiences.

If couples do not know members of their existing social network who have coped with miscarriage, they might find it helpful to seek out support groups for dealing with pregnancy loss. Several couples in our study indicated that sharing their stories in support groups filled a gap in their support needs and prompted them to be more open with each other in processing their sorrow. Practitioners could provide information to couples about pregnancy loss support groups. The development of group-based interventions could also address this need. Only a handful of randomized control trials have tested psychosocial interventions for improving management of miscarriage (Swanson, Hsien-Tzu, Graham, Wojnar, & Petras, 2009). The most common model involves a clinical practitioner, such as a nurse or midwife, providing one-on-one counseling in person (Nikcevic, Kuczmierczyk, & Nicolaides, 2007), via telephone

(Neugebauer et al., 2007), or via Internet (Kersting, Kroker, Schlicht, & Wagner, 2011). Based on our findings, we would urge practitioners to consider developing and testing group interventions, such as face-to-face support groups, as a promising way to improve coping outcomes. Some limited evidence already suggests that such groups facilitate the process of coping with stillbirth (Cacciatore, 2007) and aid in managing subsequent pregnancies after miscarriage (Cote-Arsenault & Freijie, 2004).

Limitations and Future Research Considerations

Studying couple co-ownership about miscarriage with a more socially diverse sample of couples would enhance our understanding of the nuanced nature of co-ownership. Like any study that relies on participants who readily volunteer to discuss a highly sensitive and intimate topic, our conclusions must be tempered by the scope of our sample. For instance, couples in our sample did not discuss disagreement about privacy rules, which does not mean that couples do not encounter turbulence about privacy boundaries (Petronio, 2002). Perhaps highly satisfied couples or those actively seeking support in group contexts were more likely to volunteer for our study than couples whose marriages were most deeply affected by the trauma of miscarriage. In addition, we recognize that interviewing couples together, rather than individually, might have constrained their responses and prevented them from expressing themselves in ways that they would have if their spouse had not been present. However, we did find that couples were quite candid in their interviews, often expressing deep emotions, describing pain and discomfort in graphic detail, recounting arguments not related to privacy rules, and admitting that they learned things about their spouse that they did not know prior to the interview.

Another important next step would be assessing the reasons why couples established these privacy rules, which may provide insight into how the complex issue of miscarriage differs

from other private topics. This could help develop effective communication strategies for couples dealing with loss. It may be that access rules are developed along similar criteria as other sensitive topics (e.g., culture, risk-benefit ratio; Petronio, 2002), or it may be unique criteria that should be shared to assist couples in managing their private information.

Additionally, given that couples perceive their privacy rules to be implicitly understood, it is important to assess what happens when a co-owner violates those assumed privacy rules. Learning how couples manage outcomes when faced with differing views of permeability, for example, could provide awareness of potential negative outcomes and how to successfully resolve differences. The silence couples suffer when faced with the loss of their child may be overcome through the sharing of their experience. However, for such disclosures to be effective, couples must recognize the shared nature of, and their communicative preferences related to, that experience. Managing private information is a communicative act that can give voice to those couples who have been silenced.

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