

**“Things change, things aren’t always a given”: Exploring the Experiences of  
Miscarriage: A Narrative Analysis.**

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## **Abstract**

**Introduction:** Miscarriage continues to be a prevalent experience; one in four pregnancies will end in miscarriage and is the most common adverse outcome of pregnancy. It can be both emotionally and physically impactful, yet often goes unrecognised and rarely discussed. Literature reviewed highlighted the societal and medical discourses that surround pregnancy and motherhood, yet how such socio-political discourses influence a miscarriage experience have been seldomly explored. This alongside a lack of discussion on embodied experiences prompted an exploration of the ways individuals narrate and share their stories of miscarriage.

**Methods:** Eight women who had experiences of miscarriage were interviewed to collect data that related to the ways participants constructed narratives and how these influenced their sense-of-self. An interest in embodiment theory and socio-political discourse developed from the literature review, led to the application of visual methods as part of interviews, to help generate narratives. A critical narrative analysis was then utilised to explore the data collected.

**Findings:** Participants drew from ‘medical’, ‘natural instinct’ and ‘social expectation’ discourses, which generated narratives of failure, self-blame and guilt. Discourses which adhere to linear notions of progress, led participants to feel disempowered with limited agency over their bodies and subjective experience. In the absence of societal norms and public discussion around miscarriage, participants often felt unaware and unprepared and attempted to make sense of their experience in isolation using a range of frameworks and perspectives.

**Discussion:** Findings emphasise the ways in which individuals felt disempowered with limited self-agency, and viewed their subjective experiences as neglected. Due to the lack of available discourse and prevailing assumptions which link pregnancy and motherhood to female identity, miscarriage remains a stigmatised and marginalised experience. Implications of the findings are to support a social justice agenda in clinical practice, in order to reduce the silence and taboo associated with miscarriage. Furthermore, it is highlighted that working with the body in therapy may counter a mind/body dualism, which can facilitate raising awareness of subjective experience.

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## Introduction

In the UK, the estimated rate of miscarriage is 250,000 each year and is the biggest cause of an end to a pregnancy (Tommys, 2020). It affects 25% of women who have been pregnant by the age of 39, constituting 12-20% of all pregnancies (Blohm, Friden & Milsom, 2008) with 85% of those happening in the first trimester, which is considered the first one to twelve weeks (Tommy's, 2020). However, the incidence rate is likely to be higher, as not all pregnancies are reported or medically verified (Freda, Devine & Semelsberger, 2003), women may not be aware of their pregnancy (Hardy & Kukla, 2016) and not all women seek treatment following a miscarriage (Hemminki, 1998). Miscarriage is also cited as the most prominent complication during pregnancy and the leading gynaecologic condition requiring hospital admission (Hammerslough, 1992; Nybo et al., 2000). Despite its prevalence, research suggests that people tend to underestimate the commonality of miscarriage, hold various misunderstandings of the causes and report significant difficulties in speaking about it. To this end it is an experience that has been described as a silent event even though there are often significant emotional and physical side effects (Bansen & Stevens, 1992). The perceived lack of open discussion about miscarriage is said to be closely related to the many ambiguities that make up this experience, alongside larger debates over women's reproduction, which miscarriage can become enrolled in (Reiheld, 2015).

Reiheld (2015) argues that there is a high degree of division between a woman who miscarries and society in general: *"silence, isolation and uncertainty combine to augment the suffering of miscarrying women"*. In contrast, in the case of pregnancy, *"our collective consciousness is overcrowded with multitudinous meanings"* (p.201). Miscarriage for the most part is far less understood and often described as prohibited for open discussion in a way that is

dissimilar to pregnancy (Atkins, 2010; Leith, 2009). The details of pregnancy are far more likely to be spoken about openly and publicly. Thus in the absence of public awareness and understanding of this event, individuals who experience a miscarriage can feel at odds with how to make sense of and navigate this event (Hardy & Kukla, 2016). Once considered as insignificant, transitory and overlooked by others as not being an actual loss (Lee & Slade, 1996) there is now a growing body of literature, which highlights the significance of this experience and the lasting impact it can have.

Although limited, research has pointed to the ways in which miscarriage can influence a person's sense of self and the difficulties individuals can have in comprehending this experience (Frost et al., 2007). As Layne (1997) highlights the landscape of pregnancy and motherhood is a 'noisy' one, where there is more public awareness, and clear cultural scripts for individuals to draw on. This seems salient to miscarriage, as the event involves a pregnancy, which is an aspect of the transition for women into motherhood. Social constructions of pregnancy and motherhood, may then influence a miscarriage experience, which to date have been seldomly explored. Moreover, how such constructions shape an individual's sense of self after a miscarriage can provide further insight on this experience and elucidate possible reasons for the perceived lack of open discussion.

Given miscarriage is a prevalent event, more so than is publicly acknowledged, additional research can aid in our understanding of the wider context and the ways this might impact an individual's experience. This research is therefore interested in how society responds to miscarriage and the ways that discursive practices shape the meaning and values placed on pregnancy and motherhood and how this influences stories of those who experience miscarriage(s).

## Key definitions and researcher's choice of terminology

Before proceeding further, it is important to address some terminological issues, given there is no clear agreement on what a miscarriage is. For example, the UK defines miscarriage as *“the spontaneous loss of a pregnancy before 24 weeks gestation”* (National Institute of Clinical Excellence, 2013) and a still birth as *“when a baby is born dead after 24 completed weeks of pregnancy”* (NICE, 2013), whereas in the USA, the period of distinction is usually 20 weeks. When exploring the literature on miscarriage, many studies do not differentiate between ‘miscarriage’ and ‘stillbirth’ and also include late terminations. Notably, up to the late 1990’s studies included the terms ‘spontaneous abortion’, ‘induced abortion’ and ‘missed abortion’ to refer to a miscarriage and these terms are used interchangeably in the literature during this period. The subsequent shift in terminology is commonly seen as a result of doctors and health professionals actively calling for a distinction between ‘miscarriage’ and ‘induced abortion’, due to the perceived difference of experience between people who have ‘spontaneous’ miscarriages and those who have abortions (Moscrop, 2013). Consequently, literature from 1986 to now utilises the terms ‘miscarriage’ and ‘early pregnancy loss’ to define the end of a pregnancy of up to 24 weeks. Browne (2018) highlights these terms themselves are also questionable, particularly ‘miscarriage’ with its associations to failure, for example a ‘miscarriage of justice’ or the connotation that a pregnant person is responsible, such as the ‘mis’ in ‘misplaced’ (p.62). Considering these issues, ‘pregnancy loss’ was introduced as an empathic response to women’s experiences. The term is wide ranging and comprises the end of a pregnancy whatever the duration. It is also used in cases where a pregnancy has been terminated but loss is felt, such as a ‘therapeutic’ abortion for medical reasons (Browne, 2018). However, the term ‘pregnancy loss’ has also been contested, as it is not always suitable for some women, as a loss may not be

experienced when a pregnancy ends (p.62). Similarly, the connotation of ‘loss’ for some women is the failure to keep a pregnancy. This discursive issue highlights one of the many complicated facets that surround this experience.

Kevin (2011) illustrates this discursive issue in her exploration of women’s testimonies, where she describes the difficulty some women face in drawing upon appropriate discourses that reflect their experiences accurately. She notes the struggle some women have of finding terminology that is more specific to “*the contours of miscarriage*” and raises the point that conventional phrases often fall short of describing their distress (2011, p.4). The idiom “I lost my baby” for example, evokes anger and rage in one woman as she says, “*I did not lose my baby. . . . My baby just died!*” Kevin notes, “*the grappling of the discursive limits of miscarriage grief...a rejection of the euphemistic verb lose, replacing it with ‘died’, while the object of the loss, ‘baby’-a metaphor for the pregnancy that was-remains*” (p.12). In addition, Miller (2015) highlights that the main conceptualisation of miscarriage as a loss event can be problematic as it does not always account for the many complexities of a miscarriage experience. As will be discussed further in this section, there are also political issues pertaining to the language of loss, which requires some caution around its usage. In the context of a ‘pro-life’ political climate, a sense of loss is arguably expected as the sole and legitimate response (Kevin, 2011). Accordingly, the term ‘miscarriage’ is used in this research, to speak in generally of a ‘non-induced’ end of a pregnancy of up to 24 weeks duration, as a way of minimising any emotional implications relating to the variable and subjective experience of this event.

Browne (2018), also suggests that the naming of those who are/have been pregnant leads to terminological difficulties, as speaking of ‘*pregnant women*’ can be regarded as discriminatory of pregnant men or individuals who are gender non-binary (p.62). She argues that gender neutral

terms such as ‘pregnant people’ are increasingly favoured and highlights criticism of some feminist writers who use the term ‘pregnant women’ to refer to a collective, or the ‘pregnant woman’ to denote an individual. However, moving towards a gender-neutral language is arguably not that straightforward, as Browne (2018) indicates, the terminology of ‘*pregnant people*’ and ‘*non-pregnant people*’ has had reactionary usage in the past (p.5). She argues such terms have previously been used by those who pursue an agenda that rejects protections against pregnancy discriminatory practices in the workplace, by asserting that it is not a type of illegal sex discrimination. Furthermore, the use of gender-neutral terms such as ‘pregnant people’ can be considered to cloud the feminist debate around pregnancy, which has continually been associated to femaleness and womanhood. As will be discussed further, the normative ideas around femaleness and womanhood have governed social expectations and regulations of pregnancy, which makes the idea of male pregnancy an ‘*unthinkable phenomena*’ (Toze, 2013, p. 204). Browne (2018) argues although dismantling the circular link between ‘pregnancy’ and ‘women’ is imperative in order to change prevailing images of pregnancies, ‘pregnant women’ can still be used as an analytical term, especially if the aim is to examine how struggles for control of pregnancy impact those understood to be girls and women directly. With these considerations in mind, in this research gendered terminology like ‘women’ and ‘pregnant women’ are used when discussing gendered discourses and regulations of pregnancy, which explicitly or implicitly impact upon pregnant women, and ‘pregnant people’ is utilised when the use of gender-specific terms are not imperative to the point.

## Literature Review

### A Multidisciplinary and Cultural Approach to the Literature Review

The literature review was conducted using a multidisciplinary approach, in order to demonstrate the range of diverse and complex constructs around miscarriage, which include pregnancy and maternal identity. Moreover, reviewing literature across multiple fields of study emphasises the necessity for a bio-psycho-social (Engle, 1980) understanding of miscarriage and results in a thorough and nuanced exploration of the subject area. In addition, a culturally progressive approach was employed in examining the literature (Onwuegbuzie & Frels, 2016), which emphasises the role of reflexivity at each stage of research, including the literature review. Using a cultural approach encourages the reviewer to:

*“engage in reflective practices to become aware of his/her own cultural attributes better, to recognise, acknowledge, affirm and value the worth of all participants and researchers/authors to capture their voices” (p.6).*

This proactive stance acknowledges the role that culture plays in the literature review process, alongside the reviewer’s own experiences/background, which can serve as assets or limitations when searching and interpreting literature.

In undertaking the literature review, it became apparent that pregnancy and motherhood is researched extensively and has been interpreted and understood in a variety of ways. Miscarriage on the other hand, has received less scholarly attention, with most of the research carried out by medical professionals and mainly located in the biomedical domain. Hardy and Kukla (2015) have highlighted the shortcomings of such research and argue that there tends to be a focus on the aetiology of miscarriage rather than the event in its entirety. Nettleton (1995) also states that

the body can have psychological, political and social consequences. Consequently, it was appropriate to review literature from the medical domain alongside other disciplines, due to the dichotomy that health and illness can demonstrate, in addition to women potentially seeking medical intervention to manage their miscarriage,

The apparent scarcity of research on the topic, called for a multidisciplinary approach in order to explore literature across domains. This led to a review of sociological, anthropological and feminist literature. There is a particular focus on feminist sociologists who are recognised as being one of the first to consider embodied experiences of the self and the ways in which medical and scientific descriptions of women's biological functioning are socially constructed (Nettleton. 1995; Shilling, 1993). This multifarious interaction between the social and physical self, seems central to the exploration of miscarriage experiences.

In the following literature review, a summary of the discourses used in pregnancy literature will be presented and discussed in relation to miscarriage. Namely 'medical' and 'natural' discourses will be examined, which illustrate how pregnant women are positioned and how such discourses construct motherhood and the connection these have with miscarriage. Next, a discussion of miscarriage literature will focus on the medicalisation of miscarriage, theories of attachment and grief, the ambiguities of miscarriage and literature on the politics of miscarriage. Lastly, embodiment theory will be explored and the influence this can have on understanding miscarriage experiences.

## **1. Miscarriage: Discursive Constructions and Theory**

The complexities that surround miscarriage occur not only in relation to the event itself, but as illustrated, from the very terminology that is used to denote the experience. Pregnancy and childbirth appear to be a topic far more understood which is reflected in the vast body of



literature on the topic. According to Miller (2015), those who have a miscarriage may find themselves with few resources to help construe the meaning of their experience given that “*the analogous space for miscarriage is a relative void*” (p.14). Furthermore, miscarriage is said to be an event shrouded in silence and off limits for public discussion (Layne, 1997; Reiheld, 2015). Accordingly, in order to gain a comprehensive understanding of this experience, it is important to outline the discourses utilised within the literature on pregnancy/childbirth, as by definition a miscarriage entails a pregnancy.

## **1.2 Polarised Discourses of Pregnancy and Motherhood**

The term discourse is used in this study as representing systems of statements that are grouped around clusters of terms, meanings, figures of speech and beliefs that are often conveyed in bodies of knowledge e.g. medicine (Wetherall & Potter, 1998). The process by which individuals identify with particular discourses is understood as ‘positioning’, whereby individuals do not assume static roles, rather they become ‘positioned’ through certain discursive practices, which thus generates subjectivities (Davis & Harre, 1990; Harre & Langenhove, 1991; Malson & Swann, 2003).

Much has been written on pregnancy and motherhood, wherein the collective consciousness is filled with innumerable meanings (Miller, 2015). Rich (1996) highlights that this is due to motherhood propelling women into a realm of value-laden discourses (i.e. social, cultural and economic), which can cause women to be judged in a variety of ways. Similarly, pregnancy and childbirth becomes a key site for the regulation of women. In medical discourses, pregnant women are positioned as vulnerable and passive, in need of medical ‘knowledge’, and medical professionals are positioned in particular relations of power (Sbisà, 1996). Moreover, Ettorre (2000) highlights the use of mechanistic discourse of reproduction, in which doctors are

construed as mechanics working to detect problems, thus rendering the pregnant body as a machine. This may lead to a sense of alienation from the body and of a fragmented self for women. ‘Woman-centred’ discourses on the other hand, position women as active rather than passive agents, with the ability to assert choice and control over their bodies. A potential consequence of both these discourses is it can lead to polarised positions which are heavily influenced by ideological viewpoints. This can serve to oppress and silence subjective experiences.

### **1.2.1 ‘Natural’ Discourse**

Parenthood is commonly framed as a ‘natural’ progression in adulthood and forms a central part of normative ideas around what is considered adulthood ‘proper’ (Kohler & Mencarini, 2016). According to such normative ideas, having children thus represents the obligatory trajectory of what it means to be an adult person. Consequently, ‘natural’ is one key discourse of pregnancy (Eyer, 1992; Ussher, 2006). Rich (1996) argues, such ideologies of reproduction construe ‘woman’ in terms of ‘mother’, in ways which serve to regulate the lives of women by differentiating between those who are mothers and those who are not. Pregnancy is therefore considered a privileged state as it signals the transition to the role of ‘mother’. In society, motherhood is portrayed as natural and joyful, perpetuating ideals around parenthood. Such discourses are reinforced by illustrations of Madonna and child for instance or advertisements depicting women kissing their children happily, which constructs motherhood as a role that is gratifying and fundamental for women (Jackson & Mannix, 2004; Ussher, 2006). Pregnancy is also constructed as the apotheosis of femininity and female beauty, as Browne (2018) writes, “*Pregnancy is bathed in sunlight, moonlight, God light. What could be more beautiful than the pregnant woman, deliverer of pure promise?*” (p.64)

Constructions of women during pregnancy transpose pregnant women into protective and nurturing roles. In their discursive analysis of pregnancy texts, Marshall and Woollett (2000) outline metaphors such as “*haven*” are used in conjunction with constructions of the pregnant body as “*nest like*”, “*snug*” and “*warm*” (p.356). These dominant scripts of pregnancy have been criticised as rendering invisible the contexts in which women become pregnant, and are a primary vehicle of what Scuro (2017) refers to as “*childbearing ideology*” which proposes that gendered scripts serve to perpetuate a particular embodied experience of pregnancy, which validates only its “*productive aspects*” (p.189). Furthermore, such scripts tend to privilege a certain kind of pregnant subject i.e. white, affluent, heterosexual, non-disabled and compliant; for those that meet these expectations; pregnancy produces significant levels of social approval and support (Browne, 2018). Pregnancy can be the cause of social shaming, whereby those that do not mirror this view of pregnant femininity are continually deemed as irresponsible and suspicious, such as the figure of the pregnant teen (Neill-Weston & Morgan, 2017), people from ethnic minorities (Paltrow & Flavin, 2016) or those living in poverty (Tyler, 2008). Reproductivity is said to be far more valued when it is embarked upon by privileged socio-economic groups (Tyler, 2008). Consequently, natural discourse serves to construct pregnancy as off limits to non-privileged groups or identities.

### **1.2.2 ‘Medical’ Discourse**

One of the main discourses around pregnancy is from the medical domain. This may be a result of the increasing authority and control of medical professions over pregnancy and childbirth, which has been documented widely (Arney, 1982; Ehrenreich & English, 1978; Garcia et al., 1990; Sibsà, 1996). “Medicalisation” refers to the process of defining moral, social or legal behaviours/conditions as medical problems and framing them in terms of illness or

health. Medical practice is thus permitted as the mechanism by which problematic behaviours can be controlled and eradicated (Conrad, 1992). According to feminist literature, the medicalisation of reproduction has served to legitimise medical accounts of pregnancy and childbirth over other sources of knowledge. Feminists refer to this as the '*maternal gaze*' and argue that the medical model undermines and alienates women from their bodies, as pregnancy and childbirth are closely monitored and managed and therefore 'treated' by medical professionals (Crossley, 1996; Woollett & Boyle, 2000). This notion is taken from the concept developed by Foucault (1979a) in his work on surveillance medicine, where he highlights that what is normal becomes problematic.

In the case of pregnancy, priority is said to be placed on the production of a healthy baby, which reinforces the development of risks around behaviours (Marshall & Woollett, 2000) such as advice on diet and lifestyles (Nicholson, Fox & Hefernan, 2010; Simmons et al., 2006). Moreover, practices derived from 'scientific medicine', such as antenatal classes, are presented as "*normal, acceptable and in women's best interests*" (Hewinson, 1993, p. 20). Deviations from this norm are thus considered problematic or as pathology, which serves to privilege medical/obstetric accounts over areas of pregnant people's experience (Carter, 2010). This can position such individuals with limited agency and may prevent other ways of expressing experience (Marshall & Woollett, 2000). Furthermore, it is argued that the individualisation of human issues disregards the social and economic contexts that experience is situated in (Okado, 2011).

The medical discourse of miscarriage is said to further reinforce a health and illness dichotomy, as most miscarriages are considered as evidence of the "*body operating as it should*" (Pizer & Palinski, 1980, p.26). Layne (2005) suggests that there is a medical unimportance of

such events, “*because it happens so often, it is considered normal variation in the pregnancy process*” (p.292). As a result, miscarriage is reduced to “*humdrum and dull*” (p.18) because they are rarely life-threatening, involves only routine intervention and generally cannot be stopped or reversed (Pizer & Palinski, 1980). Although this can be seen to normalise the experience of miscarriage, against a backdrop of societal silence it is argued that the medical insignificance can lead to feelings of neglect, isolation and shame (Atkins, 2010; Frost et al., 2007; Simmons et al., 2006).

Medical discourse is underpinned by assumptions around a duality between mind and body. Based on principles of Enlightenment, much of western medicine is established on the notion that the body is independent from the mind, and patients exist in isolation of societal and cultural contexts (Ussher, 1997). This mind/body dualism will be examined in greater detail in the later chapter on embodiment theory. Both ‘natural’ and ‘medical’ discourses discussed, illustrate how they can oppress women and restrict their subjectivity. The work of feminist theory can offer a critical perspective on these discourses and their impact on the positioning of women.

### **1.2.3 ‘Woman-Centred’ Discourse**

Feminist theorists have criticised the ways that reproduction is medically managed, arguing that women are often alienated and disempowered by practices of reproductive care (Davis-Floyd, 1994; Oakley, 1984; Phoenix & Woollett, 1991; Rich, 1996; Crossley, 2007). Early feminist analyses illustrate that control in pregnancy shifted from women (midwives) to men (medics) and the ‘medicalisation’ of pregnancy alienated women from the process (Oakley, 1984; Rich, 1996). Some argued for ‘woman-centred’ approaches, in order to increase women’s

autonomy and control in medically managed reproduction and to place pregnant women back at the centre of maternity care (Crossley, 2007; Marshall & Woollett, 2000). It is noted that this developed a rhetoric of ‘choice’ particularly in the management of pregnancy healthcare, where pregnant women are better able to choose how they wish to give birth. In the case of miscarriage this notion of choice is argued to be problematic. This is because by positioning women as active agents who have ‘control’ over their bodies, the location of blame for pregnancy difficulties lay with the individual (Rothman, 1989; Marshall & Woollett, 2015). This can result in feelings of failure (Kevin, 2011) and self-blame (Krosch & Shakespeare-Finch, 2017), if a pregnancy ends by a miscarriage. Furthermore, in an effort to de-medicalise pregnancy, Crossley (2007) suggests that this has caused hospitals and birthing centres to overemphasise ‘*successful outcomes*’ and overlook aspects of pregnancy difficulties (p.556). She argues that by defining issues of reproduction as medical intervention, woman-centred discourses have contributed to the invisibility of non-medically caused problems. This has been reflected in cultural discourses such as pregnancy guidebooks, which takes a person step by step through a pregnancy, commencing with the moment of conception all the way through to birth. A normative model of pregnancy is often used, where the successive weeks, months or trimesters are presented as if each stage inevitably follows another (Leith, 2009), without stipulating that a pregnancy may end at any point. In the case of miscarriage, some reading materials may discuss this at the end of the book alongside other complications of pregnancy, once a ‘normal’ pregnancy and birth has been presented (Marshall & Woollett, 2000).

It is thus argued a woman-centred philosophy which is based upon women’s rights of choice and agency cannot be actualised if women do not have adequate information (Layne, 1997). Moreover, by placing a focus on the responsibility of the individual, the location of blame

for various pregnancy difficulties is consequently laid with individuals (Marshall & Woollett, 2015). Such discourses can position pregnant people who miscarry as ‘at fault’, which can elicit feelings of shame and failure as the normative standards of ‘natural’ discourse have not been met (Leith, 2010).

Although feminist scholars have provided critiques of the main discourses of pregnancy and motherhood, there is an apparent scarcity of feminist literature on the topic of miscarriage. It is argued that a lack of a feminist discourse is one of several modes of silence surrounding miscarriage, as discussions can easily become entangled with the politics of abortion (Browne, 2018; Layne, 1999; Miller, 2015). This will be discussed further in the section, however it is important to note that a woman-centred discourse is said to be at odds with the topic of miscarriage, as it further regulates women’s lives, identities and embodied subjectivities (Marshall & Woollett, 2000).

### **1.3 Miscarriage: Key Concepts and Debates**

The following section will introduce key concepts and debates of miscarriage, examining the medical, psychological, social and political positioning of the topic. In order to avoid a narrow focus on the individual over society, literature has been drawn across multiple disciplines, to avoid an individualistic view over more collaborative means (Fox, Prilleltensky & Austin, 2009). Miscarriage is therefore considered in a wider context in order to illustrate the social aspects of this experience (Fox, 1985).

Despite the statistics on prevalence rates, research suggests that miscarriage is not afforded the same degree of acknowledgement as other events such as stillbirth and is usually seen as an insignificant and transitory experience (Layne, 1997; Simmons et al., 2006). It is argued that this is based on prevailing assumptions that pregnant people do not form strong

attachments early on pregnancy (Robinson et al., 1999). This will be discussed further in the section; however, the lack of acknowledgement is said to therefore limit miscarriage to a private event, causing it to be a topic not openly discussed. Consequently, individuals remain unaware of the commonality and can hold misconceptions about the experience. In a national survey on public perceptions of miscarriage, researchers found that 55% of people think miscarriage happens in less than 6% of all pregnancies (Bardos et.al, 2015), which is considerably less than the actual rate of 25% (Tommy's, 2020). Furthermore, 76% of respondents thought a miscarriage could be caused by lifting a heavy object and 64% said historic use of oral contraceptives could play a part in miscarriage. Studies have rebuked these assumptions, such as Hahn et al., (2016) who found no correlation between contraceptive use and miscarriage and Bonde et al., (2013) who looked at risk of miscarriage and physical activity and identified no correlation. In the same study by Bardos et.al, (2015) researchers looked just at respondents who had miscarried and found that 40% felt ashamed about the experience and 47% felt guilty. Women may also hold assumptions around the causes of their miscarriage, which can result in self-blame and feeling responsible (Simmons et al., 2006; Frost et al., 2007).

Misconceptions of miscarriage, the lack of acknowledgment of the potential impact and absence of general public awareness are all argued to lead to stigmatisation and reinforce the experience as taboo (Frost et al., 2007). Pregnancy on the other hand is publicly discussed, where the transition to motherhood is more widely understood as being associated with a range of significant emotional and physical processes (Scott & Niven, 1996; Ussher, 1989). In comparison, miscarriage is far less understood, and individuals are reluctant to speak openly about their experience.



Reiheld (1998) argues that there is a great deal disconnection between someone who has a miscarriage and society in general whereby, *“silence, isolation and uncertainty combine to augment the suffering of miscarrying women”* (p.3). As previously highlighted, the discourses on pregnancy are easily located and have received much literary attention (Hollway, 2016; Rich, 1996; Oakley, 1984). Miscarriage conversely, is described as being prohibited for public discussion in a way that the details of pregnancy are not (Reiheld, 2015). In an article on her own miscarriage, journalist Orenstein (2002) writes:

*Even in this era of compulsive confession, women don't speak publicly of their loss. It is only if your pregnancy is among the unlucky ones that fail that you begin to hear the stories, spoken in confidence, almost whispered. Your aunt. Your grandmother. Your friends. Your colleagues. Women you have known for years, sometimes your whole life, who have had this happen, sometimes over and over and over again. They tell only if you become one of them (p. 2).*

This quote demonstrates the notion of secrecy that surrounds miscarriage, which is argued to reinforce feelings of isolation and marginalisation for those who have miscarried. Moreover, Orenstein points to the sense of failure she felt, which can be seen as drawing from the ‘natural discourse’ as previously mentioned. For an event that is staggeringly common, the lack of public discussion is surprising. Writers have also pointed to the dearth of scholarly public feminist debate. Layne (1997) writes that miscarriage is subject to the *“triple edict of modern puritanism-‘taboo, nonexistence, and silence”* (p. 291).

Given that pregnancy has been noted as an important feminine issue, miscarriage is also pertinent to discussions on female identity. The lack of discussion about this event has unequivocally led to an insufficient understanding of this experience. As Foucault (1979) has

highlighted, *“there is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses”* (p.27).

#### **1.4 The ‘Medicalisation’ of Miscarriage: An Experience Ignored?**

A recurrent criticism often found in the literature on women’s experiences of miscarriage is around the medical treatment and care they received in medical settings. It is therefore important to consider the medical domain, as Hardy and Kukla (2015) suggest that bodily states and experiences such as living with cancer or chronic illness, or even being male or female are *“thoroughly mediated by medical institutions, procedures, routines and meanings”* (p.1). Such markers and bodily states are integral *“narrative signposts”* whereby social and personal identities are substantially bound up with medicine (2015, p. 2). The following section will therefore discuss how miscarriage is positioned within the medical context, as well as exploring literature that broadens an understanding of miscarriage beyond a medical event.

Within a medical context, miscarriage in one sense is a significant medical event as it entails a person going from pregnant to not, which signals a shift in medical status. However, it usually constitutes the end of medical attention, as routine miscarriages do not tend to be accompanied by follow-up care despite the physicality of the event. More often than not, medicine is unable to offer the tools for predicting or preventing a miscarriage and when individuals stop being pregnant, they tend to not be of medical interest (Hardy & Kukla, 2015). Furthermore, within medical discourse miscarriage appears to constitute the end of a medical narrative as opposed to an event within one (Lindemann, 2014).

### **1.4.1 Advancements in Biomedical Technology and Increasing Medical Surveillance**

The priority given to the production of a ‘healthy baby’ has resulted in the continual medical surveillance of pregnancy, which has become the norm in many countries, particularly the UK and USA (Davis-Floyd, 1994; Lazarus, 1994). In the UK specifically, antenatal care is provided through the National Health Service (NHS) where women register their pregnancies with doctors and antenatal clinics. Antenatal care comprises scans and a range of antenatal tests particularly aimed at women deemed to be ‘at risk’ (Marshall & Woollett, 2000). There is continued debate amongst feminists about whether such surveillance and new reproductive technologies are empowering women or still regulating further women’s lives and embodied subjectivities (Woollett & Boyle, 2000). Use of antenatal scans and biomedical tests for example, has meant greater involvement from physicians and medical professionals in pregnant people’s lives. Although this can be said to have drastically reduced mortality and morbidity rates of both mothers and their babies, feminist criticism of the medicalisation of pregnancy such as the development of prenatal screening, has aided to a theoretical separation of the foetus/baby and pregnant person in the medical view of pregnancy (Rapp, 1999; Rothman, 1986).

Furthermore, such advances in biomedicine have created opportunities to see and hear ‘life’ at earlier stages than before (Layne, 1997), such as over-the-counter pregnancy tests, which can confirm a pregnancy before an individual has missed a period. By the same token biomedicine can also provide knowledge that a ‘life’ has ended, in the form of ultrasound scans.

Although it is argued that the medicalisation of pregnancy has positioned women as at ‘risk’, Simmons et al., (2006) suggest that technological advances have also created expectations that miscarriage or other pregnancy complications have been eradicated. Research tends to show that the use of ultrasound technology provides reassurance for pregnant people (Thomas, Roberts

& Griffiths, 2017), as individuals are not informed of the potentiality of a miscarriage beforehand. Such advances in technology have also reinforced the positivist underpinnings of the medical model, where ‘objective’ truths can be ‘seen’ and measured. However, the inability of medical science to provide causes of miscarriage in all cases can also contribute to the perplexity of this experience and can be related more broadly to the ‘scientisation of death’ in western societies.

#### **1.4.2 Rationalisation and Causality: ‘The Scientisation of Death’**

Mellor (1993) argues the decline of religion in late modern societies has led to difficulties surrounding bereavement, where individuals are left to manage their loss within the private domain alongside a reduction in both public and community support (Turner, 1987). Simultaneously, there has been what Walter (1994) describes as the ‘scientisation of death’ whereby meanings and practices of death are mainly controlled by ‘expert’ groups such as doctors. Consequently, positivist modern rationality is the dominant framework that death is viewed within, where there is an outcome with a cause. This arguably creates an expectation that when a death occurs, there will be an explanation as to why and how it happened (Bauman, 1992). Thus, death becomes a rational event, which can be explained medically and biologically. The case of miscarriage demonstrates the scientisation process, however medicine more often than not, is unable to provide an explanation for the cause (Regan, 2001). This is said to make miscarriage an ‘*imperfectly scientised*’ form of death (Frost et al., 2007, p. 1006), which arguably contributes to the difficulties many individuals face when attempting to comprehend this experience.

Due to the dominance of positivist paradigms in western societies, which are based on rationality and objectivity, alternative ways of understanding human experience are generally

obfuscated. Although cross-cultural studies on miscarriage are limited, some research suggests that cultural and religious differences can influence how a miscarriage is experienced. Boyden et al., (2014) for example, found that African American women drew on spiritual or religious activities to help them cope with their miscarriage(s). Moreover, Layne (1999) describes practices in some Middle Eastern cultures, of serving a ritual meal to guests following a person's miscarriage, which functions to acknowledge the significance of the event. In cultures where human experience is conceptualised in terms of rationality, (i.e. cause and effect) other meanings can become lost. This can be problematic in the case of miscarriage as underlying reasons are usually absent.

### **1.4.3 Medicalisation and the Subjective Experience of Miscarriage**

As discussed, the medicalisation of miscarriage is often criticised as focusing primarily on the physical effects, such as pain and the management of blood loss. Medical literature on the topic highlight, that when a miscarriage does occur health professionals tend to treat the procedure as a non-emergency and may see the event as routine (Moulder, 2001, Murphy & Philpin, 2010). Due to the prevalence, it tends to be considered as “routine” (Simmons et al., 2006) which can leave those who have a miscarriage in an oddly unhelpful relationship to medicine, given the emotional and psychological impact individuals may experience. This can further reinforce a mind/body dichotomy where the body is perceived as a separate entity. Arguably, this dualism is predicated on the long-established function of medicine, which has historically been focused on the functioning of the body and the need to tend to physical symptoms. Given the dominance the medical model has in western societies, a prevalent event such as miscarriage, which cannot be reversed and is rarely life threatening, may not be considered as significant (Oakley, McPherson & Roberts, 1990). This tends to be reflected in

accounts of women about their experiences within healthcare settings, which are usually critical of the care received by medical professionals. Studies often highlight that women perceive professionals as unaware of their feelings of distress and offer a lack of effective interventions to support them (Evans, 2012; Harvey et al., 2001; Meaney et al., 2017; Moulder, 2001; Murphy & Merrell, 2009; San Lazaro Campillo et al., 2014). According to nursing literature, there are prevalent discrepancies around the standard of care provided to women. For instance, research suggests some healthcare providers view miscarriage as common place and part of their everyday work, in contrast to women where a miscarriage is usually a distressing experience (Moulder, 2001; Murphy & Merrell, 2009). It has also been highlighted that there is a lack of concern among health professionals as they manage miscarriages every day and view their work as routine (Atkins, 2010). Moulder (2001) highlights that health care professionals play a vital role in providing understanding and support to those who miscarry as individuals often feel naive and dependent on them for information, advice and care.

A qualitative study by Cecil (1994) evaluated women's perceptions on the quality of communication with medical staff in two hospitals in Northern Ireland following a first trimester miscarriage. Overall, women were dissatisfied with the standard of care received and expressed that healthcare providers "*either could not or did not recognise the magnitude of their loss*" (p. 115). These findings are also reflected in the largest national women's health survey on the experience of miscarriage in the UK conducted by Simmons et al., (2006). They found that women often described how health providers would try to normalise their experience by explaining that "*it was nature's way*" or "*just one of those things*" (p.1938), which individuals often interpreted as dismissive of their distress. Studies do highlight that the intense feelings people may experience after a miscarriage, can also impact those who are caring for them such

as nursing staff. Nurses may find themselves providing both emotional and physical care simultaneously, whilst having to manage their own emotional response to the situation (Bolton, 2000; McCreight, 2005; McQueen, 1997; Roehrs et al., 2008; Watts, 2009). Roehrs et al., (2008) found that nurses working in birthing units often felt it was difficult to provide perinatal bereavement care due to their discomfort when talking openly with people who had miscarried for fear of saying or doing the wrong thing. The same study found that nurses felt more confident and supported when there was ongoing education and training on miscarriage.

In interviews with nursing staff in a hospital antenatal unit, Murphy and Philpin (2010) found that emphasis was placed on the psychological care people who miscarry might need, yet their field observations of gynaecological wards, noted how central the observations of physical effects were such as the continual recording of the person's vaginal blood loss. Such discrepancies between women's experiences of care in healthcare settings and nursing practices, arguably demonstrates the ambiguities of miscarriage and the limited understanding that goes beyond the physical effects of this experience within the medical domain. Furthermore, in the absence of adequate support and training for medical professionals on miscarriage, individuals may perceive the care they receive as neglectful of the emotional aspects of their experience.

#### **1.4.3.1 The Emotional and Psychological Impact of a Miscarriage**

Alongside the physical aspects of a miscarriage, studies continue to demonstrate the many emotional and psychological consequences of this experience. Early studies on miscarriage have contributed to the recognition of miscarriage as a significant event, which has also helped to raise awareness of this experience.

#### 1.4.3.2 Loss and Attachment

Research into the emotional responses has found that guilt (Adolfsson, et al., 2004), self-blame (Kevin, 2011) and loss (Renner, et al., 2000) are common features in women's accounts of miscarriage. Some attempts at understanding the psychological and emotional impact have conceptualised miscarriage in relation to theories on attachment and loss. Bowlby (1958) first established attachment theory to describe the physical and psychological distress children experience when separated from their primary caregivers. The theory was expanded by Ainsworth et al., (1978) who defined attachment as an, "*enduring affective bond characterised by the tendency to seek and maintain proximity to a preferred caregiver, particularly when under stress*" (p. 10). As previously discussed, advances in biomedicine have meant individuals (in high and middle-income countries) are aware of their pregnancies much earlier than ever before. It is suggested that this has led women to have attachments with the baby/foetus at early stages in their pregnancy (Layne, 1999).

Prenatal attachment is an extension of Bowlby's theory, and is defined as "*the component of the interactional process of attachment that develops within a mother prior to childbirth*" (Gaffney, 1988, p.106). This process involves not only physical behaviours such as feeling movement but also more abstract actions like imagining the baby and fantasies of the self as a mother (Hollway, 2016; Robinson et al., 1999). Cranley (1981) developed this further and conceptualised it as "*the extent to which women engage in behaviours that represent an affiliation and interaction with their unborn child*" (p. 282). It is thus possible to understand how a person may develop attachments early on in pregnancy, or even before the confirmation of a pregnancy (Layne, 1999). This is reflected in qualitative studies, whereby some women express



an attachment towards their pregnancy despite the gestational stage of development (Frost et al., 2007; Moulder, 1998).

In line with prenatal attachment theory, Winnicott's (1960) 'Primary maternal preoccupation' (PMP) is an additional lens to view miscarriage through. In his paper, Winnicott proposes that PMP is a "*special condition that gradually develops and becomes a state of heightened sensitivity during and especially towards the end of pregnancy*" (p.586). This concept suggests that pregnancy causes a unique state of mind alongside the physical changes in the body, where the 'expectant mother' becomes primarily concerned and preoccupied with the baby/foetus. He argues that this process of preoccupation is valuable to the relationship between the mother and baby and gradually reduces over time as the baby develops. Jones (2001) argues that in the case of miscarriage or stillbirth "*when the baby is lost, the mother is still intensely preoccupied, but without a baby to focus on*" (p. 434). It is suggested this can aid in the understanding of loss and grief that some women may experience (Jones, 2001) alongside depressive responses (Robertson Blackmore et al., 2011). As a result of such understandings, several studies have conceptualised miscarriage as a loss event (Renner et al., 2000; Stinson, 1992; Trepal, Semivan Bruce & 2005), with literature comparing it to complicated grief (Kersting & Wagner, 2012). Marker and Ogden (2003) for example, suggest that parents who have experienced miscarriage go through three stages of grief: turmoil, adjustment and resolution. They note that parents grieve and present 'stages' of grief as a linear process. Arguably, such reductionist models limit other potential ways miscarriage can be experienced and implies that one stage inevitably follows the other. This can thus marginalise those who are seen not to 'follow' such norms of behaviour.

### **1.4.3.3 Miscarriage as a Traumatic Event**

There is growing literature, that suggests standard models of grief are inadequate in the case of miscarriage, with studies identifying the lasting psychological impact that individuals may have. Research has shown that miscarriage is linked to anxiety (Farren et al., 2016; Klier et al., 2000), depression (Athey & Spielvogel, 2000; Beutel et al., 1995), stress (Farren et al., 2016) and suicide (Gissler et al., 1996). In follow-up and longitudinal studies the psychological effects have been found as lasting from fourth months (Lee et al., 1996), six months (Klier et al., 2000) and one year (Robinson et al., 1994). Furthermore, experience of miscarriage can also extend to subsequent pregnancies causing anxiety and stress and can also affect relationships with partners (Williams et al., 2020).

More recent studies have conceptualised miscarriage as a traumatic experience (Engelhard et al., 2003; Farren et al., 2016; Lee & Slade, 1995). Post-traumatic stress Disorder (PTSD) may develop as a result of perceiving or experiencing a real threat of death or injury to the self or others (Engelhard, 2001). In the case of miscarriage, the threat of injury and sight of blood loss and foetus/baby has been found as sufficiently traumatic to result in PTSD in 39% of cases within 3 months of a miscarriage (Farren et al., 2016). Such findings indicate that PTSD is more common than both depression and anxiety and has been identified as affecting quality of life, relationships, ability to work and physical health (Kessler, 2000).

Although research on the emotional and psychological impact, has raised the significance of miscarriage experiences, it is argued that such studies exist within the domain of medical psychology, which can reinforce medicalisation of the event. Layne (1999) states that this can pathologise the experience as it focuses on symptomology and can disregard the subjectivity of individuals who have a miscarriage. This also neglects the social/political aspects of the

experience, and arguably locates pathology as residing solely at an individualistic level.

Neglecting the societal processes that can influence experience, can limit a comprehensive understanding of miscarriage. This can be considered as partly due to the ambiguities of miscarriage, which will be explored in the following section.

## **1.5 The Ambiguities of Miscarriage: An Experience Lost?**

One of the key features of miscarriage is the ambiguity that surrounds the experience. This makes it an experience far less understood than other reproductive processes. It can be argued that the medicalisation of miscarriage as illustrated has created a dichotomy between the physicality of the event and the often-significant emotional impact. This can lead to confusion and uncertainty around how to make sense of a miscarriage.

The lack of cultural and societal norms in the case of miscarriage in western societies can further add to the ambiguous nature of miscarriage. This can illuminate the scarcity of discussion on the topic and can help account for the discrepancies between society's response and the experiences of women. For example, there is no medical recognition that a death has occurred and more broadly speaking there are no social customs to follow in western societies/cultures. In cases of stillbirth and perinatal deaths, on the other hand, there is a birth/death certificate and commemoration/ritual (i.e. funeral and memorial) that acknowledge the death of a 'would-be-child' (Layne, 1997, p. 292). Furthermore, links can be made to societies perpetuation of the scientific method, which has historically been associated with empirical proof, i.e. the visibility of phenomena, especially, in the absence of modern technologies, which can look 'inside' like ultrasounds. Miscarried pregnancies tend to (not all) take place when a pregnancy is the most unseen, as the body has not significantly outwardly changed shape. Therefore, western societies

have a heritage of associating this lack of visibility, with silence, because something that is absent from view is not often credited with existence and given value or recognition (Al-Gailani & Davis, 2014).

Frost et al., (2007) argue that the silence around miscarriage may contribute to the most distinguishing aspects of this experience as it is “*clouded by secrecy*” (p.1011). They argue that miscarriage is a,

*Paradigmatic example of the sequestration of death, both in the sense that most women...know little about it until they experience it themselves and in the sense that its occurrence is surrounded by secrecy and is hidden from public view (p. 1003).*

Studies on people’s experiences of cancer for example, suggest that illnesses or events that have a ‘death salience’ can result in closer experiences with death in those that survive such events. Little and Sayers (2004) suggest that in cultures where discussions on death are not encouraged, survivors may:

*Turn inward to their deep selves in order to establish an understanding of what their life projects might become. Observers on the other hand, find death salience hard to live with and may turn away from the distressed survivor (p. 8).*

This may account for miscarriage being rendered a private event which is distanced from the realms of public and societal discourses. Experiences are thus hidden, which arguably reinforces the confusion and uncertainty of the event.

### **1.5.1 The Language of Miscarriage**

Scientisation Medical discourse also presents ambiguities in the language used to denote and describe miscarriage, which has been criticised for using clinical terminology that is at odds with the experience of a miscarriage (Murphy, 2000). The medical definition of a miscarriage

used in obstetrics and gynaecology refers to a miscarriage as an *“imminent, partial, or complete expulsion of products of conception”* (Norwitz & Schorge, 2013, p. 37). Clinical terminology can also be seen on the NHS website on miscarriage which states, *“Often the pregnancy tissue will pass out naturally in 1 or 2 weeks”* (2020). Such clinical language has been said to add to the confusion and distress for some individuals who may have conceptualised their pregnancy as the development of a baby (Murphy & Philpin, 2010). Indeed, on the same NHS support page it states, *“You may also find it beneficial to have a memorial for your lost baby”*. This further illustrates the multiple framings of miscarriage, which arguably contributes to the perplexity of this experience. In Frost et al’s (2007) study for example, some women were adamant their miscarriage meant the loss of a baby or child, whilst others struggled to comprehend what had taken place, questioning the term ‘pregnancy loss’, not knowing what had actually been lost.

The literature suggests there is a clear lack of conceptual resources and language available (Miller, 2015) to describe and understand miscarriage, which adds to the ambiguity of this experience. For example, there is no word for a foetus/baby that has been miscarried or aborted in English. In Japanese, it is *mizuko*, which is commonly translated as 'water child'. This is said to have originated from Japanese Buddhists, who believed that existence *“poured into a being like liquid and children only solidified gradually over time”* (Sasson & Law, 2008, p.12). According to Buddhist philosophy, the mizuko lies somewhere between a continuum of life and death but does not belong to either. The practice of ‘Jizo’ (the ritual of making an offering at a Buddhist temple), would then *“help the mizuko find another pathway into being”* (Sasson & Law, 2008, p.12). This ritual is said to mark not only miscarriages but also abortions, stillbirths and the deaths of young children (LaFleur, 1992). With the absence of similar recognition in western cultures, alongside the scientisation of death, miscarriage can be an event that is difficult to make

sense of (Bauman, 1992). Therefore miscarriage, an event clouded in secrecy, is an emblematic example of the sequestration of death, but is heightened by a range of ambiguities such as what exactly has taken place and what exactly has been “lost”.

### **1.5.2 Miscarriage and Liminality**

Reiheld (2015) suggests the difficulties around making sense of what has been “lost” may relate to the liminality of miscarriage, as it comprises of entities and conditions that are not permanently fixed to recognised categories: “*an entity that is not yet ‘human’ yet not other, or a woman’s identity as somewhere between mother and not*” (p. 11). This can elucidate the ambiguity of miscarriage, as there is uncertainty associated with the status of a ‘being’, as it is both living but not yet alive (Reiheld, 2015), which can compound the marginality where things exist outside recognised classification systems.

Using liminality to understand the ambiguities of miscarriage can be seen to draw on anthropological ideas of transition. In Van Gennep’s (1909) *rites de passage* study for example, the use of rituals (rites) are systematically compared, that commemorate an individual’s shift through changing periods of time and status within a given society. In this seminal work, he describes three main sequential stages where a person transitions from one social status to another: rites of separation, rites of transition and rites of incorporation. The first stage refers to an individual’s separation from their ‘normal’ social status, usually involving a symbolic behaviour that signifies the detachment of the individual or the group. This can be seen in the act of cutting an individual’s hair before joining the army for example. The ‘transition’ period is the next phase where an individual has left their normal social status and not yet acquired their new status. Those in this phase are deemed to be ‘liminal’ (from the Latin ‘limin’, meaning ‘threshold state’). This liminal state is considered as detached from ‘normative’ life and society, as a result

of not belonging in either category. The final stage is that of incorporation, where a person assumes their new identity having completed the passage and re-enters society with a new status, which is again followed by specific rites and rituals, such as a graduation ceremony. Miscarriage can be seen in relation to the transitional phase, as it inhabits a position between pregnancy and non-pregnancy (Murphy & Merrell, 2009; Reiheld, 2015). Murphy and Merrell (2009) propose that miscarriage can thus be conceptualised as transition rather than primarily as bereavement.

Building on Genep's analysis, Reiheld (2015) suggests that miscarriage exists along four dimensions of liminality, which can help aid in understanding the complexity of this phenomenon. The first dimension is that of parenthood, as miscarriage inhabits a space between being a parent and not. Alongside this, is the dimension of procreation, where a person who has miscarried occupies a position between having procreated and not. The third dimension is the space between life and death, as miscarriage can reveal the presence of death and thus becomes clouded in secrecy, but can also lead to perplexities over the nature of what was miscarried; *"was there a loss of potential life or loss of life?"* (Reiheld, 2015, p. 12). This leads onto the final dimension which is what associates miscarriage to political and moral debates such as abortion: the liminal space between pregnancy and abortion. Arguably, the liminal nature and sequestration of miscarriage, are major contributory factors in the entanglement with discourses on reproductive behaviours of women. The following section will explore the politics of miscarriage and how this can also contribute to the complexities that make up the experience of miscarriage.

## **1.6 Politics of Miscarriage: An Experience Discarded?**

Given the prevalence and gendered aspects of miscarriage (i.e. discourses of motherhood) there has been criticism around the lack of feminist attention it has received (Browne, 2018;

Layne, 1997; Reiheld, 2015). As previously discussed, the sequestration of death and medicalisation of pregnancy has contributed to miscarriage being treated as a private issue, or as a ‘medical problem’, which obfuscates the social and political aspects of the experience (Browne, 2018). As the highlighted literature has pointed out, there are a range of feelings a miscarriage can entail such as sadness, loss and grief. It is thus argued, that by attending to miscarriage and acknowledging the significant ramifications for women, feminists’ risk being seen to give credibility to anti-abortion movements that exhibit a leaning towards foetal life (Browne, 2018). This arguably makes miscarriage precarious political territory, which can help to elucidate the reluctance of some feminist writers to enter the scrimmage (Browne, 2018; Layne, 1997; Miller, 2015; Reiheld, 2015). Miller (2015) writes,

*The impetus to grant a degree of moral standing to the embryo/foetus in an effort to acknowledge the weightiness of what women lose when they miscarry can inadvertently and unhappily add fuel to the anti-choice fire, generating unintended and inaccurate implications for abortion politics (p. 2).*

The consequence is thus represented by a vacant theoretical space, which has arguably aided to the stigmatisation and marginality of miscarriage. Orenstein (2002) describes an apparent conflict between abortion rights and her own miscarriage experience as she says,

*There is another uncomfortable truth: my own pro-abortion-rights politics defy me. Social personhood may be distinct from biological and legal personhood, yet the zing of connection between me and my embryo felt startlingly real, and at direct odds with everything I believe about when life begins. Nor have those beliefs-a complicated calculus of science, politics*



*and ethics-changed. I tell myself that this wasn't a person. It wasn't a child. At the same time, I can't deny that it was something. How can I mourn what I don't believe existed? (p.5).*

The abortion debate is argued to have become so polarised, that exploring such contradictions is considered as politically dangerous, which has also resulted in the lack of nuanced vocabulary in political discussion on the topic (Browne, 2018). Furthermore, in the absence of a feminist discourse on the subject of miscarriage, the several silences that surround the topic have remained. Although feminists have created new repertoires of rituals for birth, menstruation and marriage, there is no such commemoration for miscarriage (Layne, 1999). Given the lack of political and social discussion, the stigmatisation and marginality of people who miscarry has been arguably reinforced, which can leave individuals at odds with how to comprehend their experience (Browne, 2018). Reinharz (1997) argues that feminist scholars and activists are well placed to fill the vacant discursive space, and change or generate new and more liberatory discourse on miscarriage. She suggests the fear, in the context of miscarriage, is if there is an acknowledgement of 'something of value' being lost then this would implicate the embryo/foetus as having inherent personhood, which would go against anti-abortion rhetoric.

The lack of feminist discussion on the topic of miscarriage can also be related more broadly to equality within the workplace. The women's movement has aided in the liberation of women being able to have careers and have helped women make up large parts of businesses and organisations. In 2018 women composed of 46% of the workforce in Europe and the UK (Catalyst, 2018). According to feminist theory, workplaces are traditionally patriarchal whereby *"women's bodies...their pregnancy, breastfeeding, and childcare, menstruation...are suspect, stigmatised and used as grounds for control and exclusion"* (Acker, 1990, p.151-152). Consequently, there has been a growing focus on tackling the taboo nature of women's

reproductive processes within the workplace such as effective practices to accommodate individual needs around menstruation (Begley, 2016), breastfeeding/pumping (Bai, Wunderlich & Weinstock, 2012) and menopausal symptoms (Pinkerton, 2015). To date there is a lack of research into those who miscarry and their experiences at work. The absence of feminist discussion on miscarriage can also inadvertently impact women's experiences within the workplace, if the experience is not considered as potentially significant.

Arguably, the feminist discourse on pregnancy and pro-choice movements, is based on certain ideological underpinnings, which are related to personhood and female agency. The propagation of woman-centred discourse can inadvertently serve to reinforce a medicalised viewpoint, which can have a reductionist approach to miscarriage by limiting miscarriage to a medical condition. Consequently, dualistic concepts of mind and body are sustained. The following section attempts to bridge this gap and considers embodiment theory, which although has been written extensively on pregnancy, remains largely absent in research on miscarriage. As a result, it seems salient to examine how embodiment theory can further understanding of miscarriage experiences. The following discussion will explore embodiment literature, alongside discussions of pregnancy embodiment, Descartes' mind/body dualism and consider the consequences of this for individuals who experience miscarriage.

## **1.7 Embracing the Mind and Body: An Experience Found?**

The bearing that the body has on experience has been widely studied yet is an aspect that appears to be rarely discussed in the literature on miscarriage. Crossley (1995) suggests that "*our body is our way of being-in-the-world, of experiencing and belonging to the world* (p.48), which seems highly relevant to embodied experiences such as pregnancy and miscarriage.

Aspects of bodily existence unique to pregnancy can be seen as a quandary in research as it entails reassessing epistemological underpinnings. As Grosz (1995) highlights, several disciplines have perpetuated a mind/body dualism: natural sciences have leant towards materialism, humanities towards idealism and social sciences has increasingly focused on discourse. Such disciplines tend to analyse bodies or discourses about bodies as texts, over theoretical interpretations of embodiment as a way of being-in-the-world (Csordas, 1990). This perspective can be said to stem largely from the work of Merleau-Ponty (1965) who suggested that the “*body is our general medium for having a world*” (p.146), thus by regarding subjectivity in isolation of the body, can compromise our ability to connect to the external world. This can have several clinical implications as it affects identity and lived experiences. According to Merleau-Ponty, consciousness itself is embodied as a subject who constitutes a world is always an embodied subject. Young (2005) highlights the “*lived body*” is perpetually layered with historical and social meaning, as opposed to viewing the body as “*primitive matter*” (p.7) which is devoid of cultural or political meaning. This point is reinforced by the work of De Beauvoir (2012) who argues that sexual difference is constitutive of much situated being-in-the-world.

### **1.7.1 Cartesian Dualism**

One of the most lasting theories of Descartes is the ‘mind-body dualism’, which posits the mind and body are distinct entities and as such can exist independently of each other. He theorised that the cognitive mind is solely responsible for subjectivity and meaning (Connolly, 2013) whereas the body is consigned to the position of machine as it is considered a ‘non-thinking’ object (Burkitt, 1999). Therefore the mind is considered as paramount, whereas the body is positioned as a superficial object (Crowley & Himmelweit, 1994; Young, 2005). This positioning also situates women to a lesser status where theorists denote reasoning, rational

thought and control as synonymous with men, in contrast to women who are identified by nature, irrationality and lack of control (Crowley & Himmelweit, 1994; Gear, 2001). The implications of these dualistic concepts can be found in Sampson's (1998) suggestion that social psychology develops "*spectators*" (p.22) who are able to objectively observe. This serves to reinforce a dualism between subject/object and suggests that reality is only attainable by a subject/mind. Consequently, the subject holds a superior position above the object as the body is rendered passive and embodied experience is negated (Grosz, 1994). Such dualism may be particularly problematic in experiences of pregnancy and consequently miscarriage where an individual's corporeality is most active.

A disembodied dualism is prevalent in much of the research on miscarriage, as the body is of primary concern within the medical domain, whereas emotional aspects of the experience are often discussed in isolation of the "lived body". Miscarriage is one example where embodiment and subjectivity can be explored as bodily processes undermine the usual mind/body relationship. Feminist writers have suggested that the embodiment of pregnancy provides an understanding of subjectivity as a set of processes rather than singular and fixed (Young, 2005). Using phenomenology, Young argues that the pregnant person is "*decentred, split or doubled*" and experiences themselves as a "*source and participant in a creative process*" (p. 46-47). Furthermore pregnancy entails a unique temporality where the person can experience themselves as separated between the past and future. This can also aid in understanding the ambiguous nature of miscarriage as the individual's identity (i.e. pregnant person vs non-pregnant) is disrupted.

### 1.7.2 Scrutiny and Regulation of the Body

As already highlighted the body is of primary concern within the medical domain. Foucault argues that the body has been “*offered to the brightness of the gaze*” (1979, p.241) as advances in medical technology have made the body more visible and less enigmatic. This gaze has been examined widely, with particular attention given to the surveillance of women’s bodies and the ways this can precipitate controlling and oppressive practices (Bordo, 2003; Diprose 1994; Shildrick, 1997). This is reflected in the sequestration of miscarriage where women maintain a silence on their bodily experience, alongside the scientisation of death which renders responsibility for their bodies to medical/healthcare professionals (Crossley, 1996).

Much has been written on gendered discourse, which serves to reinforce modesty and privacy for women over their bodies (Carter, 1995). Roberts and Waters (2004) in their discussions around menstruation, describe a “*hygiene crisis*” whereby women are compelled to conceal their bodily functions (p.9). This is particularly pertinent in the case of miscarriage due to the physical manifestations such as pain and blood loss. The miscarrying body leaks, revealing its biological truths. They suggest that women endeavour to create distance from these truths, by separating themselves from their bodies. Coutts and Berg (1993) argue that although women in western societies are no longer confined to ‘menstrual huts’, they are still required to conceal menstruation in order to uphold modesty and decorum.

Laws (1990) outlines the etiquette relating to menstruation where the need to maintain secrecy is important. Historically it has been associated with shame and lack of knowledge, often used to stigmatise and devalue women (Sveinsdottir, 2016). In some cultures, it is also linked to beliefs around women being dangerous and dirty (Stubbs & Costos, 2004). The vaginal blood

loss associated with miscarriage can be considered as an amplified form of menstruation. In their study on nursing practices and early miscarriage, Murphy and Philpin (2010) found that the physical aspects of miscarriage were a significant feature in women's accounts. They noted a struggle between an individual's actual physical experience of "*passing blood clots, fragments of tissue, gestational sacs and in some cases intact fetuses and their conceptualisation of their pregnancy as a baby*" (p.538). This disparity is also highlighted in other accounts of miscarriage experiences, where parents often imagine a fully formed baby when thinking about their pregnancy in the early stages of development (Murphy & Philpin, 2010).

By drawing on embodiment theory as previously discussed, the body can also be a site of exploration as this also appears as a significant aspect in women's experience. Tordes (2007) suggests that embodiment is interconnected to 'knowing' and it is important to consider the complexities that make up people's lived experiences. Discovering ways for women to openly explore their experience of miscarriage, to include embodiment, can present an additional dimension to current understandings of a miscarriage experience. Considering the prohibition of talking openly about blood and the other physical aspects of miscarriage, alongside an absence of embodiment inquiry, women's experiences remain private, which further serves to distance them from wider culture (Murphy & Philpin, 2010).

This can continue the stigmatisation and silence, which can trap women and prevent them from expressing their needs or from reconciling conflicting feelings. Voicing embodied experiences allows for discursive transformation, which can create new discursive spaces away from positions of success and failure (Bissel & Alexander, 2010) which feature in women's accounts of miscarriage (Frost et al., 2007,). Furthermore, if such discourses are to be disestablished, ways to articulate embodied experience that go beyond 'medical' and 'natural'

discourses are needed. The embodied nature of miscarriage can provide a significant opportunity for new discourses to be formed, which will be discussed further in the next chapters.

### **1.8 Rationale of the Study and Relevance to Counselling Psychology**

Following on from the review of the literature, miscarriage can be seen as a complex and ambiguous experience that remains hidden and not openly discussed. Furthermore, the discourses that surround pregnancy and motherhood can influence the experience of miscarriage alongside the medical settings that women tend to be in. Consequently, this research is interested in how society responds to miscarriage and the ways discursive processes shape the meaning and values placed on pregnancy and how this can influence stories of those who then experience miscarriage(s). Miscarriage is of interest, as pregnancy is an aspect of the transitory experience into motherhood. However, when a pregnancy ends by a miscarriage, what happens to this transition? Furthermore, the ways that individuals narrate life events can be considered as “*an interpretative process of self-making*” (Pals, 2006, p.176), which can help further an understanding of the impact a miscarriage experience has on a person’s sense-of-self. This can be seen as related to Counselling Psychology, as narrative accounts are connected to the therapeutic encounter and the association between personal change and life story (McLean et al., 2007).

This study is particularly focused on discourse and embodiment and explores the ways in which a woman’s body can be a site of “*demarcation and dissolution of identity*” (Russo, 1997, p.329) given the embodiment of pregnancy and the ambiguity of miscarriage. Moreover, it emphasises the significance of the body in attaining a perceptual sense of being-in-the-world (Heidegger, 1996). It utilises ideas of Merleau-Ponty (1968) who describes how our surroundings are interpreted by our lived body as the body becomes the subject of perception,

alongside Foucault (1979b) who viewed the body as a site where regimes of discourse and power ‘inscribe’ themselves (Butler, 1989). The influence these ideas have on subjectivities seems pertinent to Counselling Psychology, as an absence of available discourses and oppressive constructions of the body can lead to the pathologising of women’s experiences (Bordo, 1997, 2003; Eyer, 1992; Henwood, 1998; Okado, 2011).

Furthermore, this study draws on both Critical Psychology and social justice, which are seen as salient to Counselling Psychology (Kagan, Tindall & Robinson, 2009) as it draws attention to how oppression can become internalised (Henwood et al., 1998). Counselling Psychologists are encouraged to remain vigilant to issues surrounding social injustice both within and out of the therapeutic encounter, working to empower people (Goodman et al., 2004). Arguably, remaining mindful of issues of marginalisation and oppression can assist Counselling Psychologists to hear the voices of women who often feel neglected and silenced after a miscarriage (Atkins, 2010), whilst understanding how context can shape a person’s experience. This research is salient for Counselling Psychologists, as it presents an opportunity to enhance the understanding of the lived experience of those who have had miscarriage(s). Given the prevalence and the often emotional and psychological impact, it seems important for Counselling Psychologists to be aware of the experience of miscarriage, as this may lead women to seek therapy or could be an issue that arises during a therapeutic interaction.

It appears that much of the research on miscarriage is generated for medical professionals within medical settings, as individuals tend to be in medical environments when they are informed of their miscarriage (i.e. through routine antenatal scans) or receive medical treatment for the physical symptoms. Although research is growing on how medical professionals can treat those who miscarry, research tends to focus on the physicality and aetiology, which is argued as



colluding with dominant ‘medical’ discourses (Larsen et al., 2008). Although the lived experience of women has been identified as significant (Reiheld, 1996; Rich, 1999; Layne, 2005), and literature is growing focusing on women’s subjectivities, the embodied nature of experiencing a miscarriage is markedly absent. Research questions were designed to understand how women narrate their experience, whilst upholding a critical stance to the socio-political discourses that might be drawn on. Consequently, two main research questions were identified:

- What can women’s narratives tell us about the influence of social processes on their meaning-making/understanding of miscarriage experiences?
- What can these stories of miscarriage experiences tell us about their sense of self and identity?

## **1.9 Conclusions**

The several silences that surround miscarriage-social, political and cultural- have arguably reinforced not only the invisibility of women but also stigmatisation and marginalisation of this experience. As a result of ‘medical’ and ‘natural’ discourses, women and their needs become subject to debates over the control of pregnancy and cultural expectations around reproduction and motherhood (Reiheld, 2015). This casts a shadow on the experience of miscarriage itself and can further isolate women. Moreover, the absence of embodied inquiry leads to a potentially incomplete understanding of this event. Jung suggests that dissociation between mind and body is central to the “*malaise of modernity*,” if the body is reduced to nothing more than an object, this risks the world becoming empty and meaningless (Connolly, 2013, p. 638). Furthermore, the body is a key site in the exploration of subjectivity, as Malone

(1998) argues a purely social constructionist position can reduce understanding of the body to an “*adaptive perceptual apparatus*” (p.66).

Using embodiment theory and keeping it at the forefront of this study, both the lived body (i.e. subjectivity) and the inscribed body (i.e. dominant authority inscribing meaning) can be explored (Crossley, 1996). The apparent dearth of inquiry on embodied experience and miscarriage reflects a significant aspect of this experience that has evidently remained under explored. This alongside the other silences surrounding miscarriage, demonstrates a need to embrace embodied experiences to potentially empower women and to resist control from disembodied discourses. The lack of public and cultural discussion as examined in the literature review, points to a “*theoretical lacuna*” (Browne, 2018, p. 638) which can be said to further augment the experience of miscarriage. Yet as De Carteau (1986) has noted, “*the only place that can authorise new language is the emptied place*” (p. 74).

## Methodology

The main aims of the study are to explore: the ways in which women understand and narrate their experiences of having a miscarriage; the discourses that surround their position and the impact this has on subjective experience. Considering the medical, political and social learnings from the literature review, when developing the research method, key areas for consideration were given to issues of empowerment and social justice in order to hear the voices of those who feel they have been silenced. This section begins by providing the philosophical approach to the research and describes the rationale of the chosen ontological and epistemological position. This will then be followed by a discussion of the methodology utilised in the study and how methods relate to the research questions. Lastly, the collection of data is described, alongside a summary of participants, with an outline of the analytic steps taken to produce findings.

## 2. Aims and Values of Counselling Psychology

*As well as being a scientist, philosopher and researcher, the Counselling Psychology practitioner needs also to be an artist in order to be creative and innovative* (Woolfe, Dryden & Strawbridge, 2009, p. 638).

The quote above highlights the pluralistic nature of Counselling Psychology where a scientist-practitioner model underpins both clinical work and research (Lane & Corrie, 2006), alongside creative aspects of practice. It has been suggested that Psychology should take up its “*artistic and dialogic dimensions*” (Fillery-Travis & Lane, 2008 p. 177) rather than a restricted focus on scientific propositions. To uphold this viewpoint, this research endeavours to engage

with both the scientist-practitioner model alongside the creative and innovative aspects of the profession.

Practitioners who utilise a scientist-practitioner model, draw on prevalent research as the basis of practice whilst also reflecting on their work, by appraising and re-formulating ideas (Cooper, 2009). This is in line with Counselling Psychology as it, *“seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology”* (British Psychological Society, 2005). Practitioners are encouraged to be reflexive, which can be considered as a move away from *“a positivist epistemology of practice”* (Martin, 2010, p. 553). An aspect of reflexivity includes the identification that meaning is co-produced between the Counselling Psychologist and client (Martin, 2010). Both subjectivity and intersubjectivity are therefore valued and informs the therapeutic encounter (Cooper, 2009).

The aims for Counselling Psychologists to hold both empirical-scientist and subjective-reflective-practitioner roles can be considered as complex, as it entails managing *“two different underpinning philosophies”* (Kasket & Gil-Rodriguez, 2011, p. 21). Counselling Psychology encourages a continual engagement and reflection on this tension, both in research and clinical practice, in order to maintain a critical and resilient position (Kasket, 2013).

## **2.1 The use of Qualitative and Quantitative Methods in Counselling Psychology**

Ponterotto (2005) suggests Counselling Psychology should embrace postmodern perspectives and utilise qualitative methods for the advancement of the profession, as its main aims are to explore the complexities of human experience and to bridge the gap between clinical practice and research (Thorpe, 2013). Conversely, as the literature has demonstrated research can be viewed as a circular notion, whereby quantitative inquiry can identify areas for qualitative research and vice versa. Given that Counselling Psychologists draw on differing theories which

are deemed appropriate for clients' individual needs and subjectivity, research should also utilise approaches and paradigms most appropriate to the research aims and questions identified (Kasket, 2012). Therefore, Counselling Psychologists are free to choose between both quantitative and qualitative methods. Where quantitative research is based on the use of numerical datasets and predictions, qualitative research focuses on understanding experiences using experiential processes (Clandinin & Murphy, 2007). Due to the nature of this research and identified questions that seek to gain insight into the influences of discourses and embodiment on individuals' subjective experiences, a qualitative line of inquiry was therefore chosen.

## **2.2 Ontological and Epistemological Positions**

There are several choices of research paradigms open to Counselling Psychologists, which can guide inquiry into research questions and the topic under study (Kasket, 2012). Counselling Psychology encourages reflexivity and reflection on the nature of knowledge and the way it is generated (Ponterotto, 2005). In order to develop a research position for this research, Ponterotto (2005) and Willig's (2012) categorisations have been used, which also informed the selection of the most appropriate methods.

Ponterotto (2005) refers to positivism, post positivism, constructivism, interpretivist and critical-ideological paradigms. Alternatively, Willig (2012) discusses realist, phenomenological and social constructionist positions which run along a continuum. According to this, Ponterotto's paradigms can be divided into two categories; positivist and post positivist which view the world as predictable, with cause and effect relationships (Willig, 2012), and constructivist-interpretivist and critical-ideological, which describe an objective reality, that can only ever be interpreted (Meteyard & O'Hara, 2015). In this light, this study is underpinned by a critical-ideological

position, which recognises there are multiple “truths” where “reality” is co-constructed and based on historical, social and cultural contexts (Ponterotto, 2005). This lends itself more to the reflexive practitioner model, as it emphasises both subjectivity and intersubjectivity, reflexivity and empowerment (Kasket, 2013), whilst also valuing diversity and difference (Rafalin, 2010).

## **2.3 Methodological Foundations: Bringing Together Narratives and Embodiment Theory**

### **2.3.1 A Narrative Approach: Hearing the Stories of Miscarriage**

In order for this study to meet its aims of understanding how social processes influence women’s narratives of their subjective and embodied experience, a critical realist-social constructionist epistemological position underpins this study as suggested by Harper (2012). This stance regards the analysis of data and consideration of context as central in the production of knowledge. Given the research aims and the epistemological position, consideration was made around the most appropriate methodology to utilise. Narrative methods were regarded as aligned to a constructivism-interpretivism paradigm as, “*several narratives can organize the same facts into stories and thereby give the facts different significance and meaning*” (Polkinghorne, 1988, p.181). Stories are therefore unique and based on subjectivities (Esin, 2011).

Narrative research is based on the premise that humans are essentially interpretative by nature where events and experience are understood by generating narratives (Esin, 2011, Murray & Sargeant, 2011). Narrative Analysis (NA) is considered as in line with postmodern ontology, as it emphasises the central role that subjectivities have in the way narratives are constructed. NA suggests that individuals reflect and interpret the world continuously, and generate “selves” by the use of language (Crossley, 2000). By using narratives in qualitative research, researchers

are able to explore and understand more about individual and social processes whilst also examining multiple layers of meaning (Esin, Fathi & Squire, 2014). NA also aims to emphasise the voices of those who tend to be overlooked or marginalised in public discourse (Squire, 2008). This is also a central tenet of Counselling Psychology ethos (Cooper, 2009) and relates significantly to the experience of miscarriage as previously discussed.

Discursive methods such as discourse analysis were also considered, given the study's aims to understand the influences of social processes on the individual experiences of miscarriage. In line with a social constructionist position, discourse analysis views reality as interpreted and expressed by the means of language, where language itself is shaped by history culture and society (Burkitt, 2003). This can be viewed as a departure from conventional psychology, which regards the individual and cognitive mind solely responsible for perception (Billig, 2008).

Burkitt (2003) draws on the ontological position of Merleau-Ponty (1968) and considers the body as a "*sensible-sentient*" which navigates the everyday world (p. 338). The body therefore perceives reality and links us to the world by observing its "*depths and dimensions*" and subjective experience is subsequently expressed through language (Connolly, 2013, p.161). This position accepts that all knowledge and understanding is constructed by language and is located within a context (Burkitt, 2003). This can generate some contention, when not wishing to take on an ontological position that presents discourse as the totality of reality (Tucker, 2010). By adopting an approach that is focused purely on linguistic processes to understand miscarriage experiences, dualisms of 'body' and 'mind' may be reinforced, which has been criticised in the literature review for being oppressive and reductionist (Burkitt, 1999; Gillies et al., 2005; Grosz, 1994; McNamara, 2011). Furthermore, discourse analysis and other postmodern methods have

faced some criticism for being too enveloped in language and discursive constructions, which can inadvertently reduce the significance of the individual or subjective experience (Crossley, 2000).

Alternative methods such as Interpretive Phenomenological Analysis (IPA) on the other hand focus on the subjective experience of the participant. This was considered in conjunction with the research aims, however IPA does not have an interest in individuals' stories and can prohibit participants' use of a narrative form to tell their story. Researchers tend to have more control over the structure of the interview which can also limit narrative accounts (Crossley, 2000).

Lastly Thematic analysis (TA) was also regarded but unlike NA where the researcher's focus in the analysis is initially on the narrator, researchers using TA tend to have difficulties in retaining contradiction and continuity (which can be pernicious on the narrative as a whole), due to the way themes are created (Braun & Clarke, 2006), which can lead to the narrative becoming decontextualised (Baú, 2016).

Although the aforementioned analyses are appropriate methods for other research studies, this research and its paradigmatic perspective, directed attention towards a narrative approach. A narrative methodology can be broad, but focuses primarily on individual experiences, whilst simultaneously considering the context, culture and public discourses that experience is located within (Clandinin & Murphy, 2007). In light of this, a narrative methodology was employed in conjunction with discourse analysis in order to meet the study's aims of exploring the discourses that surround miscarriage, alongside the ways that women understand and narrate their experiences. As well as eliciting further insight into context, narrative research can also be utilised as a way to explore individuals' "*internalised and evolving sense of self*" (McAdams,



2012, p.16). Consequently, narratives can be associated to therapy, as it relates closely to personal development and life-story (McLean, Pasupathi & Pals, 2007).

### **2.3.2 The Importance of Embodiment**

Due to the focus on embodied experiences outlined in the literature review, reconsiderations were made of the traditional narrative approach. Attending to language alone, is said to risk negating an individual's experience of the 'lived body' and can discard its relevance in the exploration of meaning-making (Rose, 2007). This can have a significant impact on the understanding of miscarriage experience as outlined in the literature review. The bodily changes associated with pregnancy and physical symptoms of miscarriage occur without conscious control, where the body is communicating to the individual. The embodied nature of a pregnancy that ends in miscarriage is currently under researched and consequently should be included in discussions of miscarriage experiences.

However, as examined in the medical discourse, the body is not solely a machine with biological mechanisms; it is also inscribed with social processes (Bordo, 1997; Burkitt, 1999). Given that the experience of pregnancy is shaped by discourses about women's bodies, such as medical conceptualisations, sexualities and economies (Carter, 1995), the experience of miscarriage can also mirror such discourses.

### **2.3.3 The 'Discursive Void' of Miscarriage: Using Visual Methods to Incorporate Embodiment**

In relation to this research, a more creative approach was considered, as integrating embodiment necessitates more than verbal methods. Furthermore, the literature pointed to a 'discursive void' in western cultures in relation to miscarriage and the difficulties often found by

women in discussing their experiences (Frost et al., 2007). The use of visual methods was thus considered as this encourages narratives that are not reliant on words and allow for an exploration of the subjective experience of Embodiment. This would also further the research aim of empowerment. Moreover, the use of creative methods can be seen as fulfilling the “*creative and innovative*” dimensions of Counselling Psychology as previously discussed (Woolfe, Dryden & Strawbridge, 2009).

Although discourses are suggested to exist in the form of both language and images (Rose, 2007), bringing together the verbal and visual descriptions of experience is said to facilitate a fuller understanding of experience (Reavey, 2012). Reavey suggests that “*when we take seriously how people’s experiences are made and the contexts in which they emerge, it becomes difficult to ignore the rich complex visual media through which experiences come into being*” (p. 3). An image is claimed to enable a more visceral response, thus facilitating access to the embodied and emotional world of participants, which might evade the spoken word (Reavey, 2012).

In qualitative research, the aim is to situate the participant at the centre of meaning-making, enabling them to become active agents in the research. By allowing participants to pre-selecting images also facilitates empowerment, as it removes the researcher from these initial processes (Reavey, 2012). Consequently, participants can be seen to have greater control over the research process and how they wish to narrate their stories. Even though there was an interview schedule, the use of images was to enable participants to narrate freely and limit inhibition (Ortega-Alcazar & Dyk, 2011).

## **2.4 Overview of Methodology**

The previous section has highlighted the methods utilised in this research. In order to address the aims of the research Narrative Psychology has been drawn on, to understand a miscarriage experience whilst attending to the influence of social and political discourse. Moreover, exploration of the embodied experience has been discussed and how the use of visual methods were employed as ways to facilitate empowerment of participants and to add to the richness of data gathered. What follows is a description of the research procedures and analysis.

## **2.5 Research Procedure**

### **2.5.1 Sample**

The inclusion criteria were women aged over 18 who had experienced a miscarriage in the early stages of pregnancy and at least twelve months prior to the interview. This time period after a miscarriage was explicit, as the reviewed literature suggested that the impact of a miscarriage could last for several months after a miscarriage. Women who had experienced multiple miscarriages were included, alongside women who had children. The rationale for this stemmed from the reviewed literature, which highlighted an assumption around women with children not being “as affected” by a miscarriage. Research has pointed to this being a significant event regardless of whether miscarriage is a singular or multiple experience (Lok & Neugebauer, 2007) or whether an individual has children or not (Robinson et al., 1994).

### **2.5.2 Participants**

Data was collected from eight women who were recruited via several channels. Several charities were contacted that focused primarily on miscarriage to enquire about displaying a research poster (Appendix 2) on their online forums. For some organisations this

was deemed inappropriate and did not follow their guidelines. As a result, a post was made on 'Netmums', in a designated area for research enquiries. This fulfilled the administrator guidelines of the website. Some respondents enquired about the research but all declined to take part in the study due to a lack of availability or they were not able to openly discuss their experiences. As a result, the research was advertised on message boards at UEL and several schools, local to the researcher. These two channels generated many responses. Some individuals who came across the advertisement also discussed the research with people they knew who also made contact to state they were interested in taking part. This generated a snowball effect, which is a recruitment strategy often used in research studies which are exploratory in nature (Willig, 2012).

The initial aim was to recruit eight to ten adult participants. Although there are no prescriptive rules in relation to sample size in NA, for research using IPA for example, between four and ten participants are deemed as appropriate for professional doctorates (Hefferon & Gil-Rodriguez, 2011). Consequently, the aim was to recruit towards the upper end of this scale to assure that enough information could be gathered.

### **2.5.3 Procedure**

Respondents who showed an interest in the study were initially contacted with a recruitment letter detailing details of the research and what would be involved (Appendix 3). The interviews took place at varying locations, according to availability and convenience for the participants. This included participants' homes, participants' places of work and a private room in the University of East London, Stratford. It was ensured that the environment was confidential and safe for both the researcher and participants. Interviews were audio recorded, in

order to be transcribed after the interview. The interview commenced with a demographic questionnaire (Appendix 4) and consent forms (Appendix 5). Full demographics of the participants recruited can be seen in table 1 below.

Participant	Ethnicity	Age	Miscarriage details	Children
Rita	Asian, British	43	1 miscarriage at 12 weeks	Yes
Mina	Asian, British	32	1 miscarriage at 6 weeks	Yes
Candice	Black, British	34	1 miscarriage at 24 weeks	Yes
Grace	Black, British	45	1 miscarriage at 16 weeks	Yes
Maeve	White, British	37	2 miscarriages, both at 10 weeks	No
Louise	White, British	39	1 miscarriage at 9 weeks	Yes
Kelly	White, British	25	1 miscarriage at 12 weeks	No
Kate	White, British	45	2 miscarriages at 8 weeks & 6 weeks	Yes

Table 1: Demographics of participants

#### 2.5.4 Data Collection

As part of the recruitment, women were informed that part of the research would require them to choose up to six images before the interview which were stated as “*saying something about your experience of miscarriage*” and to bring them to the interview. As previously outlined, the study is interested in exploring how the use of selected visual aids by participants can help to both generate and construct an individual’s narrative. Photo/object elicitation is described as a non-directive approach, which uses self-selected images as the focus of an in-depth interview, which can facilitate collaboration between the researcher and participant (Lapenta, 2011; Ortega-Alcazar & Dyck, 2011).

Once participants completed the demographic questionnaire and consent forms, the interview began with the researcher using a single question, “*Can you tell me about your images?*” to facilitate a narrative related to the chosen image(s). Subsequently, prompts were used where necessary, which were derived from the semi-structured interview schedule<sup>1</sup> generated before the interview (see Appendix 6).

Lastly, a reflective journal was kept by the researcher throughout the course of data collection, alongside the recording of voice notes to capture the researcher’s initial thoughts/reactions. These recordings and journal entries acknowledge an engagement and commitment to reflective practice, an integral tenet of Counselling Psychology and also enables practitioners to reflect on their own subjective processes (Bager-Charleson, 2020). It is thus acknowledged that the researcher is as Finlay and Gough (2003) describe: “*a central figure who actively constructs the collection, selection and interpretation of data*” (p. 5) as opposed to a separate expert.

### **2.5.5 Critical Narrative Analysis**

This section will outline the analytic steps taken in the analysis process of this research before presenting the analysis chapter.

The main aims of analysis were to generate educative and operational responses to the research questions as opposed to the strict following a particular method (O’Shaughnessy, Dallos & Gough, 2013). The primary aim was to explore the ways social processes can shape individual accounts and the influence this can have on narratives (Esin, 2011).

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<sup>1</sup> A semi structured interview schedule was created in order to both meet the aims of the research and to hear women’s experiences (Bute & Jensen, 2011). Prompts were devised to facilitate narratives, for instance asking for recollection of a particular event being described, to facilitate further detail and explore developing themes.

Emerson and Frosh's (2004) critical narrative approach was drawn on, which encourages a focus on both the discursive strategies used by participants and the personal/social impact of these strategies. Focusing on both these positions enables both subjective meaning of a miscarriage and the societal factors to be explored, as outlined in the literature review. Additionally, the body can also be of focus within a critical narrative analysis which is in line with the study's interest in embodiment. Shilling (2012) argues "*the body has become a primary resource for the construction and consolidation of identity-a vehicle for displaying conformity or nonconformity to social norms*" (p. 23). In this light, narratives involving embodied experiences may demonstrate how the body can be a 'channel' which is shaped by societal norms. Emerson and Frosh (2004) highlight that although the researcher determines what areas are of interest, they should allow the narrator to maintain control over their own words. Drawing on a critical approach requires a stance that accepts the ideological nature of knowledge, whereby interpretation is contingent on social processes and power (Emerson & Frosh, 2004, Squire, 1998). Additionally, utilising a critical approach enables analysis to be directed towards social action and to this end, recognises Counselling Psychology as a site for social change (Kagan et al., 2009; Squire, 1998). Lastly, Emerson and Frosh (2004) identify the importance of researcher curiosity and the commitment of a critical approach to privileging subjective meaning-making alongside an examination of dominant social discourses. Thus, the analysis in this study draws on such ideas and is discursively informed, whilst upholding the importance of subjective meaning-making.

### 2.5.6 Analytic Steps

The initial stage of analysis entailed a reading of transcribed interviews. This was done several times in order to have familiarity with the texts and to ascertain the overall tone and articulation of the participants' stories. It was important to understand the distinctive voices individually and to find the ways they had positioned themselves in the narratives (Goodbody & Burns, 2011). A broad reading of the texts enabled a general overview of style in addition to establishing the use of metaphor and affect (Keats, 2009). Sciarra (1999) encourages a reflection of the “*empathic space*” (p. 42) within participant accounts, which enables the researcher to learn more about their world. This was employed throughout the reading and sections were then highlighted with notes made in the margins (see Appendix 7) that appeared as significant to women’s sense of self /identity, whilst paying close attention to the subjective experience (Josselson, 2011).

Given the volume of narrative accounts it was important to maintain a general framework in order to complete the analysis. Moreover, narratives elicited were from both the use of images alongside semi-structured interviews, which also pointed towards a need for employing a narrative structure. In order to capture a holistic narrative and to reduce the potential of a fragmented analysis, the narrative frameworks enabled the text to be kept as a whole (Bute & Jensen, 2011). An adaptation of Labov and Waletzky’s (1967) analytic framework was utilised, which was also employed in O’Shaughnessy, Dallos & Gough’s (2018) study on the experiences of Anorexia Nervosa. The transcripts were summarised using the following headings:

- I. Abstract
- II. Orientation
- III. Complicating action



#### IV. Evaluation

#### V. Resolution

#### VI. Coda

#### VII. Tone of the interview

These frameworks can be seen in Appendix 8. Following on from this process and in upholding the aims to identify the social and political constructs that can shape women's experiences (Fox, Prilleltensky & Austin, 2009), discourses which were discussed in the literature review were identified in the participants' stories. The analysis was carried out in conjunction with the theoretical literature in order to maintain a critical approach and to expand on existing concepts (Josselson, 2011).

Specifically, 'natural instinct', 'social expectation' and 'medical' discourses were identified. Some women also called on 'life plan' discourse as a way to resist the other discourses of pregnancy and motherhood. Once the discourses were identified, this led to a re-reading of the data in order to gain insight into participants' subjective experiences. This resulted in a thematic cross-sectional analysis of all the narratives (Bute & Jensen, 2011) which can be seen in Appendix 9. The narratives were initially grouped into the following themes:

- Physicality of miscarriage
- Shame and isolation
- Search for meaning
- Moving on from miscarriage

Finally, a visual reading was undertaken which focused on both the content and narratives generated (Banks, 2000, Keats, 2009). Additionally, images used by participants in the interviews, were examined to ascertain their role in the narratives, in the discourses identified

and as part of their subjective experiences, as a graphic illustration of their verbalised narratives (Rose, 2007). The presentation of images alongside narratives has been adopted from Fowles (2015) study on difficult breastfeeding experiences.

The following section critically examines the discourses employed by participants to narrate their experiences and explores the themes identified as a result of individuals' subjective meaning-making. Following the analysis, a discussion chapter will be presented, which explores the findings of the study and offers reflections on the research process including personal reflexivity. Finally, the clinical implications will be discussed in relation to Counselling Psychology.

## **Analysis: “First it was here, then it was gone”: The Birth of Motherhood and a Hope Interrupted**

The following section critically discusses the discourses employed by participants to narrate their accounts and explores the themes generated as a result of a cross-sectional analysis of individuals’ subjective meaning-making. Following the analysis, a discussion chapter will be presented, which explores the findings of the study and offers reflections on the research process including personal reflexivity. Finally, the clinical implications will be discussed in relation to Counselling Psychology.

### **3. Theoretical Context**

It is suggested that reality is actively and collectively constructed through language, shaped by dualisms such as man/woman and body/mind, which are socially constructed (Sampson, 1998). Moreover, authority is exerted by the ways in which discourses position individuals (Crowley & Himmelweit, 1994). By attending to ‘natural’, ‘social’ and ‘medical’ discourses, the lack of control and subsequent feelings of inadequacy and failure experienced by participants after a miscarriage will be examined, here claimed to be as a consequence of idealistic expectations of pregnancy and motherhood reinforced by medical, cultural and societal expectations.

#### **3.1 Discourse Analysis: Exploring Narratives of Motherhood and the Female Ideal**

Rowland (1992) argues that having children is generally assumed to be a natural and inevitable part of being a woman. ‘Natural’ discourse around motherhood and parenting

reinforces dominant social beliefs about the necessity for women to have children in order to be ‘fulfilled’ (Ulrich & Weatherall, 2000). ‘Social’ discourses construct motherhood and parenthood as significant and necessary parts of adulthood whereby childlessness or not wanting children is considered as unnatural or pathological (Morell, 1994). Furthermore Davis-Floyd (1994) argues that dominant medical metaphors are applied to women’s bodies in that they are treated like machines, which can lead to a sense of alienation from the body and can position women with limited agency. The following section examines individual narratives of participants, which demonstrate how such discourses were incorporated into their experiences and stories.

### **3.1.1 Miscarriage and the Disruption to Motherhood**

#### **3.1.2 Reasons for Wanting Children**

The analysis will begin with what many participants described at the start of their narratives: the moment they decided to have children and plan for a pregnancy. Participants pointed to a range of complex and compelling reasons for wanting children and drew on discourses about motherhood as a ‘natural instinct’, as ‘social expectation’ and as part of a ‘life plan’. For those who did not actively plan to become pregnant, a ‘motherhood’ discourse was also drawn upon, as they decided to continue with their pregnancy and had expectations of becoming a mother.

**3.1.3 Motherhood as ‘Natural Instinct’.** Like previous research on reasons for the desire to have children, participants constructed it as being an instinctive decision or as a biological imperative (Ulrich & Weatherall, 2000, Ussher, 2006). For example, Kate described how her desire for children extended to a physical manifestation which she experienced as a physiological ‘need’:

*It was a yearning to just welcome into the world another being really. I don't think it's something I can really put into words. It's just that aching, that longing in your- in my tummy, in my heart. Then I just really wanted to hold, to love, to mother, to nurture, to raise a little human and to give life, to carry a child and to feel what that felt like (1.189-192).*

Her desire for a child seems to be based on a bodily experience as opposed to a cognitive and rational decision-making process, which cannot be ‘put into words’. The physical basis of her desire was emphasised by a nurturing metaphor, as she expressed her wish to love and care for a child. Kate’s aspiration can be viewed as a physical need to give life to a child that was biologically hers and thus the creation of a new generation alongside her and husband. Similarly, Grace shared her desire for children as instinctive and something she would ‘naturally do’. She draws on her experiences of being around children and perceiving it as a process she would inevitably experience. She says:

*I just thought it was something that I would just do because I'd looked after kids. I grew up with my siblings and I had a lot of older siblings and they had young children when I was young and so I grew up looking after their children as well and I just thought I'd be able to do this...I didn't have any doubt whatsoever that I would have any problems being a mother (1.107-112).*

The discursive construction of motherhood as a ‘natural instinct’ can be seen to position women who then miscarry as ‘biologically flawed’ and thus denies women agency and choice. Feminist theories criticise this construction of motherhood as it functions to restrict women to a mothering role, which limits the identities available to women (Oakley, 1984).

**3.1.4 Social Expectations of Becoming a Mother.** A significant aspect of participants’ decisions to become mothers, were the societal expectations and pressures they experienced. Some participants had decided early on in their lives that they did not want children and actively rejected the idea of motherhood. Grace for example explains, *“I actually didn’t want children. I suppose I grew up in a really poor family and we didn’t have much, and I just didn’t want to not be able to give my children everything. So I just didn’t want children and that was quite a lot of my younger life”* (1.61-64). Grace describes an idealised view of motherhood, which appears to be based on socio-economic ideas around parenting as illustrated in her desire to give her children ‘everything’. She goes on to explain how external pressures to have a child became more pronounced, as her partner and peers questioned her decision not to have children. She says:

*I didn’t want children, and then my partner, we got married and then he started...oh you know ‘you’re a wonderful woman, you’re gonna be a great mother. I don’t think you’ll be able to live your life if you weren’t a mother’...and there was family when we’d go out as a couple ‘when you starting a family?’ ‘When you having children?’ And honestly I didn’t think that would affect me. I used to say ‘well when I feel like it’ but when you’re the only one without children, I was the only member of my family without children and, I just thought I’d take it in my stride, but people don’t realise the effect it has on you or on the*

*person that they're constantly questioning their decisions that they've made. That was tough actually trying to deal with what people were saying (l.253-260).*

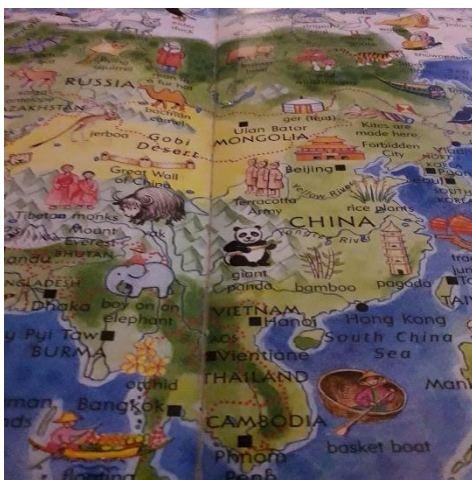
The normative ideas of motherhood being central to a relationship was seen in several narratives whereby relationships were construed as only being worthwhile when there are children. Kate shared similar external pressures, which resulted in feelings of urgency to become pregnant and have children, *"There may have been external pressures as well that came into it. It's the sort of time when family are looking on. You've gotten married, where's the baby? You know there's pressure from my husband's side, 'you've been together twenty years, what's happened?'"* (l.193-196). This reinforces the 'natural instinct' discourse whereby childlessness is constructed as concerning and abnormal. Again, there is a normative expectation that constructs motherhood as the next milestone that must be met in order to be accepted in society. Participants struggled to maintain self-agency and assuredness of their decisions against a backdrop of these external expectations. Maeve for instance, attempted to resist such societal pressures, especially amongst her peers who she compared herself to. Referring to herself as a 'feminist', she made the decision to focus on her relationship and career aspirations. She identifies her age as a factor in external expectations around motherhood when she says:

*So I'm thirty seven and you know everyone else was getting married and pregnant at the exact same time, you know, it was like why right? Why do we have to do it at that time? And there's a lot of like you're getting older and you're not going to be able to kind of thing" (l. 213-217).*

She later goes on to explain how these external pressures eventually influenced her decision to actively try and become pregnant. Her miscarriages anger her as she believes it reinforces a 'stereotype', that because of her age, she could no longer have children biologically,

*“I was really angry, really angry and I did have a moment of like, of course I would fucking go through this, I had the audacity to wait so long and be so smug”* (1.329-331). Maeve’s reaction is multifaceted in that her rejection of a ‘natural instinct’ discourse and subsequent miscarriages reinforce such discourse, whereby a ‘successful’ pregnancy is linked to biological factors such as age.

**3.1.5 Motherhood as Part of a Life Plan.** Constructing women’s desire for children as ‘natural instinct’ based on a biological imperative or as a consequence of societal pressures can hide women’s agency in the decision to have children. Consistent with previous studies, participants described having children in terms of positive decision making and part of a life plan (Ulrich & Weatherall, 2000). Several participants described how their desire for children came as the result of meeting key milestones in their life, where motherhood and having children was viewed as the ‘next stage’ in their life story. Kate for example, begins her narrative with a picture<sup>2</sup> of an atlas and uses the image to represent the moment she decided to start a family. She says:



*When I first started to try and conceive, we were in the world, we were travelling, we were working and I suppose my first start was in Thailand when we first started trying to start a family....we got married and had our honeymoon in Thailand and then that was the beginning of wanting to come off the pill to get into sort of wanting to start a family* (1. 56-61).

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Kate's description of wanting to start a family, positions her as having agency and control over her decision to try and conceive. This is emphasised by her quote '*wanting to come off the pill*', which represents an active choice in wishing to become pregnant.

Similarly, Louise's narrative is demonstrative of motherhood as a life plan as she describes a particular order of how she wanted her life to be before she embarked on motherhood. She says:

*So (name of husband) and I got married when I was 33. You could say, that was sort of late really, although we'd been together ten years prior to that, but I was a bit traditional in that sense of wanting to get married. I wanted to have a bigger house [...] I kind of wanted that order of things, and then I fell pregnant (1.134-140).*

Like other participants, Louise construes pregnancy and motherhood as something which can be planned for and controlled. This is reinforced by a 'natural instinct' discourse, which constructs motherhood as guaranteed and something that can 'just happen' due to biological drives. Furthermore, Louise draws on normative and 'traditional' ideas around marriage, whereby motherhood is perceived as the next step in a 'particular order of things' and therefore inevitable. Miscarriage appeared to disrupt this notion, and undermines the perception of motherhood as assured. This caused a significant impact to participants' world view and sense of self, as their agency was brought into question. Louise goes on to describe how she had planned her pregnancy around her job and felt that she was completely in control of her decisions and plans. She says:

*I spent a lot of time working out could I have longer off this time? If the baby was due at Christmas, then I could probably go until October half term. Because I work in a school I do feel like I live my life often in six week blocks. I call it the*

*oil rig like that [...] so in my head, although it was obviously only early days in the pregnancy, I kind of planned all of that out. So when they said that the pregnancy wasn't going to continue I felt like the rug had been pulled underneath me, because I'd had all these plans in my head that now I couldn't do anything (l. 170-180).*

Louise's use of the metaphor 'oil rig' to describe her job and how she lives her life, suggests that motherhood is also construed as predictable and straightforward, drawing on the discourse of motherhood as 'natural instinct'. The 'oil rig' signifies a sense of predictability and humdrum, which was found to be completely shaken when a miscarriage occurred. This is powerfully demonstrated by Louise's use of the idiom 'rug being pulled' from under her, which conveys the abruptness and instability that a miscarriage caused.

Rita also felt that she could plan for motherhood, which was reinforced by her experience of having two children prior to her miscarriage. She uses the image of herself and her siblings; to signify the plans she had for her own family and her desire to recreate a similar dynamic for her children. Her narrative draws on the notion that she had complete authorship of her motherhood story and could plan for the next phase of her life, in this case to have a third child. She says:

*When I look at that photo of my siblings, I think, oh, it would have been nice to have a third... my brother and I are quite close in age like my two boys, and then my sister is much younger than us, so that would have been the case, if I had a third... I think my boys would be really good big*



*brothers (becomes tearful). So I thought about the relationship between them and another child (1.3-19).*

As her two previous pregnancies had been straightforward and resulted in the birth of her two sons, she anticipated her third pregnancy to follow a similar trajectory. Drawing on ‘natural instinct’ discourse, Rita did not envisage that her preconceived ideas would not materialise.

### **3.2 The Reality of Pregnancy and Motherhood**

As discussed, a ‘natural instinct’ discourse of pregnancy and motherhood constructs motherhood as straightforward and effortless. Participants, who struggled to become pregnant, were consequently positioned as biologically flawed, or naive if they chose to reject this discourse. This was further compounded when these women then experienced a miscarriage. Participants referred to having a ‘false sense’ of security and drew on pregnancy/motherhood discourses which constructed pregnancy and motherhood as ‘inevitable’ and ‘choice’.

**3.2.1 The Perceived Inevitability of Motherhood: Expectation vs Reality.** Participants often described how their expectations of pregnancy and motherhood, was in stark contrast to the reality of their actual experience. Women felt naive and ignorant for having expectations that a pregnancy would be straightforward and becoming a mother would be an inevitable outcome. A miscarriage experience reinforced this discrepancy, which disrupted women's pre-conceived beliefs of motherhood as being easily attainable. Kate uses this image<sup>3</sup> of a pizza to represent the time and place she told her husband that she was pregnant. She described feeling excited and optimistic at the time, but the image signifies her unpreparedness for a miscarriage as in the following extract:

*“What does this image tell me?*

*Things change, things aren't always a given. It tells me that, you know that, what I thought was an inevitable thing was, was not...and sort of naiveté and a little bit of anger maybe at times and of disappointment” (1.43-47).*



Her miscarriage impeded the belief that pregnancy and motherhood is 'inevitable'. The sense of certainty around pregnancy is one that is shared across participants' narratives, which further compounds feelings of naivety and ignorance once women experience a miscarriage. Maeve, for example describes her frustration around trying to conceive and the difficulties she experienced to become pregnant, *“I was frustrated. We've been trying for six months, we actually didn't time it, we had no clue because you're raised, you're like, 'oh my God!' if you even touch*

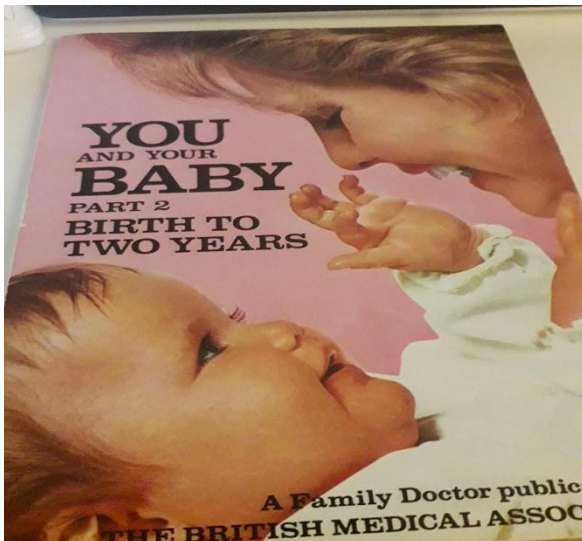
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*a boy, you're going to get pregnant and it's like, oh my God, it's actually so hard!"* (l. 594-598).

Maeve draws on 'natural instinct' discourse, which constructs women as 'biologically determined' to get pregnant. Thus, when a pregnancy does not occur or there is a miscarriage it can construe women as 'faulty' or 'biologically flawed'. Her narrative is also suggestive of societal expectations, which serve to regulate women's behaviour and to control for this 'biological drive'.

Motherhood was perceived by many participants as inevitable, which caused feelings of anger and frustration when they experienced a miscarriage. Kate describes how her expectations of pregnancy and motherhood were heavily influenced by the media and family, as she uses the image<sup>4</sup> of 'mothering books' that was given to her during her first pregnancy. She says:



*They were nice at first, they were, but then I think as time went on and it became difficult to conceive and the miscarriages and all the pain that went with it, these lovely things that were important to me weren't lovely anymore. I felt a bit resentful that my mum wasn't able to tell me about the birds and the bees, to tell me about reproduction, to advise me on issues that might*

*occur in my life rather than give me books on how to raise a child* (l.103-109).

The use of an animal metaphor 'the birds and the bees' again emphasises the 'natural' discourse, which constructs motherhood as straightforward and inevitable. Such discourse omits

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the potential of a miscarriage, which leads to unrealistic expectations of pregnancy. Kate describes her excitement and optimism when she was first given the books but becomes resentful of them the longer it took her to become pregnant. Her resentment is further compounded when she then experiences her miscarriages, as the idyllic image of a mother and baby on the front cover seems less attainable. Kate also alludes to a general lack of awareness of her physical body as she says, *“these books symbolize a sense of ignorance on my behalf, that I didn’t understand my body more”* (l.110-111). Her narrative suggests that ‘natural’ discourse does not highlight limitations of the body, which can lead to perfectionist and idealistic views of the body. Thus, miscarriage can be seen to marginalise women who do not meet such ideals.

For some participants, a public rejection of ‘natural instinct’ discourse was in itself problematic, as it constructs pregnancy and motherhood as effortless and inevitable. Women in the public eye who draw on a discourse of choice (i.e. choosing to have children when they wish), can propagate certain depictions of pregnancy as easily achievable. Rita argues how important it is to inform people of her IVF treatment to dispel the perception that becoming pregnant and having a baby is straightforward and always a certainty. She says:

*I always caveat it. When we got pregnant, it was ‘this is miraculous’! I use that word a lot and I’m not a religious person. I said, the chances of a forty three year old one using her own egg to have a baby is pretty nuts because you hear all these celebrities that have a kid at ridiculous ages and I know a couple fertility doctors personally and they’re like, Janet Jackson she probably froze her embryos when she was in her thirties, you know, where she could have her baby at fifty, all these women in their late forties, it’s- it does happen, but it’s very, very rare that you can have your own baby naturally* (l.206-211).

She goes on further to describe how open discussion of women's fertility is stigmatised, which reinforces societal expectations that becoming pregnant is 'natural' as she says:

*So one of my close friends, she used fertility drugs but she doesn't tell anybody. She told me and I said 'oh my goodness' you were forty two how did you? Then she said 'okay so I use fertility drugs' and I was like well you should probably tell people that because you give them the illusion that it was effortless, that it was a spontaneous pregnancy and it's such a taboo I guess (1.218-222).*

The secrecy that Rita describes, further marginalises those who go on to have a miscarriage, as they inadvertently go against this constructed ideal and dispel the illusion of choice and control over pregnancy and motherhood.

**3.2.2 The Illusion of Control.** Discourses of choice in women's narratives meant that women who become pregnant and then had a miscarriage often felt disempowered and experienced their lack of choice as 'unfair', as Maeve argues, "*Like unfairness of the world, all that kind of stuff... I think about it, like I know it was mostly this frustration, anger, sadness, like, why don't things work out the way that you expect them to?*" Several participants were guided by 'rules' around pregnancy, which they drew from public and medical discourses. Such 'rules' can be seen to both disempower women as it positions them with little to no agency, whilst paradoxically constructing pregnancy as within women's control as long as such guidelines are followed. Maeve based these on cultural 'tales' around pregnancy such as "*Not eating cheese on a Tuesday*" (1.68) or "*Don't bend over*" (1.67).

Rita for example says, "*I was doing everything medically I could, which was to take the progesterone, taking my folic acid and stuff*". Women drew on these guidelines from multiple

sources such as doctors and pregnancy literature, which some participants described as reassuring. However, when women experienced a miscarriage, they often felt guilty and blamed themselves if they had unwittingly ‘broken’ a particular rule. This is demonstrated by Maeve as she says,

*It's really weird because it does mess with your head and I think I'm fairly critical, like I've been saying about you know don't eat all this kind of stuff, but you get so 'just in case', you know what I mean? And I went to my friends, I had one coffee earlier and she made tea and out of politeness, I had half the tea and I started spotting then and I was like 'Oh it was the tea!' I had too much caffeine. Literally it was the first thing I thought and obviously, that's not it, like the baby had died four weeks ago, it was nothing to do with that, but you're first thinking is, I've done something (l. 673-680).*

Although Maeve was eventually able to reject the idea that she caused the miscarriage, the initial self-blame stemmed from her belief that she had gone against ‘prescribed’ guidelines around pregnancy. Many participants drew on medical discourse, which constructs pregnancy as in need of monitoring and self-surveillance. Interestingly, this discourse is reflected in pregnancy applications on smartphones that individuals can use to ‘track’ the development of their pregnancy. Such applications mirror linear notions of progress, which fail to account for different outcomes such as miscarriage. This arguably reinforces the view that one stage invariably leads to the next. Maeve describes how such technology did not include information on miscarriage and reinforced the assumption that motherhood is inevitable after a pregnancy. She uses an image<sup>5</sup> from a smartphone app she used during her first pregnancy, which she views as reminiscent of her excitement and optimism the first time she used them, but is now

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experienced as naiveté for not being prepared for a miscarriage.



*Looking at it now and the naivety of it all....Now I'm like, you shouldn't get excited until you know it's going to be ok. So I guess that is the kind of difference here. Whereas before I was like 'oh that's so cute, an innocent tiny baby,' which isn't even accurate. It's so lovely and all that kind of stuff but now when I look at it it's just naive don't get too excited it could all be torn*

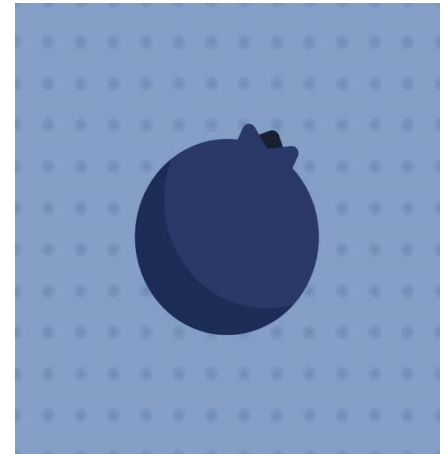
*away (l. 34-42).*

Maeve's account highlights the lack of agency that many participants described, as the metaphor of pregnancy being 'torn away' demonstrates complete powerlessness over an embodied experience. The ability to monitor a pregnancy in this way has been argued to further reinforce processes of medicalisation, where women are 'policed' and become vulnerable to advice, criticism and surveillance (Longhurst, 2005; Nash, 2013). In Thomas and Lupton's (2015) review of popular pregnancy apps, a discourse of risk was found to be central to the way pregnancy was framed, which positions women as solely responsible for a pregnancy outcome. Louise also references the use of a pregnancy app throughout her first pregnancy with her daughter and then again, during her second pregnancy, which ended in a miscarriage. She says:

*I remember when we decided to have a child and came off the pill and have the app on my phone and then the fertility app on the iPhone. Like, what kind of fruit is it? I was really lucky that everything sort of happened quite easily for us, so I kind of just thought it would happen like that the second time around. I just never doubted that (l. 635-639).*

The pregnancy apps referenced by participants are structured in a way that presents the trajectory of pregnancy as inevitably leading to one outcome: the birth of a baby. Given that Louise's first pregnancy resulted in the birth of her daughter, the app reinforced the notion that having a straightforward pregnancy is assured. Maeve uses another image<sup>6</sup> from an app she used during her first pregnancy. She says,

*So this is very reminiscent of the happiness you feel with the first one, which you don't really feel like with the second one. You never really feel again to a greater extent. So yeah that's reflective of that...blueberries is the one that I can remember [...] I think poppy seed or sesame seed is the first size, they increasingly grow. So again it's an app*



*and like I was all over it, checking it constantly, oh developmentally and this is what the size is and everything, so it's very linked to the first kind of happiness and getting like totally getting stuck into it. (1.19-28).*

Maeve's description of checking the app 'constantly' and getting 'stuck into it' is indicative of an embodied form of close monitoring and surveillance. It has been suggested that apps, "Constitute one more regime of ritual purity in the avid pursuit of attaining a 'normal' and idealised pregnancy outcome" (Thomas & Lupton, 2015, p.504). Consequently, apps may reinforce the construction of pregnant people as solely accountable for individual and foetal health i.e. this will keep you/your baby safe, which may cause feelings of anxiety, self-responsibility and blame if a pregnancy ends prematurely (Lupton, 2013). Representing pregnancy using a staged approach, such as the use of different sized fruit or increasing

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footprints, can cause feelings of guilt and distress, if women are then unable to ‘move’ onto the next stage. This is illustrated by Maeve as she says:

*It's like a jadedness, does that make sense? Well, I'm not gonna bother getting my hopes up. That's probably what it's more about, yeah, and then like having bitterness towards the app, that you shouldn't even have started using it. It's mean, for people who don't end up reaching lemon size or whatever it is, you know what I mean?" (1.58-62).*

As there is no mention that a stage may not be met, miscarriage is thus perceived as a deviation from the ‘norm’, which can marginalise and isolate those who experience it. For those who do not reach ‘lemon size’ a sense of failure or inadequacy can then be reinforced.

### **3.3 “I couldn’t hold onto it”: Identity Interrupted and the Loss of Self**

Consistent with previous studies, participants drew on discourses of motherhood as ‘natural instinct’ ‘part of life plan’ and ‘social expectation’. Such discourses were found to influence women’s identity and their sense of self after a miscarriage, which was inextricably linked to constructs around womanhood and a female ideal. Furthermore, women drew on medical discourses, which led to narratives of disempowerment and disembodiment.

**3.3.1 Miscarriage as Failure: Self-blame and Guilt.** Participants often described a sense of failure after their miscarriage, which led women to doubt their bodies and construed a miscarriage as something being ‘wrong’. Candice explained how her experience caused her to worry about being judged by others and being perceived as a failure. She says:

*It was a case of I don't know, people looking at you, like, I don't feel like they looked at me like I had failed, but I felt that way sometimes, like oh you know maybe there's something- again this thing around, 'maybe there's something wrong with her', you know? (l. 307-310).*

Drawing on discourse of motherhood as ‘social expectation’, Candice perceived her miscarriage as failure, which impacted her sense of self and led to feelings of blame. Constructs of pregnancy as ‘natural’ and controllable, often led women to feel responsible for a miscarriage, as in the following extract:

*I think it had an impact on me as an individual and again just the element of what's wrong with me? What did I do wrong and being a failure and evaluating how I could have done things differently and taking it easy and stuff (l.383-385).*

For many women, a miscarriage became inextricably linked with their identity and expectations of womanhood, given they had actively embraced the idea of becoming a mother. Becoming pregnant seemed to signify the physical actualisation of female identity, and a step towards a mother identity. A miscarriage was then seen to disrupt this process towards motherhood and caused women to feel inadequate; unable to meet societal expectations of being a woman. This is demonstrated by Grace’s narrative, as she says:

*There was something I created and I lost it. I couldn't hold onto it. There is a huge sense of inadequacy in this. There's one thing a woman does in life that nobody else can do. Only a woman can create children and yet I can't even get to that stage. I couldn't even get to the stage where this child could survive. What is wrong with me? There's that sense of inadequacy that you're just not good enough as a woman, and then even though there's other factors you just- the blame is on yourself (l. 386-392).*

Grace draws on gendered discourse, which constructs women as 'nurturers' and 'protectors'. The phrase 'I couldn't hold onto it', reinforces this construct, as it positions her as physically responsible for her miscarriage. It can also be seen as a metaphor of motherhood, as a miscarriage prevents women from being able to physically hold a baby/child. Candice also uses the same phrase in her narrative when she says, "*I felt quite inadequate in the sense that, oh gosh, I can't hold a baby anymore kind of thing, and having that feeling and having to deal with those emotions. Oh, I can't hold a baby*" (1108-111). Although Candice had a child before her miscarriage, she describes an inadequacy felt by many participants, as her perceived ability to have another child is disrupted. This can also be linked to social constructs of female identity, where fertility is viewed as the pinnacle of womanhood. This is demonstrated in Kelly's account as she describes how her happiness is closely tied with having children,

*The main thing for me from what happened to me is obviously, like the need of wanting to have a baby to feel like my life is complete. I think that is one of the key things and I don't know if it's like that for other girls or women that it's happened to, maybe some people never want to have a baby because of what*

*happened, but erm yeah, for me, it's a key part, in like my happiness and success in life (l. 446-450).*

**3.3.2 Deservedness of Motherhood.** Consistent with Ulrich and Weatherall's (2000) findings of women's infertility experiences, several women described the deservedness they felt of being a mother. Discourses of choice predicated on assumptions that women can choose when they want to have children, alongside discourses of social expectation, meant that women often felt their miscarriage was 'unfair'. Maeve for example says: "*I did feel like why is the world fucking with me? I did feel angry in that sense, as if something out of my control, was being done. Like, why? Because, I'm a bad person? Or not nice enough?*" (l. 347-349).

In an attempt to make sense of a miscarriage, women often drew on moralistic ideas, where a miscarriage was construed as some form of punishment. It meant that women's internal frameworks for living were also brought into question, as the absence of a medical explanation caused women to search for their own understanding of why a miscarriage happened. This is also demonstrated in Louise's narrative as she says:

*I knew about different people's stories, but not really thinking that- I hadn't ever thought it would happen to me [...] I'm quite an optimist, a positive out looking person. I think, if I'm positive with people that good things will happen. So, yeah I suppose (sighs) I just never even doubted that, or I would be told that there wasn't a heartbeat (l. 624-628).*

The sense of deservedness of being a mother often meant that women were determined to continue trying for a baby after their miscarriage(s) even through difficulties. This signified the intensity of their desire for children, as in the following extract from Kate's narrative:

*It's just not wanting to fail and getting what I wanted. Feeling like I deserved to get what I wanted. I deserve to be a mother, I've come this far, you can't stop now. This isn't going to be easy. I was constantly saying this mantra in my head, this isn't gonna be easy. You have to just keep going. Yes, it's going to be shit. It's going to be hard. You just have to keep going and rolling with it (l. 620-624).*

### **3.4 The Language of Miscarriage**

The analysis presented thus far, has explored the language women used in their narratives of motherhood and pregnancy, looking at words, phrases and metaphors that were employed to communicate their experiences. The following section will highlight how participants also drew on discourses which led to their disempowerment after a miscarriage, which left many women feeling isolated and disorientated, struggling to make sense of their experience. Furthermore, discourses which constructed the body as 'machine' will be examined, which caused women to feel disconnected from their embodied experiences.

**3.4.1 Miscarriage as Routine: Disempowering Medical Discourse.** A common experience for women was being involved in medical services during and after their miscarriage(s). Consistent with previous studies, women often described having negative experiences of being in a medical environment and found interactions with staff as adding to their distress (Atkins, 2010; Evans, 2012; Harvey et al., 2001; Moohan et al., 1994;; Moulder, 2001; Murphy & Merrell, 2009). Participants highlighted the medical terminology used by medics as unsympathetic and clinical, which left them at odds with how to process their experience. This is demonstrated in Maeve's account as she says:

*There were like a few things where tact wasn't amazing. I did end up having a scan the next day and again, nobody had explained anything to me and she was like, 'so I'm just going to speak with my student, so what we're doing right now is to see if there's any remaining tissue' and I was like remaining tissue?! (l. 307-309).*

Here Maeve is positioned as a passive bystander, lacking in autonomy as she is 'treated' and observed by medical professionals. This sense of disempowerment is emphasised by her quote '*nobody had explained anything to me*', which also results in her feeling alienated from her body and shocked by the physical description of her miscarriage. Grace also describes her lack of agency and sense of dehumanisation, after seeking medical treatment for her miscarriage. She says:

*It's just so not nice, the way it's all dealt with in hospitals, you know, it's just so not nice. You're just like another number and it is, you just go in, you get a scan, you get a test, you know that's it, it's gone, you know. Goodbye...You know...It's just a clinical conveyor belt (l. 319-323).*

The metaphor of a 'conveyor belt' emphasises the routineness that was often experienced by women who received medical attention after their miscarriage. This is consistent with previous research, which has highlighted the discrepancies between individuals' needs and the care they received (Atkins, 2010; Evans, 2012; Harvey et al., Moohan et al., 1994; Moulder, 2001; Murphy & Merrell, 2009). This has been found to contribute to a sense of disempowerment in individuals, which can confound feelings of isolation and shame (Layne, 2003).



Some narratives drew on a discourse of choice, where women could decide how they wished to manage their miscarriage, as in Louise's narrative:

*We got taken to the EPU [Early Pregnancy Unit] and I remember them doing another kind of internal scan, and I remember them giving me a leaflet and saying I needed to make a decision about the different, like the procedures....and I picked one (506-509).*

Where this can be seen to help women feel more in control of their experience, participants found that not having discussions around the choices available or any follow up support, added to their distress. Women felt they were treated in hospitals as a matter of routine due to the commonality of miscarriage and found staff indifferent to their subjective experiences. Louise says:

*I just remember it being really sterile and like kind of, I mean, I know it's a hospital. It's got to be, a bit sort of matter of fact, because I mean, obviously miscarriage is common and obviously they must deal with that all of the time but I suppose they can try to be compassionate (l. 550-553).*

Although Louise is describing her experience of being in hospital as clinical and sanitised, the term 'sterile' can also be viewed as a metaphor for her embodied experience of miscarriage, specifically concepts around fertility and loss. This is later demonstrated in her narrative as she says, "*I suppose like in my head it was just yeah, just sad about the fact, the concern about like, would I be able to have another one and would it be ok*" (l.148-149). Worry around future fertility was also seen in Kelly's extract, "*That may be the one time I could of had a baby, I've wasted it, obviously not on purpose...that could of been my one chance*" (l.391-393). Both 'natural' and 'medical' discourses can be seen to position women as 'failure', where a

miscarriage is perceived as signalling a ‘fault’ with the body. These discourses can often lead women to struggle with their sense of self and identity as their experiences of a medicalised environment is at odds with their subjective experience. This is seen in Grace’s account of her time during hospital after her miscarriage:

*There should be a counsellor available in the clinic, so you can talk to them straight away...someone there to help you, because you cannot process it. It's very difficult to process. You don't even know what you're doing. You don't even know how to process. You get a piece of paper with negative written on it and you're just like, horrified. Gosh, this is it. It's gone, it's over. You know, what do I do? And you're just left in this room with other women and you think God what do I do now? Just get up and go and start again and that's it. Honestly, they leave you there and then that's it, you get up and leave and go back to your life (l. 325-332).*

Like Grace, several participants described a lack of follow up care or emotional support such as counselling once they had a miscarriage. This often led to some participants feeling neglected and unsure as to how to ‘process’ their experiences. Given that the causes for a miscarriage are usually unknown, the medical model is indeed limited in its ability to provide an understanding of the event that goes beyond the management of the physical aspects of the experience. Furthermore, medical staff may deem it as inappropriate to provide an emotional response out of concern that it could be perceived as unprofessional. This can account for the narratives that described a lack of ‘tact’ from healthcare staff that treated them. It seems that in the absence of recognition of individuals’ emotional needs such as providing details of further support available, participants interpreted this as neglectful and dismissive of their subjective experience.

**3.4.2 Mechanisation of the Body.** Some women drew on discourses, which aligned their bodies with machinery. The ‘body as machine’ metaphor stems from the medical model, which attempts to reduce complexity and uncertainty of the body to predictable linearity (Crossley, 2007). The nature of miscarriage meant some participants were caught between a medical model, which functioned to reinforce the notion that bodies can be ‘fixed’, and their subjective experience. Rita, for example says:

*You know I’ve had knee surgery and stuff and I’m like the body breaks down but you get up and you just do your stuff again (becomes tearful) but there are some parts of the body you can’t control (l. 360-362).*

The use of a machine metaphor as in ‘*the body breaks down*’, demonstrates Rita’s experience of the medical model where the body can be repaired, and ‘normal’ functioning resumed. This discourse becomes problematic in the case of a miscarriage, as a pregnancy cannot be ‘fixed’ or ‘saved’. This is highlighted in Rita’s quote as she is confronted with the experience of not being able to control her body and thus her miscarriage. Her emotional response can be seen to signify the difficulties in drawing on a medical discourse to help navigate a miscarriage, as her subjective experience is diametrically opposed to such discourse.

Conversely some participants used mechanistic metaphors as a way of understanding their experience, which led to disembodied discourses. Kate described her experience receiving fertility treatment after her miscarriage. She says:

*My body was in a pretty bad way. They wanted to scrape the inside of my uterus wall. They knew that I’d had a miscarriage. Sometimes when you have a miscarriage and you have the foetus and the tissue removed, the lining of the womb becomes quite thick and that’s not very good for implantation, so they*

*wanted to remove any debris that may have been left inside me from the last miscarriage. So basically...they scrape it all out with the chisel, clean lining, clean womb, everything nice and clean* (l. 694-701).

The imagery of tools such as “scrape” and “chisel” emphasises the construct of the body as a machine, which can be seen to reinforce a mind/body dualism. Kate appears to be drawing on this discourse as a way of disconnecting herself from the body, in order to deal with a miscarriage and to move on to a potential new pregnancy. Her accentuation of cleanliness “*clean lining, clean womb, everything nice and clean*” can be seen as an attempt to rid her body of what is physically left by a miscarriage. This notion of cleanliness can also be linked to gendered discourse around menstruation, where miscarriage is viewed as the release of ‘dirty’ menstrual blood (Buckley & Gottlieb, 1988; Jeffery & Jeffery, 1996; Martin, 2001;), which is associated with shame and stigma (Sveinsdottir, 2016).

This disconnection from the body was also seen in Rita’s narrative, which again can be viewed as a way of ‘moving on’ from a miscarriage and as a means of coping with the experience. She says,

*After about three, four days and you know, you start seeing parts of your uterus coming out, I mean placenta and I’d looked it up it was like, yes these are signs, so I was immediately can I have a drink now, like can I move on with my life?”* (l. 278-381)

The mechanistic metaphor as demonstrated by “*parts of your uterus coming out*” emphasises the body as ‘breaking down’. Rita is disconnected from her body as highlighted by the use of ‘your’ instead of ‘my’, which can be viewed as a way for Rita to revert back to her previous identity and behaviours.

### **3.5 Summary of Discourse Analysis**

The ‘natural’ and ‘social’ discourses of motherhood explored in this section were found to be inextricably linked to womanhood and femininity. Such discourses alongside the ‘medical’ model constructed pregnancy and motherhood as inevitable and ‘effortless’, based on biological imperatives. A miscarriage thus positioned women with limited agency as they were thus construed as inadequate and a failure. Social expectations, alongside ‘natural instinct’ discourse could be seen to impact women’s identity as a miscarriage disrupted the transition from non-mother to mother. Jones (2001) argues that because identities are interlinked with what we do, women’s experience of miscarriage and subsequent feelings of inadequacy are confounded by a society that reinforces the positive aspects of motherhood, whilst emphasising the negative value of failure. Medical metaphors can also be seen to reinforce feelings of inadequacy when the body is constructed as machine. The case of miscarriage meant participants perceived their bodies as ‘broken’ which alienated women from their embodied experiences.

### **3.6 Cross-Sectional Narrative Analysis**

The discourses used in participants’ narratives, have highlighted the ways in which miscarriage is constructed, mainly as failure and inadequacy as womanhood is equated with motherhood. As seen in the previous section, discourses of motherhood as an inevitable outcome of women’s biology and meeting societal expectations, alongside medical discourse which constructs the body as ‘machine’ can be at odds with women’s subjective experiences due to a lack of available discourses. The following three themes explore the ways in which participants attempt to make sense of a miscarriage in their narratives, offering additional ways to understand this experience.

### 3.6.1 Pain, Blood-Clots and Sanitary Pads: The Physicality of Miscarriage

All participants described their physical experience of a miscarriage alongside the emotional and psychological impact. Many women used vivid detail to narrate the moment they had a miscarriage in addition to the after-effects, which were all found to be important parts of their experience. As previously highlighted, women were generally unprepared for the possibility of their pregnancy ending in a miscarriage, which resulted in narratives of shock and trauma when they had to experience the physical manifestations of a miscarriage. Some women described being unaware of what was happening to them, which made them feel disempowered and with limited agency. Kelly describes her experience of being in hospital once she had started bleeding at home, she says:

*Obviously, when I woke up, it was quite traumatising. I got a bed at like half three, and then I maybe woke up at like seven or eight and obviously between them few hours a lot had happened. A couple of my friends that have gone through similar things, they said they should have put me basically I don't know if you've ever seen them like these massive pads [...] because obviously I was bleeding, so obviously it was gonna come. They should have put me in one from when they moved me to the ward or even from A&E but they didn't. If they had just done that one tiny thing, I wouldn't have woken up, like literally lying in my own blood but yeah I don't think, I really didn't really know what it was, I just woke up and it was on, honestly it was everywhere. Like I've never seen anything like it (l. 280-290).*

The lack of preparation on behalf of the medical staff, alongside Kelly's unawareness of a miscarriage, meant that the extent of the physicality of the event was unknown to her. Her narrative demonstrates how she was then left to manage the psychological and emotional impact

of the physical manifestations. Kelly's experience of extreme blood loss was shared amongst other participants, whereby the physical pain and sight of blood left women in shock and fearing for their lives akin to a traumatic response (Farren et al., 2016). This seemed to be compounded by the unawareness of the physicality of a miscarriage and unpreparedness of what to do. Maeve for example, provides an account of her first miscarriage and the disbelief she felt over what was physically happening to her. She says:

*It all was horrendous. I was at my friends and I started spotting tiniest little droplets of blood, and I freaked out, and I was like, look, this is what's happening I'm kind of freaking out to my friend [...] I just felt really ill and I just remember everything, like something needs to come out of me, like, I just felt like it needed to....But then when I started, like, peeing blood, and I knew it's happening and I was just devastated. It was this weird, surreal moment where I was like, I cannot believe this is actually happening to me. Like, it literally- that doesn't give it enough weight, but that's literally my thoughts. Like, I cannot believe that I'm actually going through this. You know what I mean? You just don't think you're going to (l. 285-298).*

The extreme pain and blood loss that Maeve later describes, led her to think of the potential loss of her life, as she says, *"Like, I actually thought I was going to die because the ambulance took so long to come, I was feeling really bad"* (l. 260). The physical ramifications of a miscarriage were demonstrated to have a significant impact on women's sense of self and compounded the emotional distress around the end of a wanted pregnancy. Kate describes the physical ordeal she experienced in her narrative of her first miscarriage:

*I didn't take enough painkillers to manage the pain so I had to call paramedics. They came to the flat, yeah, I was having contractions and all sorts on the loo. I couldn't stand and couldn't move, couldn't walk. I think about two o'clock in the morning that the foetus passed into the toilet. But the pain in my stomach was intense and paramedics had to come and administer medication, so that I was all right. So that was horrendous (becomes tearful). The only thing I take from that experience... yes, you have a miscarriage, but then you have to manage the removal of the miscarriage, which again I'd- it never crossed my mind [...] I remember coming out of the toilet whilst I was trying to remove the foetus really early in the morning and just smacking my head into the doorframe and I nearly knocked myself out (l.560-570).*

Kate's narrative highlights the multifaceted nature of a miscarriage, where women often have to manage not only the emotional and psychological aspects but also the physical experience of a pregnancy ending prematurely. The distress that can come from this aspect is emphasised by Kate's need to purposefully hit her head against the door frame as a means to cope with the process of 'removing the foetus'.

**3.6.2 Naming the 'Mess': Dispelling Taboos of Female Reproduction.** As highlighted, 'natural instinct' and medical discourses around pregnancy and motherhood often left participants feeling unprepared for a pregnancy to end by a miscarriage. Consequently, women described their distress and shock at having to cope and manage the physical manifestations of a miscarriage, alongside the emotional impact of not being able to continue with their wanted pregnancy. Participants referred to their lack of knowledge as being caused by an absence of



open discussion on miscarriage in both the medical and social spheres. This was seen in narratives to cause feelings of isolation and uncertainty around how to navigate their experiences. For some participants, their interview was the first time they had discussed their experience, like Mina when she says, *“I've actually never spoken about it in this much depth”* (l. 220-221). The lack of societal discussion on female reproduction can be seen more broadly as associated with patriarchal discourses in the regulation of women’s bodies. Murphy and Philpin (2010) argue that the loss of vaginal blood associated with miscarriage is similar to a magnified form of menstruation, which although is a shared experience amongst many women, has historically been shrouded with secrecy, shame and used to stigmatise and devalue women (Sveinsdottir, 2016). This is demonstrated in Maeve’s narrative as in the following:

*That's like the side of women that we don't really want to know about, the bloody side of things. I just think let's demystify it a bit more, I would hope that eventually, because I think things are shifting a lot for women. Generally, I think with pregnancy and birth and child care is still by and large, it's still a bit outdated and I think that's tied up with this idea of like we don't talk about any of the mess and you're not supposed to tell (l. 235-239).*

Maeve highlights the secrecy that often surrounds the ‘mess’ of female reproductive processes and advocates for more societal discussion on such issues. By describing the physicality of miscarriage, participants can be seen to reject patriarchal discourses on women’s embodied experiences of reproductive processes. Mina uses the image<sup>7</sup> of a sanitary pad to help narrate her experience of a miscarriage. Mina was not aware of her pregnancy until she had the physical manifestations of a miscarriage. She says:

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<sup>7</sup> Image reproduced for educational purposes in accordance with the fair dealing exception to copyright law

*I thought I was having a normal period. I went to the loo and something came out...I freaked out. I was like, oh my God! I shouted, something just came out of me, and my husband was like what is it show me. I'm like, no, no, no, I'm not going to show you... he saw it and he almost gagged and just the thought of it as well I'm sorry....So that was that moment that happened (l. 6-12).*



Although Mina was unaware of her pregnancy, she later draws on discourses of motherhood in her narrative, where she describes feelings of guilt and responsibility for the miscarriage. Her quote demonstrates the elements of secrecy where menstruation, more generally is usually dealt with privately, in the ‘backstage area of the toilet’ (Martin, 2001, p.25). This is emphasised by her reluctance to show her husband what had physically happened to her.

Participants felt their knowledge of pregnancy and miscarriage and more specifically the reality of the physical aspects, stemmed largely from female friends who had first-hand experiences, as opposed to social or general knowledge. Louise for example, describes being told what would physically happen during a miscarriage by her friend, as in the following:

*She said to me, be prepared after you've had a miscarriage for it to look like a scene from Jaws. I don't think like, I'm so glad she said that because I don't think that anybody would have prepared me for the amount of blood that there was and I remember like standing in the shower, like the blood coming away from me and thinking, oh my God, like it's happened now, and the physical kind of thing, to look at it in the bath and seeing, like, you know, the reds (l. 428-433).*

The analogy Louise draws on ‘like a scene from jaws’ emphasises the significance of what can physically happen to individuals during a miscarriage such as shock and blood loss, and the perceived importance of being prepared for this aspect. Maeve also reflects this in her narrative as she says,

*I had to go to the hospital because I lost so much blood...I was explaining to someone and they were like oh, that happened to me after I gave birth to a baby. Right, and I was like, that's a thing that can just happen. Then the other thing was, oh yeah I was pissing blood and they were like yeah, that's like, that's what happens after you have a baby, you're constantly bleeding, and I was like I didn't even know that stuff... it's like we don't want to talk about it. It's like the blue on the pad; we don't really want to talk about the messy side of either of those things (l.197-204).*

The description of her “*pissing blood*” can also be an attempt to emphasise the physical realities of what can happen after a miscarriage. Maeve’s account further highlights the secrecy that surrounds female gynaecological processes (Roberts & Waters, 2004), which consequently reinforces the stigma that is often associated with miscarriage. Interestingly, like Mina, Maeve references a sanitary towel when she says ‘blue in the pad’ as a way of highlighting common depictions of menstruation (blue liquid is often used instead of blood in advertisements on sanitary products) which also reinforces female reproductive processes as taboo, shameful and prohibited from societal view (Stubbs & Costos, 2004; Sveinsdottir, 2016; Weiss-Wolf, 2017).

She later draws on gendered discourse around blood as she says, “*Like men bloody fighting, yeah, that's fine. Men do that, but women have blue periods*” (l. 227-228). Maeve can

be seen to highlight patriarchal discourse that construes menstruation and other physical aspects of female reproduction as ‘dirty’ and ‘dangerous’ (Stubbs & Costos, 2004).

**3.6.3 Surrendering to the Body: Attempts to Reclaim Control.** As discussed in the previous section, many participants described the lack of control they experienced when they were having a miscarriage, which often left women feeling disempowered and with limited self-agency. Women who felt in control of their decision to have children, felt at odds with their miscarriage experience, as their worldview was disrupted. Rita for example described her frustration as she could ‘*control so many other things*’ (l.365) but could not prevent her pregnancy from ending. Rita draws on ‘natural instinct’ discourse to help make sense of her experience and to cope with the physicality of a miscarriage. She says, “*It was just a very long period with, like weird looking stuff in the discharge, yeah, and so I guess that reassured me, my body was doing what it needed to do*” (l.395-396). Owing to the fact that a miscarriage cannot be halted, participants appeared to draw on ‘natural’ discourse to reclaim control and have a sense of agency. For example, many participants did not want to have a medical intervention to manage their miscarriage, and consequently relied on their bodies to go through the physical process. Grace says,

*I went for a scan and the embryo wasn't developing so they were going to terminate the pregnancy, they said this is not viable, and I said no. I said I've miscarried before, I've been through this. I'm not going to go through a medical procedure. I said, if it's not working my body will reject it (l. 166-169).*

The rejection of a medical model can be seen as a way of establishing a sense of control over an uncontrollable event. Similarly, Louise, described her relief at not needing to have a medical intervention as in the following,

*I was planning to go in to have the procedure to remove it on the Tuesday [...] I'm sort of really grateful that I didn't have to go into hospital and then it happened Monday night at home...I couldn't control it happening, but at least I was in my own house and it was me that did it rather than like having to rely on anybody at the hospital.... I think it's because my body, like my brain and my body knew that it was gonna happen on the Tuesday [I see] and then I just had the contractions on the Monday evening and then, yeah and then it passed away, erm I remember like being in the shower at like 2:00 a.m. in the morning and all of that sort of stuff, but actually being grateful...and I just wonder whether like something in my body and my brain knew that I didn't want to go through with it in the hospital. I was really grateful that I didn't have to (1.181-202).*

Louise can be seen to draw on 'natural instinct' discourse whereby the functioning of the body is based on biological drives, as her body 'knew'. Although she could not control the actual process of a miscarriage event, Louise describes a sense of solace at being in her home and not needing to 'rely' on anyone. The natural instinct discourse is thus used by participants to accept the bodily processes and inevitability of miscarriage, which paradoxically allows for the attainment of control.

### **3.7 “You just don’t talk about it”: Miscarriage Unspoken**

As previously highlighted, 'natural instinct' and 'medical' discourse and discourses based on the assumption of choice; construe pregnancy and motherhood as inevitable and effortless. The analysis has shown that such discourses generate narratives of failure and inadequacy when women then experience a miscarriage, as it is closely tied to maternal and female identity. This

was shown to impact participants' ability to talk about their miscarriage, and for some women their interview was the first time they had discussed their experience. Furthermore, the physical manifestations of a miscarriage and its connection to menstruation can be seen to contribute to the stigmatisation of a miscarriage experience and female reproduction.

The unspoken nature of miscarriage meant that women were not prepared when they had one, or often relied on incomplete information gathered from external sources such as the media. Participants described knowing much more about pregnancy and childbirth, which caused miscarriage to be far less understood. Maeve highlights how her knowledge of physical symptoms of pregnancy came from a TV programme as she says:

*There are two bits of information that I got, totally random and didn't have much impact until later. So one of them was on party of five, which is just a stupid nineties show, which I watched in the 90s and re-watched recently and will probably watch again soon, but one of the characters on it has been trying forever to get pregnant, and she ends up, I think they do in vitro even, and she's obviously so anxious about it, and she spots and she goes to the doctor and she's hysterical almost and they test her. They're like, it's fine. You have low progesterone. Sometimes that causes spotting...so that was one piece of information. So when I did start spotting, I was like, OK, I do remember that this can be okay (1.149-160).*

Maeve later describes having a 'false sense of hope' as the information she quotes here did not include a miscarriage or what to do in the event of one. The lack of public and societal awareness often led participants to feel ashamed and isolated, which reinforced the stigmatisation of a miscarriage experience.

**3.7.1 Shame and Isolation: The Hidden Pain of Miscarriage.** Consistent with previous studies, the silence around miscarriage meant many participants felt alone in their experience and often had to cope and manage their distress in private. Despite efforts of early researchers, miscarriage still appears to be a ‘hidden loss’ (Frost et al, 2007), whereby women find it difficult to vocalise their experience. This is often linked to a sense of shame and guilt as illustrated by Mina’s narrative:

*There’s so much about pregnancy and labour. Nobody shares and I don’t know if that’s a cultural thing you don’t tell people. You don’t tell people that you miscarry you know? Oh God, it’s that I don’t know that it’s looked down upon you? You couldn’t carry a child. I don’t know it’s something you don’t talk about* (l. 182-185).

Studies on infertility, often illustrate the social isolation and sense of stigma that women experience (Whiteford & Gonzalez, 1995). Greil (1991) describes this as a ‘secret’ or ‘private’ stigma as it is not socially visible in the same way as other identities (such as disability). Frost et al., (2007) argue that miscarriage has a similar ‘veil of secrecy’ (p.1011) which can also be linked to stigma. In the absence of open discussion and public awareness, miscarriage becomes a deeply private event, which can reinforce feelings of shame and guilt. Candice for example, draws on a discourse of illness in her narrative, which constructs the body as ‘infectious’, she says:

*I remember when it happened and stuff I didn’t want to go to people’s houses who had a baby. Not because I didn’t want to see their child but because they would feel like I would make their child die and stuff, I don’t know how to explain it, like I was infectious* (l. 518-521).

Candice's use of an illness metaphor, again emphasises how a miscarriage can significantly impact on a person's sense of self, as she felt 'infectious' and unable to be around people. In the void of preparedness and understanding, women were left to construe their own causes and explanations for having a miscarriage. This often manifested in self-blame and guilt, as participants questioned their own behaviours and actions. For example, Kate says, "*I went into the gym and I was really excited, and I started to work out and a few weeks later, I miscarried and I blamed my workout. I blamed too much exercise, too heavy weights, too much strain on the body*" (l. 142-147). The sense of blame further adds to women's shame and reinforces the silence around the experience.

Bauman (1997) highlights that in cultures where death has been 'scientised', a death which does not seem to have a cause is particularly difficult to make sense of. In the case of miscarriage, there are multiple ambiguities, particularly what has been 'lost' which adds to confusion and uncertainty (Hey at al., 1996). This is also reflective in the terminology used by participants to describe their experience.

### **3.7.2 Embryo, foetus, baby, 'it': The Interchangeable Characterisation of Miscarriage.**

*"I know it's probably just like cells and tissue together but it was mine"* (l. 211).

The above quote by Mina, demonstrates a distinctive feature of participants' narratives: the different terminology used by to describe their miscarriage, which has also been highlighted in other studies on miscarriage (Murphy, This can be seen as indicative of the ambiguity and confusion that women experienced and highlights the difficulties in making sense of a miscarriage. Like Mina, participants tended to oscillate between impersonal descriptors such as "it", technical terms such as "foetus and embryo" and terms such as "baby" and "child" which signifies the equivocal nature of the discursive framework around miscarriage. As previously



highlighted, the lack of public discussion and societal scripts for this experience, can lead to difficulties in understanding/identifying what has been 'lost' (Frost et.al, 2007). This can be further compounded by the absence of a tangible entity which was also found in the narratives. For example, Louise's says, "*Usually if an animal dies or whatever, you or a person dies, you kind of like, you know, it's there and it's physical. Whereas for me, it wasn't*" (l.114-116). Layne (2000) suggests that the confusion individuals may face is increased by the difficulty in identifying the death as the death of a person. The ambiguity of the foetus/baby can mean the reality of what has taken place is difficult to grasp (Frost et al, 2007). This is illustrated in Kelly's account as she describes the moment, she had her miscarriage:

*I went back to sleep and when I woke up again; I went to the toilet because obviously they have to monitor everything that comes out of you... I had to pull my trousers down and it was in there in the pad and I didn't know what it was like, you know, do you remember them, like gooey aliens you used to get? That is the first thing that came into my head and I was like, because you could see it's like definition, but it's still quite attached, but it was like you could see where the head was to the body and it just reminded me of them like those gooey alien things and so I rang the chord and she came in and I just remember saying to my mum is that my baby? (l. 291-302).*

The description of what Kelly was physically confronted with, demonstrates the perplexity of a miscarriage whereby expectations do not coincide with the reality of the event. It is thus experienced as 'alien', which brings into question the status of what has been 'lost'. Pregnant people may have fantasies and preconceived ideas of a 'baby/child' (Frost et al., 2007),

which can lead to certain expectations of the physicality of the foetus/baby. This can be seen in Kelly's question when she asks, "*is that my baby?*"

The interchangeability of terminology used by participants also appeared to function as a potential coping mechanism for individuals, especially for those who did not have children at the time of their miscarriage. As previously discussed, the multiple discourses of motherhood that are linked to female identity, may lead to a devastating sense of "*unfulfilled potential*" in women who do not have children (Frost et al, 2007, p. 1014). Kate for example describes how she became pregnant after fertility treatment and subsequently miscarried, "*I had my first cycle and fell pregnant and it was great. Wahoo! It was really good and then three months later, I lost that child. That foetus*" (l. 711-712). Kate can be seen to oscillate between the terms 'child' and 'foetus', which can be indicative of her attempts to make sense of her miscarriage. The word 'child' is connected to motherhood and is part of a 'mother' identity, which has been disrupted in the case of a miscarriage. Her use of the term 'foetus' can thus be seen as a way to cope with the emotional impact of not becoming a mother. This can be seen further in her narrative, when she says:

*I was really quite sad and quite pragmatic at the same time. Okay. It's done. It's gone. It's finished. I carried no great loss for that foetus. I lost what I lost. I suppose I was upset about what could have been, what should have been, all the dreams that I'd had attached to this baby* (l. 741-745).

Kate's account illustrates the multitude of framings that participants used to make sense and cope with their miscarriage. The pragmatism that Kate describes was shared across narratives, as a way to 'move on' if women wanted to have another pregnancy. The emotional impact and attachment to the pregnancy can be symbolised by the terms baby/child, whereas the

term foetus may be used to disconnect and detach herself as a means to cope with what happened.

**3.7.3 The Displacement of Miscarriage: A Matter as Out of Place.** Alongside the ambiguities of language around miscarriage, participants often described feeling physically out of place in both medical and private settings (Pitt et al., 2016). This reinforced the hidden nature of a miscarriage experience, alongside feelings of failure and inadequacy, when they were amongst other women who were further in their pregnancies. Many women found this added to their discomfort and distress as in the following example by Candice who had to stay in hospital during her miscarriage:

*I was quite worried and quite scared in the hospital, my husband stayed with me, I was very, very anxious and I mean that night I couldn't sleep when I was in the hospital. It can be upsetting because you're in the hospital, on the ward with all these other women. You can hear what they're going through, like the first or second stages of labour. You can hear their babies on the monitors moving around and stuff like that...so it can be quite upsetting hearing, being there and hearing that stuff (l. 195-201).*

This quote highlights the isolation that many participants experienced as they often had to suffer in silence. Women also found being in hospital waiting rooms with other women was also difficult and heightened their sense of being out of place. Louise describes her experience of waiting with others after the scan which informed her of the miscarriage:

*I remember looking at the women in the waiting room thinking, oh, you're here to have these scans or are you here because you've been told that news? Like, I'm*

*not trying to make eye contact with them because I didn't know whether they were here, because it could possibly be good news or bad because they'd be given the same story as me. So that was kind of a weird feeling* (l. 517-522).

In addition to feeling 'out of place' in hospital and medical settings, some participants also described being at odds amongst women who were pregnant, after they experienced a miscarriage. Part of this was again due to the hidden nature of miscarriage, where physical aspects of an early pregnancy are not visible. Candice says, "*Some of the other women are at the last stage of pregnancy and stuff and then you can see like their bellies are quite big and you're there and your situation is a lot different...You don't feel like you're kind of part of them*" (l.206-208). In this quote, the physical loss of a 'growing belly' can heighten women's experience of isolation and thus position women as 'other'. Their identity is disrupted as they are no longer a 'pregnant woman' and have to relinquish the transition of becoming a 'mother'. Participants felt this ambiguity was difficult to understand by others who had not been through a similar experience. This also seemed to add to women's loneliness and confusion.

**3.7.4 The Ripples of Shared Experience.** As highlighted, many of the participants had minimal to no prior knowledge about the potential of a miscarriage or the physical process involved, and few were aware of how common it was. Indeed, many women described how it was only after their own miscarriage that they became aware of their own relatives and friends had also miscarried (Frost et al., 2007). This provided some reassurance for women, as it alleviated feelings of isolation and shame. Maeve for example says, "*People after the first one, came out of the woodwork and all of a sudden I realise that many people directly linked to me but a lot of people linked to them have gone through this, which was quite comforting*" (l. 336-339). It

seemed that once participants began to openly discuss their miscarriage to others, the commonality of the event was realised. Louise uses the image<sup>8</sup> of a letter that was written to her by a friend who shared her own miscarriage experience. She says:

*Although the letter is brief, it's just the contents just resonated so much. It just made me feel that somebody else knew exactly how I felt and that, you know, again, people don't talk about it, so you don't know. I mean, when I found out I was pregnant with that baby, I didn't tell my mum or my sister, who I'm really close to. I didn't want to tell them until I had the scan (l. 29-33).*



This ‘passing down’ of experience appears to be a valuable and powerful resource for women, who are otherwise unaware of miscarriage or who feel isolated in their experience. With such lack of public/societal awareness, women are left to navigate their experience with little knowledge. It can be of great relief, when women are told of other women’s experiences. Louise describes this further in her narrative as she says:

*I think there was one bit which kind of summarizes, I mean (name of partner) is really supportive, but it says ‘in my experience, men are sad and disappointed, but it's us that feel it in our core’, and I think that's, you know, like you never forget it... this letter is now over 4 years old, I just keep it in the drawer where I keep my tights (laughs). It's just at the bottom of it and then I just get it out every now and again. I think sometimes, like, you know, there are days where I kind of, don't ever*

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<sup>8</sup> Identifiable features have been obscured to maintain participant anonymity

*think about it and so I suppose, it's part of your history or your story. I don't know if I'll ever throw it away* (l. 11-25).

The significance of hearing and sharing experiences of miscarriage is palpable. The experience itself, as highlighted by Louise's quote, illustrates the impact to a woman's sense of self, as it is felt in 'our core'. This deeply felt experience is also reflected by the image of the letter being kept in Louise's drawer next to her tights, and further symbolises the private and hidden nature of a miscarriage. It can also represent a need to mark and remember a miscarriage in some way.

### **3.8 “There was no celebration, no mourning, nothing”: The Search for Meaning and Remembrance**

As previously discussed, there is a lack of open discussion and societal awareness of miscarriage. As a result, there are no public signs or rituals to provide positive social sanction for a miscarriage (Frost et al., 2007). This final section of the analysis will therefore explore the variety of ways women constructed a sense of meaning from what happened to them and highlight the unique means of commemorating their experience. It will also discuss how participants attempt to dispel the stigma and taboo of miscarriage and highlight the ways women moved on from their miscarriage.

**3.8.1 Frameworks of Meaning.** A common reaction to the uncertainty of miscarriage was to find causes and explanations. As previously illustrated women often blamed themselves for a miscarriage if they engaged behaviours or if they went against cultural and medical ‘rules’ of pregnancy, like having caffeine. Participants still felt responsible even when they were given assurances by doctors, partners and friends that they were not to blame, as they struggled to understand why they had a miscarriage (Frost, et al, 2007). Kate illustrates this as she says:

*I used to get cross at myself for not taking it easier on my body, may be working out too hard and not being aware of how exercise can sometimes be detrimental. I know what I was doing wasn't a factor in losing the child, but nevertheless, I needed something to sort of hang on to (l. 152-155).*

The vacuum left by miscarriage in terms of an explanation, is often filled by a multitude of reasonings and justifications. Like Kate, several women questioned their own actions and felt responsible. Others attempted to reframe their experience into a more positive narrative, by seeking to present the miscarriage as a fortuitous event. This is reflected by Candice as she says,

*“Sometimes we go through situations, no matter how traumatic or upsetting or stressful it is, it could be a whole lot worse. I could be here with a baby like severely disabled and it doesn't have a very good quality of life. How would that be? (l. 476-481).*

This framing is also illustrated in Mina’s narrative as she says:

*I would make myself feel better because I'd say, well you weren't ready for it anyways. So maybe it's a good thing that it happened. Actually, I think that happened because we weren't prepared. We didn't want to try then, and maybe that's why it didn't happen (l. 253-254).*

Participants often evoked pre-modern concepts like fate (often conceived as nature) when looking for the possible causes of their miscarriage such as “it wasn’t meant to be”. Some women also relied on their faith for religious meaning where miscarriage became seen as God’s will, as in Candice’s narrative:

*I feel like it helped in a certain way and I feel like talking to my daughter about heaven and things and the baby, being there you know, it just helped to comfort everybody, gave us all like an inner peace if that makes sense. I’m at peace with it, with everything that had happened, although it was really traumatic and stuff, I’m not angry at anyone. I’m not angry at God or at myself, and I remember people saying to me, that God knows best (l. 472-477).*



### 3.8.2 Ritual and Remembrance.

*My sister's very religious and they have a mass for unborn children, and you go to the mass and you take a white carnation for every child you've miscarried and you pray for the child and I put my four carnations there, and honestly, something changed within me after I did that. Maybe that was a sense of relief, but it was that action that had the most effect than anything else, because I didn't seek out support for it because I didn't realize how affected by it I was at the time and it's just that now realizing, gosh, I have healed, there's been a lot of healing (l. 348-354).*

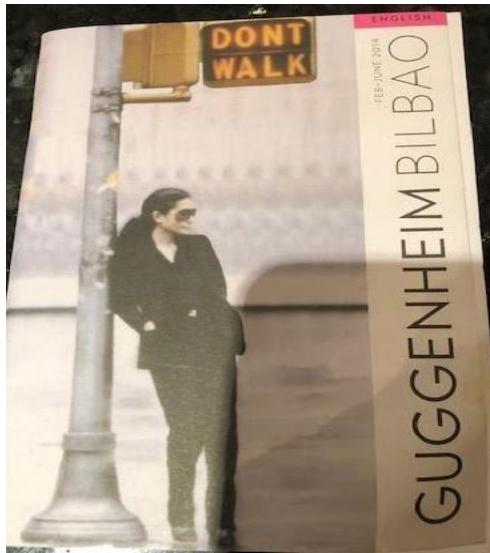


The above quote from Grace illustrates the significance of marking a miscarriage and the beneficial impact this can have on participants' sense of self. Grace uses the image<sup>9</sup> of a white carnation to represent the sense of 'relief' she experienced as she had not realised the extent to which her miscarriages had affected her. In the absence of societal/cultural customs around miscarriage, participants often found individual ways to mark their miscarriage and remember their loss privately. This created narratives of empowerment, as individuals utilised means that were unique and representative of their subjective experiences.

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<sup>9</sup> Image reproduced for educational purposes in accordance with the fair dealing exception to copyright law

Kate uses the image<sup>10</sup> of a museum program taken whilst she was on a school trip, to symbolise how she decided to mark her miscarriage. She says:



*When we had the scan and they give you that letter that says when the baby lost the heartbeat, I just tried to track back and think what I did on that day. It turned out I was at that museum and I was trying to think, what did I do? Did I feel anything? Did I feel ill on that day? Did I eat anything I shouldn't of? Did I drink anything I shouldn't have? And all of those things. You*

*obviously track back when you find out you're pregnant but also this was the day that the baby died, and so again, I suppose I just wanted to keep it to know that I marked it somehow (l. 100-118).*

Unlike pregnancies that end after twenty-four weeks gestation where the birth/death is registered, a miscarriage is not afforded similar processes. Kate's narrative illustrates a central part of this experience for some participants: the need to mark and remember the miscarriage and thus the foetus/baby. This is also reflected in Candice's narrative, as she uses an image of a toy given to her at hospital when she had a miscarriage. She describes how it represents a memory that her daughter and family can share. She says:

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<sup>10</sup> Image reproduced for educational purposes in accordance with the fair dealing exception to copyright law

*It gives her kind of happy memories and the memories that she has. She knows that her brother or sister has it. When she hugs it and stuff like she can remember, she can use it as a way to remember them. It kind of gives her some comfort, but I guess it's just a reminder. I don't know, it sort of gives us an opportunity to kind of be part of that memory, if that makes sense (l. 24-29).*



Kate uses the image of baby clothes to describe how she told her husband she was pregnant; she says:

*These little Christmas booties, little baby booties and a little box. I didn't say anything to him. Not in the restaurant but I took this out of the box and it's pretty obvious that I was pregnant (l. 23-25).*



Although Kate did not use the image to represent a need to mark or remember the miscarriage, she went on to explain how she kept the items several years after her miscarriage. This can be seen in some way, as a desire to 'hold onto' something, which symbolises her experience.

For many participants, the interview was the first time they had openly discussed their experiences of miscarriage, which led women to reflect and realise aspects about their experience

they had otherwise not thought about. This is reflected in Mina's narrative as she attempts to make sense of what had happened, "*There was no celebration, no mourning, nothing. It was a little thing that happened and that was it. I think that's what bugs me the most. What was it? Why did that happen?*" (l. 31-34). The lack of celebration and mourning as Mina says, again illustrates the ambiguity of the event, where women are often left to find individual and unique ways to understand their experience. Mina later reflects on her faith in the interview and is confronted with the grief of her experience. She says:

*M: Now thinking about it I've never prayed for it. I've never thought of it like that.*

*I: And what does that mean to you?*

*M: It means a lot because you pray for things you love. You pray for things that are yours. You pray for things that mean something to you. The fact that I haven't, does that mean it didn't mean anything to me? It must do, it was a part of me. Yet ultimately it was nothing, it was nothing but it could've been. I've actually never spoken about it in this much depth. That bothers me that I didn't pray for it because if I didn't pray for it then I don't, I don't know... (becomes tearful) (l. 212-217).*

### **3.9 "It did change me": Life after Miscarriage and Reaffirming Self-Agency**

The final aspect of analysis will explore the ways in which participants described 'moving on' from their experience. Women were resilient and resourceful in their narratives and often utilised strategies to reaffirm a sense of agency. Rita for example describes how she

became more interested in her physical well-being and reconceptualised the function of her body. She says,

*It made me even more determined to get fit. Now I'm not having a baby, I'm not trying for a baby, maybe I should run a marathon because I was thinking, oh I can concentrate more on my swimming and cycling. Maybe I should get jogging again. So there are other things to do with my body besides producing a baby (l. 450-454).*

Like Rita, participants found ways to regain control and feel empowered, such as focusing on new goals. In contrast, other women found that their experience made them more accepting of uncertainty and stoic towards life. Louise demonstrates this as she says,

*I suppose it just made me see that everybody has a vulnerability and you can't control everything and actually that's okay and so I think it changed things in my head a little bit, to make me realise that you just can't be perfect all the time...a bit more acceptance that it's ok if things don't go to plan" (l. 334-339).*

Louise illustrates what other women described in their narratives: a profound change in their sense of self. Kate says:

*It did change me for sure, it did. I can't deny it, absolutely. And even now, as a mother I'm just incredibly protective and just incredibly grateful for what I have and I think that I would still be, had this experience not happened, but it's just added a depthness and richness to motherhood that I don't think perhaps might have been there if I hadn't gone through this journey before (l. 897-901).*

Alongside the multiple meanings that participants derived from their experience, a miscarriage was also found to alter perspectives on life and motherhood as well as having a lasting impact on their overall self-concept.

### **3.9.1 Summary of Thematic Analysis**

The thematic analysis has described the multiple ways a miscarriage experience can influence women's sense of self, in the context of ambiguity and silence around this event. 'Natural' and 'medical' discourses of pregnancy and motherhood, alongside 'social expectations' around female reproduction, created narratives of failure, shame and disempowerment. Furthermore, the unpreparedness of miscarriage led to a disruption of participants' worldview and frameworks of living. The analysis was also able to demonstrate how women, in the absence of cultural awareness of miscarriage, attempted to both resist and utilise the identified discourses to reclaim control and find individual ways to make sense of their embodied experiences. The implications of these findings and proposed ways Counselling Psychologists can respond are discussed in the next chapter, alongside personal reflections on the process of research and possible areas for future development.

## **Discussion**

The following chapter will discuss the findings of this study and identify the potential clinical implications for Counselling Psychology and healthcare professions. Utilising the structure suggested by Willig (2012) a summary of findings will be presented, followed by personal reflexivity in relation to the undertaking of this study. This will lead to a discussion on epistemological reflexivity, examining the ways the study produced knowledge and highlighting the strengths and limitations of the research. Lastly the clinical implications will be discussed, explicitly in relation to Counselling Psychology and the discipline's objective around social justice.

### **4. Summary of Findings**

The main aims of this research were focussed on understanding the ways that women narrate their experiences of miscarriage, paying close attention to how social processes can shape the construction of these stories and influence such women's sense of self. The structure of the analysis attempted to reflect the forms of women's narratives which usually began with their decision to have a child/children or to continue with a pregnancy, followed by their miscarriage experience, ending with their attempts to make sense and find meaning from their miscarriage.

It was seen in the analysis that women drew on prevailing discourses of motherhood as reviewed in the literature, mainly 'natural instinct' and 'social expectation', which were found to be inextricably linked to their constructs of female identity. Furthermore, the analysis demonstrated the unpreparedness women felt of having a miscarriage, given the absence of social and cultural discussion on the topic. Within this context, the identified discourses were

seen to reinforce expectations around pregnancy and motherhood as being inevitable, which produced narratives of failure and shame once a miscarriage was experienced. The analysis also demonstrated how women drew on medical discourses, which constructed miscarriage as an ‘illness’ and the body as ‘machine’. This was found to alienate women from their bodies and created narratives of disconnection and disempowerment. Furthermore, new technologies that are based on linear notions of progress (Leith, 2009) in the form of pregnancy tracking apps, led to narratives of self-blame and guilt when a miscarriage was experienced. Such apps also reinforced self-surveillance and pregnancy monitoring associated with the medicalisation of pregnancy.

The medical discourse alongside ‘natural instinct’ and ‘social expectation’ were found to be limiting, restricting participant’s agency and the ways they were able to narrate their experiences. This was seen to compound the ambiguities of miscarriage, as demonstrated by multiple characterisations (i.e. terminology of miscarriage) and the subjective experiences of women who often felt alienated. By exploring embodiment, some women rejected the medicalisation of miscarriage and turned to their body in an attempt to regain control and self-agency. This was demonstrated in narratives where women “surrendered” to the biological processes of the body and resisted medical discourse. Other opportunities for empowerment were also identified. Functions of the body were reconceptualised with women offering alternative views of the body and resisted dominant discourses of female identity, which are based largely on the potentiality to have children. The body also became a site from which to resist patriarchal discourses of female reproduction. By naming and openly discussing the ‘mess’ of a miscarriage, women were able to dispel the stigma and taboo nature of miscarriage and thus give voice an otherwise silent experience.



In the absence of cultural/social awareness of miscarriage, dearth of public discussion and the lack of preparedness and clinical explanation, women were often left to navigate their experience in isolation. For many participants, their sense of self was deeply affected, as their worldview and frameworks for living were disrupted and brought into question. Without societal rituals, participants demonstrated individualised ways of making sense of their experience and expressed varying needs to remember and mark their miscarriage in some form. Furthermore, women drew on empowering discourse as they expressed a need to pass on the awareness they gained from their experience, in order to educate and prepare others for not only the potentiality of a miscarriage but also the physicality of the experience.

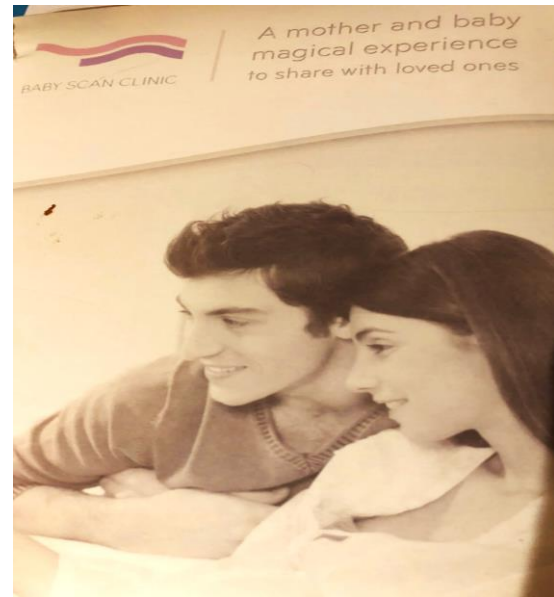
#### **4.1 Personal Reflexivity**

##### **4.1.1 Personal Reflections on the Position of Researcher**

Personal stories are not created within a private mind, no more than they *'fall from the sky'* (Reissman, 2008, p.105). Rather they are embedded within wider, culturally available stories that particularise ways of seeing the world and shape one's position within it. Context is a key part of narrative research. In order to contextualise this study, I have chosen to write the following reflections to recognise the position I hold within this research. I am aware of my position as a 'mother-researcher' in conducting this study and also as someone who has experienced a miscarriage. My reflections and process of undertaking the research is arguably influenced by this dual role. Much like the approach I encouraged participants to use in their stories, I pre-selected two images to elicit the following reflections:

### Image one: “A mother and baby magical experience”

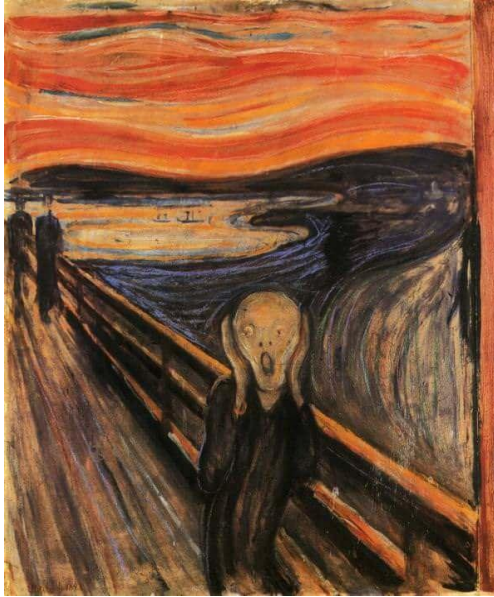
This image is of a leaflet used in an antenatal clinic where I was able to have a scan of my pregnancy during the first trimester. I am aware of the positive expectations I had at this time, and the feelings of excitement at being able to see the development of my pregnancy, which may have been influenced in some part by the description of the scan being a ‘magical experience’. I am now also aware of the reference to the pregnant person



as a ‘mother’ with ‘baby’ implying an established dyadic relationship and personhood. The image accompanying these words is of a young, white heterosexual couple who both appear ‘happy’ while they view the scan together. My experience of the scan was in stark contrast to the image depicted. Firstly, I am not white, and am struck by images used in mainstream depictions of pregnancy and motherhood which are frequently unrepresentative of diverse and non-white populations (Morris & McInerney, 2010). Secondly, my lack of awareness and understanding of miscarriage meant the image reinforced my expectations that a pregnancy would inevitably lead to fully developed baby. Like other participants in the study, I too was informed during a twelve-week scan that the baby/foetus had died. I struggled to comprehend what had happened. Having been told that I miscarried, I was then taken by a nurse and what was referred to as a baby up to this point was now called a ‘foetus’ and ‘contents’, as I then had to decide how to ‘manage’ the miscarriage. I was given information on the options, which was presented in a straightforward,

clinical manner. My experience in contrast felt very complicated and it became increasingly difficult to disentangle the many layers of the experience.

**Image two: ‘Silent scream’**



A few weeks after my miscarriage, I shared my experience with a few friends and family members. I was struck by the varied reactions. In trying to comfort me I was reassured by others that I “could always try again”. Other people didn’t know what to say and I felt awkward, embarrassed and ashamed for trying to talk about it. At the hospital where I was informed about the miscarriage, I was also unable to communicate how I was feeling. This image makes me think of the turmoil and anguish that I felt but could not express. It felt impossible to convey the pain and distress I experienced. As time has passed, I have better understood these experiences and became interested in the ways they shaped my sense of self and identity. I cannot completely bracket off this aspect of myself in conducting this research but I have remained mindful to keep it running in parallel, rather than enmeshed with this thesis. I did not feel able to speak about what had happened to me, and this study is driven by a commitment to hear the voices of women who I can identify with. Nonetheless, I have been consistently aware to avoid reinforcing the silence, and to not allow my personal experiences and ‘mother’ identity to eclipse my ‘researcher’ position.

Sciarra (2011) describes research that involves personal experience and raises the issue of researchers “*going native*” (p.40). He outlines a tension between the researcher role as ‘expert’ and a potential conflict between identifying the distinction between the researcher and participants. He highlights how this can lead to difficulties in facilitating participants to narrate for themselves. Furthermore, Letherby (2002) illustrates a tension in analysing data from her own personal, intellectual and political viewpoint as this can advantage her voice over others. I am reflective of the ways in which my relationship to this project has shifted, since I decided to embark on the study. Initially, I felt a need to validate my experience through the research as I sought explanation and an understanding of what I had gone through. Over the course of the training, I have become more robust and less reliant on external validation. This has been reflected in my initial interest in discourses of power (i.e. medical) and resulting control over experiences of miscarriage, to my current nuanced and integrated understanding, that has evolved since embarking on the project. I have more of an awareness that another researcher or me at a different moment time may not have heard the participants' stories in the same way (Fowles, 2015).

#### **4.1.2 Hearing Participants’ Voices**

A tension that I have reflected during the course of the research has been aspiring to impart the participants’ subjective experiences and simultaneously upholding a critical ideological position. The lack of feminist discourse on the experience of miscarriage and political connections to the abortion debate, meant that narratives had to be heard sensitively. Brown (2004) notes that a progressive approach should be taken to feminist psychotherapy, whereby the process of work should be underpinned by “*a conscious and intentional act of*

*radical social change*” (p.30). Yet, others argue the need for caution with such radical approaches as this must be balanced with staying close to and holding onto real distress (Ussher, 2002). Hubert (2002) argues that the emotional experience should be acknowledged in women’s narratives, alongside empathic understanding, in order to maintain a focus on subjective experiences.

Reflecting on the research journal I kept throughout the research process, I faced an ongoing dilemma as I moved into the analysis stage. In attempting to uphold the individuality of each participant’s account, assimilating concepts and themes was often a conflicting process. Harter (2009) states that: *“meaning does not reside in the mind or words of any single participant but rather emerges in the interfaces between people, stories and contexts”* (p.142). It was challenging to uphold this viewpoint at times, as my objective to gain an understanding of the uniqueness of women’s voices and privilege their subjective experience, was threatened by the pursuit to incorporate themes. The process of analysis entailed interpreting and critically arguing the ways that discourse influenced narrative accounts, which occasionally felt insensitive and perfidious to the poignant experiences I had with participants. Letherby and Williams (2002) highlight this tension as an inevitable aspect of research and suggests the impossibility of bringing together a complete representation of participants in a body of work where the aim is to make a difference, arguing researchers either speak for others or abandon aims to make a positive change through impactful research. I reflected on Jansdotter’s (2008) work on the female prostitute where she illustrates her pursuit in preserving the ‘subject’ who she suggests is *“just a figure circulating in a narrative”* (p. 309). It was useful to have this image in mind, throughout the analysis process, as it helped me to relinquish the responsibility of capturing the ‘subject’ fully in isolation of their context, keeping in mind they are inevitably linked. Rather

than provide an exact account of participants' experiences, my critical position was aimed at understanding the re-telling of their stories.

## **4.2 Epistemological Reflexivity**

The following section will discuss some methodological concerns, firstly the power dynamics within the interview process and secondly the use of images.

### **4.2.1 'Researcher' or 'Therapist': Power Dynamics in the Research Encounter**

Drawing on my experiences of the interview process, I am reminded of the emotional and often distressing narratives women described. For most participants, our interview was the first time they had discussed what had happened to them. This often posed a dilemma of wanting to provide them with the opportunity to voice their experience, but I was aware this could also cause them distress. One way of mitigating this was to inform participants at the beginning of the interview that they could stop at any time and to actively ask if they wished to continue when they appeared to be distressed. Such participants all wanted to continue, and I was struck by their resilience and determination to tell their stories in order to help others and break the stigma of this experience.

During the interview process I became aware of my therapeutic training and how this influenced some of my line of questioning. Although I maintained a continued effort to be aware of my own biases and researcher position, the co-production of narratives meant that my own subjectivity shaped the process (Willig, 2012). Some interactions with participants point towards the impossibility of having a completely transparent self, impervious to social processes even in a research environment (Diprose, 1994). The following interaction will help illustrate this and

also highlight how this relates to the therapeutic encounter, specifically power dynamics within therapy and ways that dialogue can both restrict and illuminate understanding of a person's sense of being in the world (Heidegger, 1996).

This example is taken from the interview with Candice, where in exploring her experiences I draw on my Cognitive Behavioural Therapy (CBT) training and use a 'therapeutic script':

*I: What do you think that said about you, that you had a child?*

*Candice: I guess it was something to be proud of, knowing that I had gone through the pregnancy journey [...] that's the only thing I can think of (l. 358-664).*

In this interaction I ask Candice what it said about her that she had a child after her miscarriage. The way in which the question is phrased can be seen as typical of the scripts often found in CBT when a person's 'core belief' is explored (see, Westbrook, Kennerly & Kirk, 2011). Candice's response appears to be restricted, as the question did not allow for her to elaborate on her experience. My question can be viewed as reinforcing the success/failure dualisms constructed in the 'natural instinct' and medical discourses that Candice draws on in her narrative. As I would still want Candice to voice her subjective experience, it may have been more useful to explore her feelings rather than asking what it says about her as this can result in individualising and pathologising her experience.

Unintentionally, I facilitate an understanding of identity that is individualistic, which is a criticism made of Psychology (Fox, Prilleltensky & Austin, 2009). What is illustrated in the above interaction is described as a "*meta-narrative*", whereby the therapist is positioned as the expert (Milton, Craven & Coyle p. 64) as individuals' experiences are conformed to a modernist

model. This example demonstrates how my different roles in relation to the research influence the co-production of narratives, as my ‘therapist’ role superseded my ‘researcher’ or ‘mother’ positions.

#### **4.2.2 Understanding and Utilising Visual Data**

Using images in this research proved to be a useful method in generating narratives and allowing participants to have control over the form of interviews. Nonetheless, it should be noted that my inexperience of using this method may have resulted in the possible underuse of images. Direct questions around the images themselves may have generated more understanding around the meanings of the image as directed by the participants (Collier & Collier, 1986).

#### **4.3 Limitations of the Study**

While every effort was made to recruit participants from various streams, it proved to be a challenging part of the research process. This could have been due to the topic under study, as highlighted in the findings, the experience is not openly discussed, and awareness is often limited. The sample therefore consisted of individuals with a range of ages and experiences such as individuals who had children at the time of the interview and some who did not. In the pursuit of wanting to offer such women an opportunity to discuss their experience, I drew on literature that outlined the impact a miscarriage can have even on women who have children (Robinson et al., 1994). This underpinned my decision to include such individuals, which proved to offer valuable insight into this experience. However, it should be noted that this may have influenced the experience of a miscarriage as they already inhabited a ‘mother’ identity. Furthermore, one



participant Mina, was not aware of her pregnancy until she had a miscarriage. This may have shaped her narrative, as knowing about the pregnancy before the miscarriage could have generated a different response. Interestingly Mina still drew on ‘social expectation’ discourse, which was linked to her identity as a woman and produced a narrative of failure and shame. This highlights the potential impact this experience can have, when there is a lack of public discussion and societal awareness, even on individuals who are unaware of their pregnancy beforehand. This could be an interesting area to develop in further research.

## **4.4 Clinical Implications**

The final section will explore the clinical implications of the study and how this relates to Counselling Psychology, other healthcare disciplines.

### **4.4.1 Breaking the Silence**

This research has highlighted the complexities and ambiguities surrounding miscarriage, which can make it a particularly difficult experience to comprehend. This seems to be compounded by the lack of public discussion and awareness of the topic, which often leads to miscarriage being a strictly private experience (Frost et al., 2007). It is apparent from the findings, that there remains a need for a continued pursuit in breaking the silence around miscarriage and to make individuals aware of the prevalence of this experience. The lack of preparedness that was common throughout women’s narratives, also indicates a necessity for information to be more widely known. Furthermore, it seems imperative for medical staff to receive more guidance on how to assist individuals with the psychological and social aspects of the experience such as offering follow up support or counselling. This was reflected in

participants' narratives who often described being neglected by staff and left to 'get on with it' which is consistent with other studies (Simmons et al., 2006).

In the absence of explicit discursive frameworks to understand this event, women were often found to draw on discourses that construct miscarriage as failure and inadequacy. This reinforces the stigma of the event as also highlighted in the findings, patriarchal discourse around female reproduction can also lead to difficulties in openly discussing this experience, which can result in feelings of shame and isolation and reinforce the stigma of miscarriage. This is salient to Counselling Psychology as therapy has been criticised for locating pathology within the individual, which can avert a focus to the sociocultural context (Craven & Coyle, 2010). Although previous research has indeed helped raise awareness of this topic, the tendency to conceptualise miscarriage as solely a loss event, has meant the socially embedded aspects of this experience are missed. Being mindful of the discourses that surround miscarriage may assist clinicians when working with women who express personal failure and guilt, in order to help alleviate potential shame and stigma.

The study has also highlighted the ways women described a desire to mark and remember their miscarriage, which seemed to help some individuals navigate their experience in the absence of more public forms of expression. A potential clinical intervention within Counselling Psychology and therapy could be to introduce this concept of marking and remembrance as an aid to processing this experience. This can be particularly helpful considering the ambiguous nature of a miscarriage, where there is often an absence of a physical entity. Women who described this aspect of their experience as significant can help inform clinical practice, where there are no public signs or rituals to provide positive social sanction (Frost et al., 2007, Murphy

& Philpin, 2010). Drawing on more holistic approaches such as this, seems important for Counselling Psychology and its pluralistic ethos (Cooper, 2009).

#### **4.4.2 Working with the Body**

The physicality of a miscarriage as described by the women in the study, was identified as being a significant aspect of this experience. For some participants their interview was the first time they had openly discussed the physical manifestations of their experience, which as highlighted in the analysis may relate to the stigma and shame around female reproduction (Sveinsdottir, 2016). A further clinical implication of this is a call for clinicians to therapeutically engage in discussions which emphasise the complexity of experience including the body as being and knowing, whilst remaining mindful not to separate the body from its social constructions (Tordes, 2007). Arguably this is not a new concept for body psychotherapists who conceptualise the body as a *“physical manifestation of something much larger and less definable”* (Brown et al., 2011, p.93). This is pertinent to the embodied experience of a miscarriage, considering the ambiguous nature of the event and the lack of discursive frameworks. Body work is thus one possible way to help individuals gain agency and control over an uncontrollable event. Diprose (1994) points to the way in which we understand our sense of being-in-the world (Heidegger, 1996) as problematic and questions whether ‘being’ is shaped by the mind or matter. In psychology, understanding of the individual has been largely based on the principles of cognitivism whereby the mind is the source for change and free will reinforcing Cartesian dualism of mind/body (Burkitt, 1999). Consequently, Young (2006) argues the increase in understanding of the brain has meant bodily experiences have become rejected and therapy more focussed on cognitive processes. This can be seen to reinforce dualisms as subjective experience

is entwined with prevailing discourses of power (Burkitt, 1999). CBT for example emphasises a view that rational thought is the most credible way to bring about change, over emotional exploration or body interventions (Feltham, 2008). This can be problematic in the case of miscarriage as there is usually an absence of a medical cause or understanding and the physical effects can continue for some time after the event (Lee & Slade, 1996). Furthermore, the ambiguity of what exactly has been ‘lost’ can be difficult to comprehend which can make rational thought difficult to channel. Therapies that are focused on measurable goals and outcomes suggest that a homogeneous world is attainable, which reinforces marginalisation (Fox, Prilleltensky & Austin, 2009). One way to avoid such oppression is in the pursuit of therapeutic practice which recognises fully our embodied experiences.

#### **4.4.3 Social Justice**

One main consequence of the political debate surrounding abortion, has resulted in a lack of feminist discourse on the topic of miscarriage (Frost et al., 2007; Layne, 1997). Moral issues relating to foetal and embryonic personhood poses a clear dilemma when attempting to examine the experience of miscarriage through a feminist lens. This is because an acknowledgement that something of ‘value’ has been lost, would accede an inherent personhood of embryos/foetuses (Reinharz, 1992). The study has demonstrated the significance of a miscarriage for women and where findings are not generalisable to every woman, it does highlight how the experience can deeply affect an individual’s sense of self and identity. A feminist discourse need not detract from pro-choice debates as both miscarriage and abortion can be viewed as social issues (Browne, 2018). Layne (1997) suggests that feminist scholars and activists are well placed to generate new and more emancipatory discourse of miscarriage as they have already critiqued the

patriarchal dimensions of female reproduction. More feminist repertoires of miscarriage could help alleviate much of the distress and alienation that accompanies this experience. However, even in the absence of this, women in the study found individual ways to resist disempowering discourses such as talking about the ‘mess’ as seen in Maeve’s narrative or educating young people as in the case of Louise. In speaking freely about their experiences, women endeavoured to challenge the status quo, which is reflective of Counselling Psychology’s agenda for social justice.

The findings of this study provide an important opportunity for Counselling Psychology to challenge dominant discourses and empower individuals (Fox, Prilleltensky & Austin, 2009). One way to do this is by the dissemination of this research. Most of the participants who took part in the study actively wanted to help raise awareness of a miscarriage experience and hoped the research would lead to changes within professional/clinical practice. To this end, findings have already been presented at the British Psychological Society’s (BPS) conference 2019 (Appendix 10) and will also be presented as part of a series of training events on Women’s health at Queen Mary University of London.

#### **4.5 Summary of Clinical Implications**

This chapter has highlighted how findings can be applied to help further an understanding of miscarriage, and to help alleviate the distress and confusion that can be experienced. Firstly, findings suggest a necessity to provide more information on the prevalence of miscarriage in medical settings, alongside guidance on follow up care and support such as counselling, to help manage the emotional and psychological aspects of this experience. Secondly, there is a need for

clinicians to be mindful of the social context of miscarriage in order to facilitate the challenging of disempowering discourse. Body work is an example of encouraging embodiment, which can help integrate a person's sense of self. This can reduce a mind/body dualism in order to consider the full complexity of the experience. Lastly, the discussion highlights the ways in which findings can serve Counselling Psychology's social justice agenda by raising awareness of this experience and advocating for less oppressive discourses.

## Conclusion

The findings of this study illustrate the ways that meaning is constructed and understanding of the self is in relation to context, alongside embodied experiences (Manafi, 2010). Examining discourses that construct motherhood and womanhood, demonstrates how social context can influence the experience of miscarriage and the impact this can have on an individual's sense of self. The discourses identified such as 'natural instinct', 'medical' and 'social expectation' were found to reinforce disembodied and disconnected subjective experiences and generated narratives of failure and inadequacy. In the absence of public discussion and lack of emancipatory discourse, miscarriage is positioned as taboo and women are often left to navigate their experience in isolation, with little support or positive public sanction.

Furthermore, the politicisation and patriarchal dimensions of female reproduction have arguably led to the public/social neglect of miscarriage, which reinforces the silence and shame that was found to surround women's experience. The findings identify resistances to such disempowering discourses, such as 'naming the mess' and 'marking and remembrance', which can be seen to generate less oppressive discursive practices. Exploring discourse alongside the subjective experiences of women, offers further insight on the complexities of miscarriage and the ways in which women attempt to comprehend and find meaning from their experience. Whilst also exploring embodiment, understandings can be broadened, and thus applied to interventions in therapeutic settings in order for women's stories to be voiced and heard.

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## Appendices

### Appendix 1: Ethical approval form

School of Psychology Research Ethics Committee

#### NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**REVIEWER:** Gordon Jinks

**SUPERVISOR:** Sultana Choudhry

**STUDENT:** Majda Rogers

**Course:** Professional Doctorate in Counselling Psychology

**Title of proposed study:** TBC

#### DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students

are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

#### **DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY**

*(Please indicate the decision according to one of the 3 options above)*

APPROVED

**Minor amendments required** *(for reviewer):*

**Major amendments required** *(for reviewer):*

--

**Confirmation of making the above minor amendments** *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

*(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

**ASSESSMENT OF RISK TO RESEACHER** *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / ~~NO~~

Please request resubmission with an adequate risk assessment



If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer (*Typed name to act as signature*): Gordon Jinks

**Date:** 22/6/18

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee*

**RESEARCHER PLEASE NOTE:**

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Amendment to title:

# University of East London Psychology



## REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

### FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

**Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.**

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original

ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

### **HOW TO COMPLETE & SUBMIT THE REQUEST**

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: [Psychology.Ethics@uel.ac.uk](mailto:Psychology.Ethics@uel.ac.uk)
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

### **REQUIRED DOCUMENTS**

1. A copy of the approval of your initial ethics application.

Name of applicant: Majda Barouagui Rogers

Programme of study: Prof Doc Counselling Psychology

Name of supervisor: Dr. Rachel Tribe

Briefly outline the nature of your proposed title change in the boxes below

<b>Proposed amendment</b>	<b>Rationale</b>
<b>Old Title:</b> How do women construct the self in their	

narratives of a miscarriage experience?	To include participant quote and encompass the breadth of the research study.
<b>New Title:</b>  “Things change, things aren’t always a given”: Exploring the experiences of miscarriage: a narrative analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	
Does your change of title impact the process of how you collected your data/conducted your research?		No

Student’s signature (please type your name):

Majda Barouagui Rogers

Date:

12/10/2020

TO BE COMPLETED BY REVIEWER		
<b>Title changes approved</b>	APPROVED	

**Comments – N/A**

Reviewer: Glen Rooney

Date: 12<sup>th</sup> October 2020

## Appendix 2: Recruitment advertisement poster

# Research on Impact of Early Miscarriage

I am interested in finding out about the experiences of individuals who have had miscarriage(s) during the early stage of pregnancy. I hope to understand how this experience affected you. I also hope to understand how this may have been influenced by external factors such as peers, family and wider society.

If you are over the age of 18 and have experienced a miscarriage(s) up to 24 weeks of pregnancy and are interested in sharing your experience for the purpose of my research then please contact me and I can provide you with further details of what the study will involve.

Thank you.

Majda Rogers

Counselling Psychologist in Training

[U1148885@uel.ac.uk](mailto:U1148885@uel.ac.uk)



### **Appendix 3: Participant invitation letter**

#### **University of East London**

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ



#### **The Principal Investigator**

Majda Rogers

Email: [u1148885@uel.ac.uk](mailto:u1148885@uel.ac.uk)

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

#### **Who am I?**

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a professional doctorate in counselling psychology. As part of my studies I am conducting the research you are being invited to participate in.

#### **What is the research?**

I am conducting research into exploring the impact of early miscarriage.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

#### **Why have you been asked to participate?**

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve women over the age of 18 who have experienced a miscarriage(s) up to 24 weeks of pregnancy, at least twelve months



ago. I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

### **What will your participation involve?**

If you agree to participate you will be asked to take part in an interview which will ask questions regarding your miscarriage experience. The interview will last approximately 60-90 minutes and will be audio recorded in order for it to be transcribed for subsequent analysis.

Prior to interview you will be asked to consider and bring with you up to six images relating to your experience. These images will be used as part of the interview process and copies will be taken for use in the write up of the study and any subsequent publications. Consent relating to the reproduction of images will be discussed and confirmed prior to the start of interview.

I acknowledge that the topic of the research is personal and sensitive and may be difficult for participants to discuss. Therefore I would draw your attention to the following organisations that may provide support prior to or after participation.

Misscarriage Association: [www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)  
or 01924 200799

Tommy's: [www.tommys.org](http://www.tommys.org)  
or 0800 0147 800

Cruise Bereavement Care: [www.cruise.org.uk](http://www.cruise.org.uk)  
or 0808 808 1677

For general support with mental help and counselling:

MIND- [www.mind.org.uk](http://www.mind.org.uk)  
or 03001233393

SANE- [www.sane.org.uk](http://www.sane.org.uk)

or 0845 767 8000

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

### **Your taking part will be safe and confidential**

Your privacy and safety will be respected at all times. Your identity will be protected and confidentiality maintained by keeping your name and contact details in a safe place that only I have access to. This information will not be shared with anyone else. The data collected will be treated confidentially by anonymising-changing all names and identifying references (e.g a name of a place) in the transcriptions of interviews. My research supervisor and examiners will read extracts from the anonymised transcriptions of interviews. Anonymised transcripts and visual aids will be kept in the event of any research or publications in which the data will be used. Data will be kept for no more than 6 years.

In the event that a serious or imminent risk is identified confidentiality may be breached. This would involve first notifying to my supervisor and then if appropriate external organisations for assistance. You will be made aware should confidentiality need to be broken.

### **Location**

Interviews will take place at a mutually convenient time in a private room at the University of East London or at your home. If preferable and possible interviews can be conducted over skype/telephone.

### **What if you want to withdraw?**

You are not obliged to take part in the study and should not feel coerced.

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data.

### **Contact Details**

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

If you have any questions or concerns about how the research has been conducted please contact the research supervisor **Dr. Sultana Choudhry**, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: [s.choudhry@uel.ac.uk](mailto:s.choudhry@uel.ac.uk) or

Chair of the School of Psychology Research Ethics Sub-committee: **Dr Mark Finn**, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: [m.finn@uel.ac.uk](mailto:m.finn@uel.ac.uk))

## **Appendix 4: Demographic Questionnaire**

### **Demographic Information**

1. What is your current age? \_\_\_\_\_
2. Are you? a. Heterosexual b. Homosexual c. Bisexual d. Other \_\_\_\_\_
4. Which gender do you identify with?
3. What is your racial identity?
4. What is your religious affiliation?

### **Background information**

1. Can you please indicate how many miscarriages you have had and at what stage of pregnancy this occurred (and the age you were at time of loss)? For example, 1 miscarriage at 10 weeks, 34 years old
1. Do you currently have children? If yes, could you indicate how many you have and at what point this occurred in relation to your miscarriage(s). For example, miscarriage at 35, child at 37, ectopic 40)

## Appendix 5: Participant consent forms

### UNIVERSITY OF EAST LONDON

#### Consent to participate in a research study

##### Exploring the impact of early miscarriage



I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

Additional levels of consent

**Transcript only**

I am aware that the transcript will be anonymised and shared. I freely and fully consent to these extracts being used in the write up of this study and any subsequent publications. Having given consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

### **Visual Images**

I am aware that I will be asked to provide visual images as part of the interview process and I freely and fully consent to the following images being copied and used in the write up of the study and any subsequent publications.

Please circle as appropriate: Image 1 / Image 2 / Image 3 / Image 4 / Image 5 / Image 6

Having given this consent I understand that I have the right to withdraw from the study as any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....  
Date: .....

**Visual images with faces blurred**

I am aware that I will be asked to provide visual images as part of the interview process and I freely and fully consent to the following images being copied and used in the write up of the study and any subsequent publications if any faces are blurred in the printed images.

Please circle as appropriate: Image 1 / Image 2 / Image 3 / Image 4 / Image 5 / Image 6

Having given this consent I understand that I have the right to withdraw from the study as any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....



## **Appendix 6: Image instructions and interview schedule**

### **Using Images**

The following information will be provided to participants prior to the interview.

Before the interview I would be grateful if you could collect some images e.g personal photographs, pictures from magazines which you feel say something about your experience of having a miscarriage. Please bring these images (up to 6) with you for the interview. I will ask with your consent, to take copies of these images when we meet. During our time together, I will ask you to tell me more about your chosen images and I may have some more questions about these and your experiences.

### **Interview Schedule**

Ask the participant to place the images on the table for both of us to see.

Can you tell me about these images in turn?

Prompts

- What made you choose that image?
- What can the image tell us about your miscarriage experience?
- How do you feel about the image?

### **Additional questions**

These may be asked at any point during the interview and may be used repeatedly as necessary.

### ***External Factors***

What were your thoughts around having children before you became pregnant?

What were your expectations of pregnancy?

What were your ideas/thoughts of parenthood?

Prompts

- How were these expectations created?
- How did this differ from reality?
- What were other people's expectations-partner, family, friends, midwife?

### *Sense of self/identity*

Could you tell me about what happened when you miscarried?

How did that make you see yourself? / How do you see yourself?

How did you understand that experience?

What did that say about you?

### General Prompts

- When was that?
- How did that come about?
- Who else was involved?
- Where did that take place?
- How did that make you feel?
- How did you understand that?
- What impact did that have?
- Can you tell me more about...?

## Appendix 7: Example of annotated transcripts

210 P5: I think it's related. I like all of my I have all of mine. I guess my view on all of this is it's  
 211 very much from this like feminist perspective, which I had. Like I said when I was like, why  
 212 such restrictions? And I also. So I'm thirty seven. And and you don't all everyone else was  
 213 getting married and pregnant at the exact same time. You know, it was just like why right? *age*  
 214 Why do we have to do it at that time? And there's a lot of like you're getting older you're  
 215 Not going to be able to kind of thing, which is so annoying that I have now fed into the  
 216 stereotype. But. But then I remember seeing this article on like the research that they're  
 217 talking about, the fact that between 20 and 30, that 30 actually apparently your fertility  
 218 doesn't change that much. It's at 40 that you should worry a bit more  
 219 apparently. But the research that they were using before to say between 20 and 30 or 30  
 220 was so old, whatever is some 300 year old research that it wasn't properly researched *general*  
 221 and it was looking it was just like general fertility rates. How long do people live in that  
 222 time? What about people not actively trying to have babies like that and consider any of  
 223 those factors? What about the men in it? So I just feel like there's a lot of pressure on the  
 224 women to like. If anything goes wrong, it's on the woman and the fact that she eats cheese  
 225 Do you know what I mean? And so I think it's like men. So, yeah, that's just to give context  
 226 to my general perspective. But like men like bloody fighting. Yeah, that's fine. Men do that. *general*  
 227 But like, women have blue periods. Do you know what I mean? So I do think it's like a  
 228 weird. I don't know. Patriarchal way of talking about women's issues. People should talk  
 229 about- this idea you shouldn't tell people. Because. Because? Because why? Why  
 230 wouldn't you tell anyone during that risk time? Because what? You'd be embarrassed do  
 231 you know how horrific that is to go through. Surely you'd want the people around you to  
 232 know The reality is, you do end up telling people after any way because you're going  
 233 through this horrible thing. But before you realize it, it just seems like oh it's taboo. *periods*  
 234 You know, that's like the side of women that we don't really want to know about, *bloody*  
 235 like the bloody side of things. Yeah. I just think like let's demystify it a bit more. And I think I  
 236 would hope that eventually, because I think things are shifting a lot for women. Generally, I  
 237 think with pregnancy and birth and child care is still by and large, it's still a bit outdated. *side*  
 238 And I think that's tied up with this idea of like I don't talk about any of the mess. And like  
 239 oh, you're not supposed to tell. And I understand because you don't wanna freak the  
 240 woman out about giving birth. But then what you know what I mean, she's gonna tear or  
 241 she's going to do whatever, you know, and I mean, like, maybe I just feel like had I known  
 242 because it is the second time I was like. I mean, obviously, it's sad, but strangely, like so I  
 243 started. So the first time I started spotting and within twenty four hours, the whole thing  
 244 was done. But then they don't tell you that like your next period feels like another bloody  
 245 miscarriage because you're just like bleeding like crazy again. So like that you don't know  
 246 what's happening you're bleeding the whole time. And then the second time I knew things  
 247 like tidbits like if you're clotting over a certain size, then that's an issue if you're filling up a  
 248 pad more than once an hour. Right. That's an issue. Like all of those indicators which were  
 249 helpful for me. But because I've gone through the experience, I was I started spotted three  
 250 days later that it finally kicked in. So I was really sad then when I went to the to get a scan.  
 251 And so I kind of grieved with my part. We both grieved about it then So by the time it  
 252 started kicking in, like we his family was supposed to be coming to stay with us There was  
 253 like, it was all this like. yeah, let's just carry on as normal. Like, I don't want to stop them  
 254 for this. And then it started happening. I was like, right. I got it. Like, I've got this under  
 255 control. Like, it wasn't as obviously as much as I said. But it was like I felt more informed.  
 256 And then everything went wrong. I felt informed so that I was I can now I'm going to call  
 257 the ambulance or whatever, because I had those things. But imagine, like, you don't get  
 258 that information. And like I had mentioned to somebody, I was like, oh, yeah. Like, I  
 259 actually thought I was going to die because the ambulance took so long to come. I was  
 260

*general*  
*periods*  
*bloody*  
*side*  
*taboo*  
*demystify*  
*scan*  
*scared*  
*grieved*  
*I thought I was going to die*  
*you didn't get informed*



There is something wrong here. But then. Those with very few and far between those moments, because the other moments of dealing with the fear and the anxiety seemed overwhelming.

Researcher: so you mentioned the trauma of the miscarriages. Is that how it felt at the time? That it was a trauma.

P1: Yes, it did. See what else was. It's just it's just so not nice. The way it's all dealt with in hospitals. You know, it's just so not nice. You're just like another number. And it is. And. The. erm It's not you just you just go in. You get a scan, you get a test. Oh, you. You know that it it's gone, you know Goodbye. Go back to your fertility, nurse. You know, it's just. So inhuman for such. The point of life the creation, of life It's just a clinical conveyor belt method in the hospitals. And you know, at that point, there should be. Well, now, with hindsight, I don't even know how it is now. There should be a counselor available in the clinic. You can talk to them straightaway. should Be someone there to help you because you cannot process it. You. It's very difficult to process. You don't even know what you're doing. You don't even know how to process. You get a piece of paper with negative written on it and you're just like. Horrified. Gosh, this is it it is gone, it's over. You know. What do I do? And you just left in this room with other women. Mm hmm. and you think God What? What do I do now? Just get up and go and start again. And that's it. Honestly, I should leave you there and then that's it you get up and leave and go back to your life. I don't think that. erm There doesn't seem to be. Bearing in mind I had my miscarriages or fifteen years ago, I still think that I don't know how things i hope things have changed since then, but yeah, I think that there does need to be greater support even. Pointing them to a support avenue as opposed to just leaving them at the end with this piece of paper with negative written on it. That's an image a Post-it note with negative written on it. That's the last thing I have of losing my the the end of the process of losing all three of them. That's the lasting image.

Researcher: so how did you you said It's really difficult to process that. So how did you make sense of it? Do you remember

P1: You know, I don't think I ever did, actually. It's just now sitting here talking to you. I'm just thinking, hold on a minute. It's not that I didn't process. I've. Processed me as a person and now looking back on it and realizing that, gosh, I have processed because I'm stronger because. But talking going back to talking about it, I haven't actually sat and spoken to anyone about it. I've been to my sister's very religious and they have a mass. for Unborn children. And you take you go to the mass and you take a carnation for every child you've miscarried and you pray for the child. And I put my four carnations. And honestly, something changed within me after I did that. Maybe that was a sense of relief. But it was that that action that had the most effect than anything else, because I didn't seek out support for it. because I didn't realize how affected by it I was at the time. And it's just. That now realizing, gosh, I have healed, there's been a lot of healing. And. erm for the benefit for me. erm But at the time. I just I lived with that baggage for too long and it could have been. I could have been helped at this stage at the hospital. You know, at the end. And think that that would have been a good intervention point for me.

Researcher: and how long after the experiences and miscarriages were you able to go to the mass and use the carnations?

P1: Well, gosh, that was stop 10 years later. Yeah, that was about my son was about 10 was about 12 years after. It was a long it was a long time. And. Yeah. Because it was

## Appendix 8: Narrative Frameworks

### Grace's story

**Abstract:** Grace begins her story by describing how growing up in a poor family influenced her decision not to have children. However, she recalls the pressure she felt to become a mother and being told by others that her life would be “empty without a child”. She describes how getting married reinforced the expectation that she should start a family, which became inextricably linked to her identity.

**Orientation:** She described that she was years old, separated from her ex husband living in London with her 21 year old son

**Complicating Action:** Grace became pregnant shortly after

She began to compare herself to others in her peer group and family and was “the only one without children”. This led her to actively try and become pregnant and ultimately changed her decision to have a child. After a period of trying to conceive she was diagnosed with unexplained infertility. Determined to become pregnant, she underwent fertility treatment which resulted in her conceiving triplets. She described how this pregnancy ended in three separate miscarriages in the space of two weeks.

**Evaluation:** Grace described how it was difficult to make sense of her miscarriages as she felt unprepared and left by medical professionals to “get on with it”. The miscarriages left her with feelings of inadequacy, failure and self-blame. She described how it made her feel worthless and affected her identity as a woman. She recalls having expectations that having a baby would be straightforward.

**Resolution:** Grace decided to have IVF treatment in order to help her conceive and have a baby. She draws on medical discourse and explains that she became pregnant and was advised by medical staff to terminate the pregnancy as the “embryo was not developing” and the pregnancy was not “viable”. Grace recalls how a later scan revealed that the pregnancy was developing and was told by medical professionals she was originally pregnant with twins and most likely had a miscarriage of one of them. This pregnancy resulted in the birth of her son, which was an experience filled with worry and trepidation, as she feared another miscarriage. Grace often speaks of the lack of preparedness of having a miscarriage and being neglected by medical professionals. She describes not being able to process the miscarriages until ten years later when she attends a religious mass that commemorates miscarriages and babies who have died.

Coda: Grace ends her narrative by advocating for more support for women who have had miscarriages as she felt neglected by medical professionals. She describes how a miscarriage impacted her psychologically and reinforced her belief that she was a “useless woman” and believes that counselling would have helped her at the time of her miscarriage.

Overall Tone of the Interview: Grace was angry when she described the external pressures around having children and when she spoke of her interactions with medical professionals. It seemed that her identity as a woman had become reliant on her ability to have a child which she was resentful of.

### **Rita’s Story**

Abstract: Rita begins her story by discussing her expectations for having a family and how she wanted to replicate the family composition she grew up in. She described having two siblings and being close in age to her brother and wanted to recreate this for her own family. She had two sons and wanted a third child to replicate her own family dynamic and envisaged her children as being “good big brothers”.

Orientation: At the time of the interview Rita was 43 years old living with her husband and two sons in London.

Complicated action: Rita describes how she and her husband began trying to conceive for a year. She explained that she was aware that her age could have been a factor and so decided to have IVF treatment as she felt “science can fix this”. Having researched the process Rita said she knew about the risks of miscarriage. She described having the first round of IVF and became pregnant shortly after. She recalled being optimistic and did “everything that she needed to”. She draws heavily on scientific/medical discourses to help illustrate her experience. Rita describes the moment she realised she was miscarrying, having started bleeding and looking up signs of a miscarriage on the internet.

Evaluation: Although Rita describes being aware of the potential for a miscarriage, she does describe the sadness she experienced after she was told there was “no heart-beat”. She recalled going through a process of “mourning” which seemed to surround the loss of her fertility and the family composition she had envisaged alongside the pregnancy itself. She describes feeling out of control of her body, not being able to stop the miscarriage and needing to “accept” the process. She draws on medical imagery to illustrate how she made sense of the physicality of her miscarriage.

Resolution: Towards the end of her story, Rita returns to the aspect of control and describes how the miscarriage made her reflect on her decision not to have children sooner. She discusses the

issue of celebrities and images in the media that portray women in their forties and fifties becoming pregnant and explains how this can paint the picture of pregnancy being “effortless”. The final part of her narrative sees Rita try to make sense of her sadness as she questions whether she is still mourning the loss of the miscarriage or if it is connected with the loss of her fertility and the difficulty in accepting her body cannot have a pregnancy anymore.

Coda: Rita speaks of remaining hopeful that she can come to accept what has happened and that she will not have another baby. She describes trying to move on with her life by focusing on her physical fitness, which suggests her attempts at regaining control and looking at other functions of the body besides producing a baby. She ends by saying that she tries to keep busy suggestive of a means to distract herself of the internal feelings the miscarriage brought up for her.

Overall Tone of the Interview: Rita speaks softly throughout, but becomes tearful when she recalls her family dynamics, images she had for her family or when she speaks of her children. She finds it difficult to stay with the sadness and smiles as if to indicate that she wants to move on in the telling of her story. She often speaks in a pragmatic way, drawing on medical discourse to help illustrate her experience.

### **Kate's Story**

Abstract: An overriding feature of her narrative was the sense of deservedness she felt of being a mother. There is an immense sense of frustration towards her struggle at being able to have a baby. Her story begins with her describing a vivid scene where she tells her husband she was pregnant in a “pizzeria tucked away in soho.” She described how this came after they had both decided to actively try to have a baby and the expectations of starting a family. She describes how her body felt ready to have a baby and she anticipated it to be a straightforward journey. She describes feeling naive and frustrated at herself for thinking that having a baby would be inevitable.

Orientation: Kate described that she was 43 years old living with her husband and five year old son in Greater London.

Complicating action: Having spent several years trying to conceive, Kate and her husband decided to have IVF treatment. She then becomes pregnant and describes feeling excited and optimistic about her future. Kate draws on medical terminology in the majority of the narrative to help explain her experience. She describes how a routine scan then revealed that her pregnancy was “null and void” and would not progress further. Kate then explains the physical experience of miscarriage which is marked by intense pain and confusion. She draws on clinical discourses as she describes this experience using medical terminology such as “embryo” and “foetus” and uses mechanistic imagery to illustrate the physicality of the miscarriage “scraping it out with a chisel”. Kate describes having two other miscarriages which intensified her need to have a baby.



Evaluation: Kate's narrative is punctuated by an overwhelming desire to have a child which causes her to become pragmatic and detached in her descriptions of the last two miscarriages. She draws on medical discourse when she describes the physicality often using "it" and "foetus" but uses terms such as "baby" and "child" when she describes the meaning attached to the pregnancies. The miscarriages appeared to have impacted her sense of self, as she often explains how she felt external pressures to have a child. She explains how she became angry and jealous at others which caused her to feel like a failure.

Resolution: Kate describes becoming pregnant again. Her previous miscarriages influenced her expectations of the pregnancy as she realised that having a baby was not a given. She said that she did not allow herself to "invest" in the pregnancy out of fear that she could have a miscarriage and her narrative suggests a conscious process of detachment in order to cope with the uncertainty. She gives birth to her son, but describes feeling "robbed" of the optimism and excitement of being pregnant.

Coda: Kate ends the interview with an image of her travelling to the desert, where she went to "heal" from her miscarriages. She describes how she used the experience to symbolically mark her loss and to have a form of closure. She finds meaning in her miscarriages as she explains the experience fundamentally changed her and provided her with a "richness and depth" to motherhood.

Overall Tone of the Interview: Kate spoke honestly and openly about her experiences and her narrative seemed to be processed and integrated. She was matter-of-fact when discussing the aspects of her experience and journey into motherhood, which could be suggestive of either her determination or detachment from the emotional impact.

### **Louise's Story**

Abstract: Louise's narrative begins at the point in which she attended a routine scan during her twelfth week of pregnancy. She had been told that the baby had "lost the heartbeat" and she explains how she tried to locate the time and place she was in when it happened. This brings up a line of questioning around what she was doing at the time, in case she did something to "cause" the miscarriage. Her attempts at remembering the time act as a symbolic marker of the pregnancy as she describes the ambiguity of not having a "physical body" to represent her loss.

Orientation: At the time of the interview Louise described herself as 43 years old living at home with her husband and five year old daughter and three year old son.



Complicating Action: Louise draws heavily on aspects of control and how this had been a significant feature throughout her life. She describes how the miscarriage left her feeling out of control and her overall narrative is marked by her quest to regain it. She explains how she had decided to have a medical procedure to manage her miscarriage but was relieved when she miscarried at home the day before she was due to go into hospital. She expresses how this left her feeling in control again as she did not have to “rely on somebody else” to manage and “remove the baby”.

Evaluation: Louise describes how the miscarriage made her feel guilty as she questioned if she did anything to cause it. This seems to be related to an overarching theme of guilt, which is also connected to her identity as a working mother. Her narrative suggests a drive for her to be perfect and a need to demonstrate that she could do “everything” as a working mother. Her miscarriage appears to have brought her perfectionism to a head as her ability to control aspects of her life was not transferable to her pregnancy and subsequent miscarriage. Louise attempts to make sense of her experience by acknowledging uncertainty and comes to accept that it is ok if things do not go to “plan”.

Resolution: Louise uses her experience to help inform others, mainly by teaching her students about miscarriage in the school she works in. She explains how she was unprepared for her miscarriage as she did not have the awareness that it could happen to her. She describes how she views education as an important factor to help people discuss miscarriage so that it is less hidden and stigmatised.

Coda: Louise ends her narrative by going back to the element of control and seems thankful that she did not need to have medical intervention to manage her miscarriage. It seems that she is able to counteract the feeling of guilt and loss of control of the miscarriage by her body’s ability to “naturally” go through a miscarriage and that she “physically did it”.

Overall Tone of the Interview: Louise was softly spoken throughout the interview, and appeared tearful during the retelling of some parts of her story. She seemed very composed during these moments which implied her need to control her emotions.

### **Maeve’s story**

Abstract: Maeve begins her story by describing her expectations around pregnancy and the excitement and happiness she felt when she found out she was pregnant the first time. She explains the use of a pregnancy app that helped her track her pregnancy week by week and the images used to demonstrate the size of the developing “baby.” She describes how this makes her feel naive and frustrated that she was unaware of the potential to have a miscarriage and the assumption she carried that nothing would go wrong.

Orientation: She describes herself as a 38 year old woman who lives with her fiancé in London.

Complicating action: Maeve describes the moment she realised that she might be having a miscarriage when she started bleeding. She recalls a scene from a TV programme which reassured her that this was normal, and how this helped her not to panic. She explains the physicality of the experience and the frustration she felt at being unprepared and for not seeking help sooner. She also describes the fear and powerlessness she felt when she was taken into hospital because of her blood loss and thought she would die. She draws on vivid imagery to help illustrate her experience, such as “pissing blood” alongside the emotional aspects of her miscarriages. Throughout her narrative she gives equal weight to both the physical and emotional components of her miscarriages and describes in great detail the physical experience of a miscarriage. She draws on feminist discourses around the functioning of the female body and it seems her graphic descriptions are an attempt to openly discuss the “mess” that is often concealed in public discourse on female embodiment.

Evaluation: Maeve often refers to the “hoops” women have to go through in general society and feels frustrated that she found herself adhering to “rules” around pregnancy. She describes how after her first miscarriage she began to blame herself and was angry she had tried to go against the prescribed “rules” around pregnancy. She felt external pressure to have children as she was comparing herself to peers who were becoming pregnant and having babies. Her sense of pressure was further compounded when she then experienced a second miscarriage. She described feeling jealous, resentful and angry that no-one could understand what she was going through. The second miscarriage led her to question her value as a partner as she felt unable to “give” her fiancé a child.

Resolution: Towards the end of her narrative, Maeve attempts to find some resolution around the prospect of not having children. She describes how her identity became interlinked with her desire for children and the miscarriages brought her identity into question. She delves into a discussion around the possibility of not being able to have a child and is unsure whether she would like to try again.

Coda: She concludes the interview by reiterating how miscarriage is a taboo subject and advocates for more public awareness and information. She describes how this may help alleviate the isolation and loneliness she experienced.

Overall Tone of the Interview: Maeve’s overall tone is one of anger and frustration. She goes into significant detail when describing the physical aspects of her miscarriages in order to not only highlight her pain and distress, but also as a possible act of resistance to patriarchal ideas of the female body.

## **Kelly's Story**

**Abstract:** Kelly suggests early on in her story that her life has been filled with feelings of isolation and powerlessness, which is encapsulated in her experience of having a miscarriage. She describes her struggle in coming to terms with what happened and emphasises the importance of having a child in her life.

**Orientation:** Kelly is a 25-year-old woman who lives with her boyfriend in London.

**Complicating Action:** Kelly often refers to the lack of understanding she experienced from those around her, especially from her parents in relation to her pregnancy and subsequent miscarriage. She describes how she felt judged by others for becoming pregnant at a young age, which caused feelings of shame and isolation. She refers to her miscarriage as “traumatising” as she felt unprepared and unaware of what was happening to her.

**Evaluation:** Kelly's sense of self appears to have been fragmented before her miscarriage, as she describes having low self-esteem and feeling “lost” before becoming pregnant. Her miscarriage seems to have confounded this and left her with thoughts around not being good enough and of being a failure. Her current sense of self seems tied to an overwhelming desire to have children as she states she will “only be happy” when she has a child. Her miscarriage has left her with the fear she may not be able to have children or that she will miscarry again.

**Resolution:** Kelly's story does not have a positive resolution and suggests a preoccupation with needing children in order to validate her sense of self. She expresses concern that although the miscarriage was out of her control it may have been her “one chance” at being a mother, which leads to self blame.

**Coda:** Kelly did not offer a specific coda, but reiterated her desire to have a child. She explicitly describes how her life is incomplete without a child and having a baby is a “key part” of her happiness and success.

**Overall Tone of the Interview:** Kelly was softly spoken throughout the interview but became visibly sad and upset when describing her expectations of the pregnancy and the meaning she ascribes to having children. Interestingly, she uses the term “baby” when discussing her miscarriage, which is suggestive of the attachment and meaning she held towards the pregnancy.

## **Mina's Story**

**Abstract:** An overriding feature of her narrative is the sense of guilt she carries for not being aware of her pregnancy and subsequent miscarriage. She is regretful that she did not acknowledge her experience and “just got on” with her life. Her miscarriage has influenced how she discusses pregnancy with others, as she tries to prepare them for the possibility of a miscarriage.

**Orientation:** She described herself as a 33-year-old woman who lives with her husband, six year old and four year old sons. The interview takes place in a busy cafe after she has dropped her children off to school.

**Complicating Action:** Mina describes the moment she believes she had a miscarriage and recalls the features of what physically happened, an image she says has stayed with her. She assumed it was a period at the time, but having heard about her friend's miscarriage, she drew parallels with her own experience of what happened and believes she too had a miscarriage.

**Evaluation:** Mina struggles to make sense of her experience and often questions the legitimacy of her feelings as she was unaware of her pregnancy. She oscillates between rationalizing the experience such as “we were not ready for it anyway” and imagining the outcome of the pregnancy as she longs to have a daughter. She frequently draws on her faith and religious beliefs when she tries to make sense of her experience which appears to provide some degree of comfort. There is an overarching sense of guilt and sadness that she did not mark the pregnancy and miscarriage such as saying a prayer.

**Coda:**

Mina has tried to use her experience to better prepare others who are pregnant. She describes wanting to educate others over the unpredictability of pregnancy and to dispel the assumption that there will inevitably be a “happy ending”. She comes to the realisation that she has “tucked away” her experience and is determined to begin discussing her feelings with her husband and others close to her.

**Overall Tone of the Interview:** Mina is softly spoken throughout but there is much uncertainty throughout her narrative. She poses numerous questions, around how she should feel and how she should see her experience, which illustrates how she uses the interview to try to make sense of her experience.

## **Candice's Story**

**Abstract:** Candice draws heavily on her faith and religious beliefs which appear to have provided her with a framework in which to navigate her experience. She uses religious imagery to illustrate how she has coped with her miscarriage and the meaning she ascribes to her experience.

**Orientation:** She describes herself as 33 year old woman who lives with her husband and 8 year old daughter in London. The interview is held over skype in order to allow her to pick up her daughter from school.

**Complicating Action:** Candice describes feeling positive and happy during her pregnancy and was excited for her daughter to have a “brother or a sister”. After having a routine scan she was told that there were some complications with her pregnancy and spent some time in hospital. She describes feeling “out of place” on the ward as she was amongst other women who were in the final stages of pregnancy or who had given birth. She describes the moment she started bleeding and had thoughts around having a miscarriage. She explains the confusion amongst medical staff as they were unclear and did not prepare her for her eventual miscarriage.

**Evaluation:** The miscarriage left Candice with feelings of guilt and inadequacy and she describes how it affected her confidence and self-esteem. She explains the difficulties in seeing friends who were pregnant at the same time get further along in their pregnancies and the sadness she felt when they had their babies. She uses her religious faith as a way to cope with what happened and makes reference to an afterlife and peace. She makes sense of her experience by using re

**Coda:** Candice ended her narrative by describing her focus on other areas of life in which she feels more in control, such as raising her daughter and her career and education. She is anxious to think about becoming pregnant again as she worries about the risk of miscarriage. She draws on her religious faith as she describes having future children as “god’s will” which appears to provide her with a degree of comfort when thinking about the present and her future.

**Overall Tone of the Interview:** Although Candice appeared sad during the majority of her narrative, the tone of the narrative appeared to be that of acceptance. The religious imagery she employed seemed to help Candice find meaning in her miscarriage and solace to move on.

## Appendix 9: Collating Narrative Themes

### *Example of Initial themes: Participant 1*

#### **Physicality of Miscarriage**

Pain, blood, blood clots  
Body doing what it's supposed to  
Nature taking it's course  
Sanitary pads  
Period  
Debris  
Angry at the body  
Healing  
Trust in the body  
Alien

#### **Ways of coping**

Detaching  
Withdrawal of others  
Looking for causes  
Finding meaning  
Religion/faith/spirituality  
Framework

#### **Marking the miscarriage**

Research  
Moving on with life  
Burying/suppressing/parking feelings  
Self-blame  
Uncertainty  
Why me

#### **Control**

Inevitability

#### **Emotional Turmoil**

Shock  
Confusion  
Ambiguity  
Anxiety  
Fear  
Anger  
Emotional strength  
Grief  
Acceptance  
Jaded  
Jealousy  
Gutted  
Numb  
Disappointment  
Resentment  
Loss  
Crushed  
Lonely  
Guilt  
Self-blame  
Isolation  
Suicidal  
Fear  
Judgment of others

Panic

Emotional turmoil

Death

Out of place

Begrudge others who are pregnant

**I was never the same-the lasting impact of Miscarriage**

Changes you somehow

Moving on

Jadedness

Strain on relationship

**Expectation vs Reality**

Jinxing pregnancy

media/images misleading

Pregnancy literature

naiveté

Taking the body for granted

Deservedness

Loss of future

Planning

Meeting milestones

False sense of hope

Fear mongering

Deservedness

**Silence**

People don't talk about it

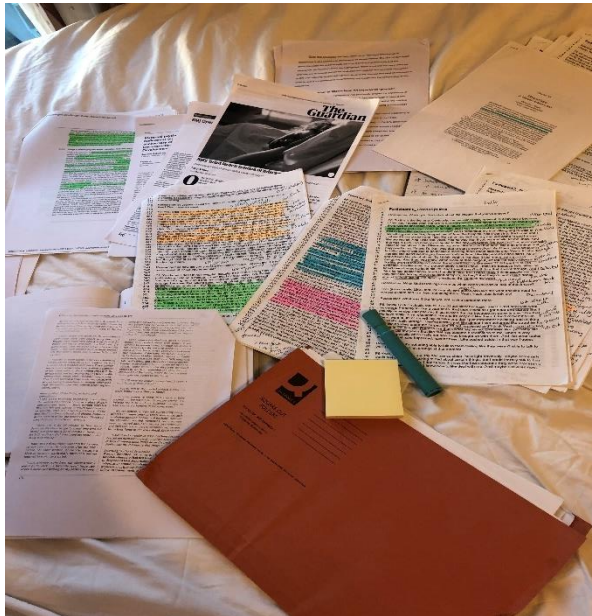
Stigma

Taboo

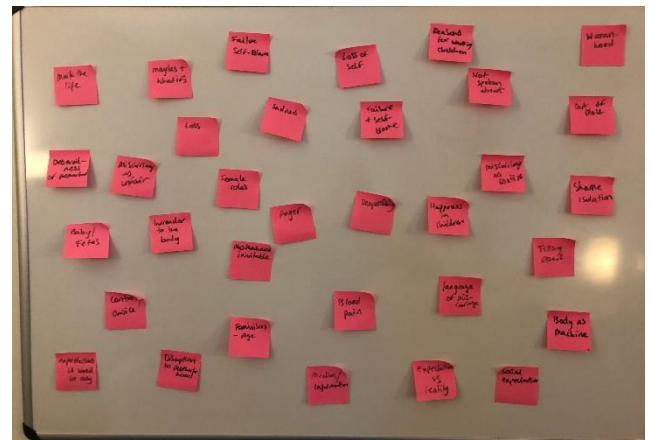
Hidden

Ripples of experience

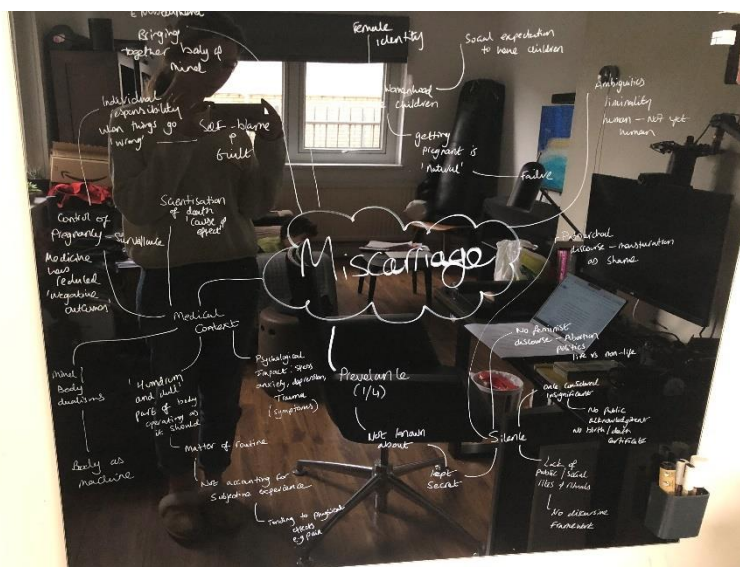
## The analytic process:



Above: moving between theory and data



Above: Collating and arranging themes



Left: The analytic map



## Appendix 10: Oral Presentation of the Research at the British Psychological Society Seminar Series 2019



UNIVERSITY OF  
**BATH**



Aston University  
Birmingham



### British Psychological Society Seminar Series

*Approved by the British Psychological Society for the purposes of Continuing Professional Development (CPD)*

### Exploring the potential for creative and arts-based methods for applied psychological research

### Seminar 1: 21 May 2019, University of Bath, Visualising and storying applied psychology

10 West (Dept of Psychology) Room 2.47

Time	
9.30-10.00	Registration
10.00-10.15	Welcome and introduction (Cathy Randle-Phillips and Catherine Butler)
10.15-11.00	<i>Visualising research: Making visual methods work in applied psychological research</i> Dr Hannah Frith, Principle Lecturer, School of Applied Social Science, University of Brighton
11.00-11.30	Morning break (and poster viewing)
11.30-12.30	Postgraduate Student and Early Career Researcher Short Presentations Inspecting gendered discourses: Memory work in sport and physical activity Dr Bryan Clift & Dr Jessica Francombe-Webb, Department for Health, University of Bath The discursive void of early miscarriage: exploring the potential for visual methods Majda Rogers, Professional Doctorate in Counselling Psychology, University of East London Building rapport: Using LEGO® to explore lived experiences of entrepreneurs Helen Williams, PhD student, School of Management, Swansea University
12.30-1.30	Lunch (and poster viewing)
1.30-2.15	<i>'To hell with facts! We need stories!' Using story telling methods in applied psychological research</i> Dr Naomi Moller, Senior Lecturer in Counselling Psychology, The Open University
2.15-3.00	<i>From one-use cameras in a hair salon, to Instagram in a Business School: The changing use of visual methods in workplace research</i> Dr Harriet Shortt, Associate Professor in Organisation Studies, UWE