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**Women's perceptions of their experience
of miscarriage decades after the event: an
interpretative phenomenological analysis.**

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SUBMISSION OF THESIS FOR A RESEARCH DEGREE**Part I. DECLARATION by the candidate for a research degree. To be bound in the thesis**Degree for which thesis being submitted **PhD**Title of thesis **Women's perceptions of their experience of miscarriage decades after the event: an interpretative phenomenological analysis.****This thesis contains confidential information and is subject to the protocol set down for the submission and examination of such a thesis.****NO**

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ABSTRACT

Miscarriage is a common occurrence. More than a quarter of all conceptions result in miscarriage with the majority of miscarriages occurring in the first 12 weeks of pregnancy. However, there is very little research into the long term impact on women. This thesis explores how women perceive their experience of miscarriage many decades after the event. Five women who had experienced miscarriage between 14 and 28 years ago took part in unstructured, in-depth interviews. I subsequently analysed these using interpretative phenomenological analysis (IPA). IPA attempts to explore an individual's personal perception or account of an experience. Thus, it is a suitable method for exploring how women perceive miscarriage many years after the event. Throughout, I have also made transparent how my own experience and assumptions about miscarriage may have influenced this research. I have focused on the many facets of reflexivity and described the process of taking part in a series of bracketing interviews to examine my beliefs. Three super-ordinate themes emerged from my analysis: **Memories of the Initial Impact of Miscarriage, The Longer Term Consequences of Miscarriage and Making Sense of Miscarriage in the Present**. I found that for the majority of the women in this study miscarriage was a complex event with both short and long-term psychological consequences. Many years later, it is anxiety, linked to trauma and shock that my participants recall most intensely. However, over time, the women in this study have come to an acceptance of their experiences of miscarriage and they perceive it has made them more resilient and able to look towards the future with optimism. Ultimately, I hope that raising awareness of the long term psychological effects of miscarriage and the needs of women who miscarry, might lead to a more compassionate understanding from health professionals and by society in general.

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*This thesis is dedicated to Peter with all my love and is written for the baby we both loved
but never knew.*

A special thank you to all my participants for your most generous gift. Without you I could never have undertaken this research. In her interview Tess told me:

“Gosh! I do so like- more than like-I’ve run out of words, the notion of this being a memorial”.

I hope she will find this fitting.

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Now, as my dear colleague Sally recently reminded me, I am handing over this thesis with love as that is how it was made.

*“And soon the night of weeping
Shall be the morn of song”*

GLOSSARY

Abortion: the premature expulsion from the uterus of the products of conception, either the embryo or a non-viable fetus

Early miscarriage: the loss of a pregnancy up to twelve weeks of gestation

Embryo: in humans, the developing organism from fertilisation to the end of the eighth week

Fetus: the unborn offspring in the post embryonic period after major structures have been outlined, in humans from nine weeks after fertilisation

Miscarriage: the loss of a pregnancy up to 24 weeks gestation

Neonate: a new born infant

Neonatal death: the death of a new born infant in the first few weeks after birth

Perinatal loss: refers to miscarriage, abortion, stillbirth, and postnatal death

Perinatal death: the death of an unborn child occurring in the period shortly before or after birth; variously defined as beginning with the completion of the twentieth to twenty-eighth week of gestation and ending 7 to 28 days after the birth

Post-natal death: the death of an infant after birth

Pregnancy loss: the natural death of an embryo or fetus before it is able to survive independently

Products of conception: fetal and placental tissue

Reproductive loss: the experiences of miscarriage, stillbirth, perinatal and infant death, and the loss of normal reproductive experience such as that associated with infertility and assisted reproduction

Silent miscarriage: when the fetus dies in utero and is discovered by ultrasound scan before the fetus is expelled

Spontaneous abortion: an abortion occurring naturally; popularly known as a miscarriage

Stillbirth: a child being born dead after 24 weeks

Termination: a medically directed abortion prior to independent viability, using pharmacological or surgical means

Therapeutic abortion: an abortion which is induced to save the life or health (physical or mental) of a pregnant women

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Liminality

Years ago now
You slipped
From my hand
Left
To be lost in time
Where I could not follow.

Yet still you are there,
In the blurred edges of my life,
In the pauses where my body
Meets the world.

I glimpse you in the shadow moments.
Those barely perceptible
Thresholds,
When dusk becomes night,
Dawn day
And the moments between life and death
Are just a breath away.

Where pain is untouchable,
Tears bank high in nimbus clouds
Grey, black, monstrous,
Storms brew, never to break
And my bones crack
With the ache I feel
At your loss
Still.

(LdC, 20.04.13)

CHAPTER 1: INTRODUCTION

In this thesis, I set out to explore how women perceive their experience of miscarriage many decades after the event. I consider whether miscarriage has long term psychological effects on women and how women make meaning of their experience of miscarriage both in retrospect and in the present.

Background and motivation for my research

The motivation for this research began twenty two years ago when I had a miscarriage at twelve weeks in August 1993. I had previously had two uneventful pregnancies and up to this point, I had not seriously considered the possibility that anything could go wrong with what appeared to be another normal pregnancy. I was on holiday with my parents and two young sons and I was unaware at the time of the impact that first small drop of blood on my bath towel was going to have on my life. I consulted an emergency doctor who sent me home to my own GP and after a series of examinations and a scan at my local hospital, five days later I miscarried my baby alone in my bathroom at home. I was severely shocked and traumatised by the extent of the pain, the bleeding and the sight of fetal tissue. My GP was sympathetic but I was distressed by her attitude to the miscarriage. My world had fallen apart and yet I felt she was treating it as a minor health issue. She reassured me that I was young, that miscarriages were very common and I could become pregnant again very quickly. All I knew was that I was aching for the baby I had lost and I could not contemplate ever becoming pregnant again. A few weeks later the summer holidays ended and I returned to work as a teacher and tried to move on with my life. However, after several weeks, I felt ill and exhausted. I was having panic attacks and I couldn't sleep. The day came when I just couldn't get out of bed. I was given anti-depressants and

tranquillisers and I did not return to work for six months. I was very agitated and depressed and started to experience agoraphobia which meant I couldn't leave the house easily, even when accompanied, and it was impossible for me to drive my car. Looking back, I know that my doctor was concerned about my state of mind as I was visited at home quite regularly.

I still had sufficient energy to beg my doctor for something more to be done and I was initially sent to see a psychiatrist at my local hospital. This encounter was extremely bizarre. The young doctor I saw sipped coffee throughout our consultation. He demonstrated a relaxation technique that involved lying down with my head on a book and suggested that to overcome my anxiety, I should buy a pair of running shoes and take up jogging. He seemed oblivious to the fact that I could barely leave the house and was only able to come to the hospital after drugging myself with a large dose of tranquiliser. However, in the long term he did me a favour because my anger after this encounter energised me to want to get better on my own. I read some self-help books on depression and anxiety. I forced myself to go out walking; at first to the end of the road and then a little further every day. I regularly did relaxation and breathing exercises, listened to music and danced around my living room. Eventually, I took some advanced driving lessons from a very sympathetic driving instructor and slowly and imperceptibly life improved.

During this time, my doctor arranged for me to see a therapist who very fortuitously had experience of working with mothers suffering from post-natal depression. I continued to see her regularly for the next two years. She encouraged me to talk about my feelings but also to write and for the following twelve months I wrote a series of poems about my miscarriage, never guessing that I would quote extracts from these in a thesis on miscarriage over twenty years later. Over the next few years, my recovery continued. I no

longer dwelt much on my miscarriage, although I was aware of its legacy. The acute agoraphobia had passed but I still found it difficult to travel long distances, particularly on my own. Occasionally, I had flash backs to my miscarriage and I often dreamt about babies and childbirth.

Several years later, I began counselling training and became interested in the area of bereavement and loss. I began to reflect more about my experience of miscarriage and I wanted to understand more fully why it had such a big influence on my life. I went to see another therapist and began to explore how I had made meaning from my experience of miscarriage. I began to realise that in many ways what had been a traumatic experience had changed me and to a certain extent had become transformative. I talked about the fantasy baby I felt I carried inside me, alongside the undefined presence of a Shadow Child which I discuss in more detail in my Reflexivity Chapter.

When I started to volunteer as a bereavement counsellor, I heard stories from other women about their miscarriages, some that were very different to my own and some that had resonance for me. I noticed that for certain women miscarriage had not been a transient experience but one that had a profound and long lasting impact. It had changed their relationships with their partners, altered the dynamics of their families and had a lasting psychological effect.

After I completed my MSc in Counselling Psychology, I did not plan on undertaking any further research. However, during a serendipitous encounter in a university coffee shop with two of my former tutors, I blurted out that if I ever had the opportunity, I knew that I would like to undertake further research into the long term effects of miscarriage on women. They encouraged me and I approached my supervisor. I was aware at this point of the continuing long term psychological effects on me; how difficult I found it to talk about

miscarriage and the residue of anger and disenfranchisement I still experienced. I felt guilty about my sorrow for an event that had happened so many years ago and shame that I had not been able to recover in the way that I believed was expected by those around me. I longed to know if this was how other women felt years after their miscarriages or whether these feelings were unique to me. I was also increasingly aware of how little was written about the long term psychological effects of miscarriage and that astonishingly it was a neglected area in counselling research. It was at this point that my PhD journey began.

Research aims

Inevitably, my aims have changed and developed as the research progressed and throughout I have allowed the process to be driven by the data (Smith, Flowers & Larkin, 2009). At the beginning, I believed that miscarriage was a taboo subject and that women who miscarried were disenfranchised from expressing their grief in modern Western society. I also felt strongly that the experience of miscarriage needed to be heard and validated and I saw my research as an opportunity to give women a voice and to allow them collectively to tell their own stories. I wanted to explore whether miscarriage had a long term psychological impact on women and I was curious to compare other women's experiences with my own. Also, I sought to develop a methodology that allowed my own experience to be an integral part of the research.

I had no doubt that individual therapists recognised the fact that miscarriage could have psychological consequences for some women, yet inexplicably, it appeared to be disregarded in the counselling and psychotherapy literature. Therefore, I hoped that my research might lead to miscarriage becoming less neglected in this area. Throughout the literature in general, there is a call for more psychological intervention for women after

miscarriage and I wanted to raise awareness of this need, particularly in the area of perinatal mental health.

Furthermore, after I completed the data analysis of my transcripts, it became clear that some of my participants had experienced a lack of understanding of the psychological effects of miscarriage from various health professionals. A review of the literature confirmed that this was also the experience reported by other women who had miscarried. This led me to hope that I could raise awareness among health professionals of the long term effects of miscarriage on some women and facilitate a deeper understanding that these may last a lifetime.

However, during my revision of the third section of my Findings and Discussion Chapter, it became clearer to me that my participants were not describing miscarriage as taboo or disenfranchised in the same way as I experienced it. This required me to modify some of my initial aims for this research and I discuss the impact of this in my Reflexivity Chapter.

Planning the research

I chose to use a qualitative approach for this research because I wanted to explore the subjective experience of women's perceptions of miscarriage many years after the event. Interpretative phenomenological analysis (IPA) is an approach that was developed initially in Health Psychology. It focuses on trying to understand how participants make sense of their own experiences whilst at the same time acknowledging this is an intuitive process that is dependent on interpretation by the researcher (Smith et al., 2009). There is emphasis on how a person makes sense of an experience in the past from their present perspective and therefore it seemed appropriate for research exploring how women perceive their experience of miscarriage many decades after the event. The phenomenological belief that the body and the world are interconnected (Finlay, 2011) also felt apposite for a study into

an apparent failure of the body through miscarriage. Likewise, I found the idiographic nature of IPA attractive as it resonated with my own beliefs about the uniqueness of individuals. Since I was planning on undertaking in-depth unstructured interviews with a small sample of five women, I wanted a method that would allow me to focus on individual accounts as well as the similarities and differences between them and this is distinctive to IPA (Finlay, 2011).

The five women that I recruited to take part in my research were between the ages of 47 and 65 years old at the time of the study. In line with IPA's requirement for a small homogenous and purposive sample (Smith et al., 2009), between them they had experienced ten miscarriages, two stillbirths and one abortion, four were married and one divorced. Three of my participants went on to have subsequent healthy pregnancies after their miscarriages and one adopted a baby.

Before I began the process of interviewing my participants, I wanted to explore my stance as a researcher and to examine my own assumptions and beliefs about miscarriage and how these might influence the research. I sought to find a way of attempting to integrate my own experience of miscarriage into the research rather than attempting to set it aside as I believe that this is neither practical nor necessary in qualitative research. Therefore, I decided to take part in a series of three bracketing interviews (Newman & Tufford, 2012; Rolls & Relf, 2006) and these took place at significant times during the research process. I undertook the first bracketing interview just before my first research interview. This was transcribed and themed using thematic analysis (Braun & Clarke, 2006). Subsequently, the themes that emerged have formed the basis for my Reflexivity Chapter. The second bracketing interview took place after I completed my research interviews and the third at the end of the data analysis.

I had initially planned on presenting my findings and my discussion in discrete chapters, as this is standard practice in IPA (Smith et al., 2009). I was aware of McLeod's (2011, p. 274) warning to qualitative researchers of the importance of keeping findings separate from discussion so that readers gain a clear sense of what has been discovered from the research. However, when I tried to produce a discrete findings chapter, which contained a close reading and interpretation of my participants' transcripts, I became aware that it would be more illuminating to dialogue straight away with the extant literature. Similarly, when I attempted to write a separate discussion chapter, I wanted to include examples from my transcripts to further elucidate my arguments and I found myself replicating extracts from my findings. Therefore, I had to find a different structure that would more acceptably fulfil the aims of my research.

Smith et al. (2009) make it clear that, for more experienced researchers using IPA, it is appropriate to merge the findings and discussion sections and not to have a clear distinction between them. Therefore, I felt justified in settling for one long combined findings and discussion chapter separated into three sections based on my three super-ordinate themes. I felt this method allowed me to engage fully with the analytic interpretations of quotations from my participants' transcripts but at the same time to deepen the interpretation and analysis through a discussion of where these emerging ideas fitted within the context of the literature. I felt this method made my arguments more comprehensible to the reader as they were fully contained within each section and not separated between two chapters. It also gave me the space and freedom to include extracts from my research diaries and bracketing interviews so the reader had a deeper appreciation of my thought process during the analysis and interpretation and how this changed and developed as the research progressed. Thus, I was facilitating my readers' participation in

the hermeneutic dialogue through offering an insight into my process of understanding how my participants make sense of their experience of miscarriage (Smith et al., 2009).

Significantly, up to this point, I had only undertaken a preliminary literature review in order to ensure that I had a sound rationale for my research question (Willig, 2013). At the beginning of my planning for this research, I had deliberated about when to undertake a formal literature review. I agreed with Finlay (2011) that the researcher, “needs to focus on lived experience rather than theorizing” (p. 185). Thus, I was attracted to the position in grounded theory (Strauss & Corbin, 1990), that too much initial immersion in the literature may stifle the researcher’s ability to allow new meanings to emerge from the data.

Furthermore, I was aware of the debates around undertaking a literature review too early in phenomenological research because of the necessity to try to set aside preconceptions, particularly, during the initial stages of the research (Finlay, 2011; Smith et al., 2009).

Therefore, I intended to read the substantial literature on miscarriage after I had completed my interviews, data analysis and the writing up of my findings. Then, I proposed to undertake a formal literature review and use it to inform a discussion chapter. However, these plans changed when I decided to combine the findings and discussion chapters together.

It was a challenge to simultaneously make sense of an overwhelming amount of data, to analyse my findings and at the same time illuminate them through dialogue with the literature without having undertaken a formal literature review. In retrospect, I think it might have been less time consuming to have carried out a complete literature review at the start of my research. Yet overall, I think this organic process has allowed me to be open to the unexpected in my participants’ accounts and has enabled me to present a full and

rich account of their experiences of miscarriage without being unduly influenced by a body of extant literature.

All these experiences have brought home to me the complex and unpredictable nature of planning for qualitative research. A detailed description of how I eventually decided to structure my thesis is set out below.

Structure of the thesis

After this introduction, the second chapter in my thesis is my Reflexivity Chapter because I wanted to acknowledge from the very beginning how my own experience of miscarriage has impacted on this research. Here, I explore the different types of reflexivity that I have engaged in (Aherne, 1999; Tufford & Newman, 2012) and the challenges that each has presented. I discuss why I have used extracts throughout this thesis, from my three bracketing interviews (Rolls & Relf, 2006; Tufford & Newman, 2012) and my reflexive research diary, to illuminate my process of interpretation and to make explicit for the reader my own personal engagement with the research. The themes generated from my first bracketing interview are used as headings in this chapter. They act as signposts for the stages in my journey and illustrate how I have made meaning of my own experience of miscarriage through the research process.

The third chapter is my Literature Review. It is a historical narrative review (McLeod, 2013) that aims to set my research question in its social and historical context. I begin by giving an overview of pre-twentieth century attitudes to miscarriage. I then show how these have been modified and developed up to the 1950s. From there, I explore how attitudes have changed through the decades until the 1990s, when my participants had their miscarriages, and then on into the twenty-first century, up to the present day. I review the literature that in particular concentrates on the psychological consequences of miscarriage

and the attitudes of health professionals. Finally, I examine some of the controversies surrounding miscarriage in the contemporary literature.

Chapter four is my Methodology Chapter. This chapter is divided into three sections. Theoretical Foundations, The Research Process and Data Analysis. Here, I discuss the philosophical approach underpinning my research and I consider why I have chosen to use interpretative phenomenological analysis (IPA) (Smith et al., 2009) as the most appropriate research methodology for addressing the aims of my research. I give an account of my research process, including how I undertook my bracketing interviews, and I present an abridged table of my findings. I explore what makes good qualitative research and discuss the concept of discovering the “gem” in qualitative research (Smith, 2011). I also consider the ethical dilemmas that I faced whilst interpreting my data and in undertaking sensitive research into the intricacies of miscarriage.

The fifth chapter is my Findings and Discussion Chapter. This contains my analysis and discussion of the three super-ordinate themes and the sub-ordinate themes that emerged from my data. I have divided this chapter into three sections according to my three super-ordinate themes. Throughout each section, I have focused on illustrating how my themes both converge and diverge and I have compared my findings to those in the extant literature. I have also retained an idiographic perspective and placed emphasis on my participants’ own unique perspective where appropriate. At the end of each section, I have included a reflection on my thoughts and feelings regarding my analysis and discussion of my findings. As part of my reflexive process, I have woven throughout each section extracts from my research diary and from my three bracketing interviews. In the conclusion, there is a poetic representation (Grbich, 2013) of my findings ‘*Giving voice: women’s experience of miscarriage*’.

The first section of this chapter looks at the super-ordinate theme: **Memories of the initial impact of miscarriage**. I explore themes around how the traumatic nature of the physical process of miscarriage may have a psychological impact on women and how this is often compounded by the attitudes of other people and health professionals towards miscarriage.

In the second section, I discuss the super-ordinate theme: **The longer term consequences of miscarriage**. Here, I observe how miscarriage can influence the desire for another baby and cause women to want another pregnancy quite quickly, despite reproductive difficulties. I discuss how subsequent pregnancies may cause anxiety that something will go wrong again and the impact this can have on a woman's family life and relationships.

Finally, the third section examines the super-ordinate theme: **Making sense of miscarriage in the present**. I reflect on how making meaning of miscarriage many years after the event can be complicated and involve many contradictions. I look at my participants' experiences in the light of traditional grief models (Parkes, 1972/ 1996; Stroebe & Shut, 1999; Worden, 1983/2010) and the theory of continuing bonds (Klass, Silverman & Nickman., 1996; Rando 1985). Lastly, I consider how miscarriage can be life changing and how my participants view taking part in this research as validating and as a way to commemorate their lost babies.

Chapter six is the conclusion to this thesis. Here, I present an overview of my key findings and comment on the overall limitations of my research. This is followed by my recommendations for future research. The chapter ends with some final reflections on the challenges involved in undertaking qualitative research into women's experience of miscarriage decades after the event and I consider what I have learnt from the process.

CHAPTER 2: REFLEXIVITY

Reaching for the moon

“I didn’t think this PhD was going to be about me”

When I first began this research nearly five years ago, I was under the impression that although I had experience of miscarriage, I would need to set this aside so I could focus exclusively on the experience of my participants. I remember distinctly telling my supervisor that “I didn’t think this PhD was going to be about me”. Like all good supervisors, she smiled enigmatically and let me discover the truth for myself. Before long, I realised that I could not divorce my own assumptions about miscarriage from how I responded to the experience of my participants. I was going to become the sixth participant in this research and my own experience of miscarriage needed to be heard.

Bracketing or embracing?

This revelation meant that I had to find a way to include my voice and my experience of miscarriage without overshadowing the experiences of my participants. I began to explore the theory of bracketing within phenomenological research and to consider how this term is linked with the concept of reflexivity. I was aware that Aherne (1999, p. 410) argues that, “bracketing and reflexivity are fruit from the same tree” and that contemporary writers such as Finlay (2011) and Langridge (2007) suggest that phenomenological researchers need to engage in both bracketing and reflexivity. I therefore required a method that would allow me to embrace both these concepts. I wanted to find a way to explore my own assumptions about miscarriage and my stance as a researcher but I instinctively felt that I did not want to set aside these attitudes. I had an image that my arms were like bracketing symbols and could be used to gather up my opinions and carry them right into the heart of my research. Merleau-Ponty (1968, p. 138) describes the relationship between

researcher and researched as, “a reciprocal insertion and intertwining of one in the other”. This metaphor speaks to me of how my experience of miscarriage and my participants’ experiences are closely woven together in this research. How I have faced the challenge of coming to understand and to make transparent which are my threads and which my participants in this complex tapestry is the substance of this chapter.

What is bracketing?

The term bracketing has its roots in phenomenological philosophy and in what Finlay (2011, p. 23) calls the “phenomenological attitude”. Through bracketing, I can dwell with the phenomenon of miscarriage intuitively, and attempt to perceive it in a new and original way. This process requires deep reflection and my aim is to connect in the moment with my own experience. Drew (2004) describes this practice as “self-discovery” and as a form of “transcendental subjectivity” (p. 222) and similarly Le Vasseur (2003) views bracketing as an awakening of our curiosity as we set aside our natural assumptions about the world. However, there appears to be a recent trend within qualitative research to use bracketing superficially. It is often described as merely a way to attempt objectivity, or to set aside preconceptions in order to reduce bias (Lowse & Prowse, 2001). Similarly, the concept appears to have become separated from its origins in phenomenology with many different definitions and no set way of implementing it within qualitative research (Gearing 2004; Finlay, 2008; Le Vasseur, 2003; Tufford & Newman, 2012). It is therefore important for me to clarify how I see bracketing within my own research.

My approach sits within the “phenomenological attitude” described by Finlay above and is also linked to Gearing’s (2004) description of “reflexive bracketing” which he describes as a modern development within qualitative research where the researcher openly

acknowledges her assumptions and beliefs and is aware of their influence on the research. I am also attracted to Tufford and Newman's (2012) description of bracketing as "a multi-layered process that is meant to access various levels of consciousness" (p. 84). I believe that throughout this research, I have engaged in numerous methods that have allowed me to access these levels of consciousness and to come to a deeper understanding of my own experience of miscarriage and I discuss these throughout this chapter. This engagement has enabled me to embrace my subjectivity and bring it openly into the heart of my research as I attempt to interpret my participants' own personal experience of miscarriage. Through being a reflexive researcher, I am able to reconcile the almost contradictory stances required by IPA of being distanced and detached but also open and connected to my participants' experiences (Finlay, 2011). Reflexive practice also allows me to use my own experiences of miscarriage as a source of insight as I interpret how my participants perceive and make sense of their own experience of miscarriage.

How I have used reflexivity in this thesis

The concept of reflexivity

It is very clear to me that there is a close link between the term "bracketing" in the phenomenological tradition and the concept of "reflexivity" which is used more generally in qualitative research. Indeed, how reflexivity is defined may depend on the methodological tradition being adopted by the researcher. Finlay (2002) describes it simply as "Thoughtful, conscious self-awareness" (p. 532). Etherington (2004) explains reflexivity as "the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) inform the process and outcomes of inquiry" (p. 31). In this sense, reflexivity goes deeper than reflection and is very similar to "bracketing" as described above. I see both bracketing and reflexivity as helpful and

almost synonymous concepts. They both require me to be transparent about my involvement and to be aware of the impact this may have on my research (Finlay, 2011). In my view, if I consider myself a trustworthy and accountable researcher, it is my responsibility to be reflexive (Gough, 2003).

Methods of reflexivity

Willig (2013) outlines two types of reflexivity, epistemological reflexivity and personal reflexivity. I have engaged in epistemological reflexivity throughout my research by adopting a critical stance, questioning my choice of methodology and the decisions I have made in designing and undertaking this research. It can be difficult for a reader of qualitative research to know fully whether what they are being told is an authentic account, particularly if the researcher is writing about themselves (McLeod, 2013). Therefore, I hope by including pertinent extracts from my bracketing interviews and my research diary, I can show how I have come to particular interpretations and understandings and illustrate the depth of my personal engagement with the research. I believe that by making my research process more explicit to the reader, I am inviting them to enter into a deeper understanding of the research and enabling them to make a more informed judgement on its trustworthiness (McLeod, 2011). I discuss the part reflexivity can play in evaluating my research more fully in my Methodology Chapter.

Secondly, by revealing the influences on my research process and through making my own personal values and beliefs transparent, I have participated in personal reflexivity and it is this process that is the main focus of this chapter. Throughout my research, I have used many different methods of being reflexive. From the very beginning of this research, I have kept a research diary in which I have explored my motivations for undertaking this research and recorded a detailed account of my thoughts and feelings as I undertook my

research interviews and engaged in the process of theming and the analysis of my findings (Tufford & Newman, 2012). I have engaged in many discussions with my supervisor and with my personal therapist, which have helped me to develop my ideas, clarify my thoughts and feelings and explore the personal impact of this research. I have also undertaken a diverse range of activities such as workshops, presenting at conferences and creative writing which have inspired me to think deeply and reflexively on my research process. Significantly, I have undertaken three bracketing interviews which are described in more detail below. I have also worked hard to develop a personal voice that is suitably academic but will also resonate with my readers more intimately because I want to undertake qualitative research that people can relate to on a personal level (Finlay, 2011).

Creative activities

The idea for the title of this chapter ‘Reaching for the moon’ came after I took part in a workshop on the use of the Six Part Story (Lahad, 1992). I found myself drawing a small black cat that had to undertake a long and hazardous expedition in search of the moon and I saw in this an analogy for the experience of miscarriage and my own research journey. It also brought to mind the words of one of my favourite songs by Irvine Berlin also called ‘Reaching for the moon’. The words of this song speak to me because they encapsulate my experience of miscarriage so well.

*The moon and you appear to be
So near and yet so far from me
And here am I on a night in June
Reaching for the moon and you,*

*I wonder if we'll ever meet
My song of love is incomplete*

I'm just the words, looking for the tune

Reaching for the moon and you.

I'm just the words, looking for the tune

Reaching for the moon and you.

(Irvine Berlin)

Writing and researching this PhD has felt like setting out on a perilous journey in search of the moon and yet I am not sure what the moon symbolises in this metaphor. Since ancient times the moon has been associated with menstrual cycles and female fertility so I might be making an unconscious connection with the moon and my miscarriage. Conceivably, there are also associations here with the fear of embarking on a pregnancy after a miscarriage connected to the idea of research as a dangerous quest. Perhaps I am the black cat in my story, searching for answers about why I had a miscarriage and why it had such a profound effect on me. Possibly, as it says in the song, I am looking for the words to go with the tune and being both the lyricist and the composer of this research is challenging. I am seeking to discover whether my experience of miscarriage has parallels with other women's experiences and at the same time still yearning for my lost baby and she is the 'you' in the song who often feels so near and yet so far from me. For now, all I know is that the quest continues and this metaphor of searching for something that feels just out of reach has become the theme song for my research.

Reflexivity and bracketing interviews

During the process of this research, I decided to take part in three bracketing interviews (Rolls & Relf, 2006; Tufford & Newman, 2012) because I wanted to create unique spaces, at important moments in my research, for facilitated reflection. The first took place in February 2010 before I began the research and this is the interview that I have themed and discuss in detail below. The second took place in March 2011, after I had completed interviewing my participants and the third in February 2012 as I was completing the process of theming across the transcripts. During these interviews, I talked about my own experience of miscarriage, my continuing motivations for undertaking this research and the research process. They also nurtured my growing awareness of how I made meaning of my own experience of miscarriage and helped me to consider the personal impact of my research. I also saw bracketing interviews as a way of creating a relationship that could provide support with emotional or ethical issues that might arise when undertaking my research (in addition to personal therapy and supervision) and as a method to increase my understanding of how it felt to be interviewed on such a sensitive topic as miscarriage (Rolls & Relf, 2006). I believe that this method has been successful because I have gained better understanding of how my research stance has influenced my ability to enter the essence of my participants' worlds. Undertaking bracketing interviews has also allowed me to engage more intimately with the research process.

The first bracketing interview

I asked a trusted colleague, whom I will call Heather, to facilitate all three of my bracketing interviews. I decided to theme the transcript of my first bracketing interview using a thematic analysis (Braun & Clarke, 2006) because I wanted to find an effective method to distil and then present the essence of my own experience of miscarriage from

eighteen years ago. I also intended to use my findings as another data set in this research (Drew, 1989). However, initially, I was not certain how I would use this data set and it was only much later that I decided to use it as part of my Reflexivity Chapter. I opted not to theme my second and third bracketing interview because I felt that the content was more focused on my research process rather than my memories of miscarriage and I was also aware of time restraints. I return to this discussion more fully in my Methodology Chapter, along with a detailed account of the procedures I adopted for these interviews and the subsequent thematic analysis.

In this section, I have used the themes, generated from my first bracketing interview, as headings or signposts for an exploration of my role as a researcher and my perceptions of miscarriage many years after the event. I have illustrated these themes with quotations from my bracketing interview transcript that get to the heart of my unique perceptions of miscarriage. The quotations are written in italics so they are easily identified. In the brackets, B1 indicates the extract is from my first bracketing interview, followed by the page number and then the line number of my bracketing interview transcript. I have also included in my discussion, extracts from my second bracketing interview (B2: March 2011) and third bracketing interviews (B3: February 2012) where I think these serve to make more explicit the underlying ideas and emotions present in these themes. However, there are no page or line numbers recorded; only the date of the interview is indicated, because I have not transcribed these interviews. This method allows me to present a rich description of my own experience of miscarriage many decades after the event. The four themes that emerged from my thematic analysis are as follows: *Time Travelling*, *Creative Forces*, *Wind-Egg*, and *Shadow Child*. Below, I have used these themes as headings for my account of how I have used reflexive practice in my research.

Time travelling

You never know which part of the continuum you are on (B1:14/514).

Inevitably, undertaking a bracketing interview took me back to remembering the physical process of my own miscarriage. During the bracketing interview, I talked to Heather, the interview facilitator, about the visceral memories of my miscarriage and the difficulties of separating how I feel about the miscarriage in the present compared to the past.

Unsurprisingly, during my bracketing interview, I was taken back to the blood, pain and horror of the experience and I have included an account from this section of my bracketing interview in my Discussion Chapter under the first super-ordinate theme. I have also observed this struggle with the time continuum in my participants. When I read their transcripts, I am struck by the vividness and immediacy of their memories of miscarriage so many years later. It is not always clear whether they are describing their feelings in the past or the present and the sensation is one of time travelling. I also discuss this phenomenon in more detail in my Findings and Discussion Chapter under the theme ***The physical process of miscarriage.***

Unsurprisingly, my perceptions of my experience of miscarriage have changed over time and I have been aware of this throughout the process of undertaking this research.

Principally, I noted this when writing my Findings and Discussion Chapter and engaging with Dee's experiences of miscarriage and comparing them to mine. Neither of us went on to have subsequent children and noticing this similarity led me to examine more closely the story I have told myself around my decision not to try for another baby. Whilst analysing and interpreting Dee's transcript, I began to realise that my decision to avoid another pregnancy after my miscarriage had been fraught and painful and certainly not as pragmatic as I had thought. In recent therapy, I have gradually reframed this story and the

knowledge that my recollections of this time are now nearer the truth is healing and restorative.

This theme is also linked to the process of writing my thesis and to the hermeneutic elements in my methodology (Finlay, 2011; Smith et al., 2009). I believe that my struggle to place facts and feelings about my miscarriage accurately in time is also mirrored in my tussle with my super-ordinate themes. As I have explained in my Methodology Chapter, it took nearly two years for my three super-ordinate themes to emerge in a satisfying chronological order that eventually made sense to me. It was as if through the process of theming, I was struggling to make meaning of the muddle and chaos inherent in my experience of miscarriage and part of that was to establish some chronological order in my themes. I have often used the messiness of miscarriage as a metaphor for the experience of undertaking this research. This is seen towards the end of my second bracketing interview when I tell Heather:

This research is not containable. It spills out and is messy. I am having images of blood. I'm sitting in the middle of this pool; I'm not outside it...As a researcher do I allow that messiness or do I tidy it up?(B2: March 2011).

To a certain extent, I feel that acknowledging this messiness and allowing myself the time to revisit and reflect on my traumatic memories has been cathartic. The image of travelling in time symbolises how I have allowed myself to look again at what happened to me when I had my miscarriage and to recollect and make meaning of my experience in tranquillity. I have been granted the opportunity to metaphorically travel back in time and to make further sense of what happened when I had my miscarriage. It does feel as if by sorting out and clarifying my memories and learning to live with them, I have been clearing up the mess left by my miscarriage. Finlay (2011) sees these subjective experiences of time as

linked to the “life world” and part of what she describes as the “phenomenological project” (p.15). She argues that we make meaning of our experiences from the past by overlaying them on to experiences in the present or projecting them into the future. This is linked to the “hermeneutic circle” where we draw on our past experiences to make sense of or to interpret present experiences and anticipate those to come (Finlay, 2011, p. 52). I find this concept easier to relate to if I call it time travelling. This theme of time travelling is also linked in my mind to theories about how we form and process traumatic memories and in my Findings and Discussion Chapter, I explore whether experiencing traumatic events leads us to remember them more vividly (Brewin, 2007).

There is also a connection in this theme to theories about how I construct memories and the difficulties I face in sustaining bonds with my unborn child (Klass et al., 1996). Again, I have explored this idea more fully in my Findings and Discussion Chapter and Literature Review. By writing and reflecting on this theme of time travelling, I have allowed memories to resurface and through these I remain attached to my lost pregnancy. However, this can be a painful process as the theme below illustrates.

Wind-egg

This is an empty research. This is a wind-egg, a false pregnancy. That’s the analogy- that taps into my biggest fear around all this (B1:17/626 –627).

This quotation voices my deep- rooted fear that I might be undertaking worthless research; that my study will uncover nothing of importance and my findings will echo my miscarriage and bear no fruit. I explain this anxiety more fully below:

I don't know where that's come from but it's in my head. That there's nothing there and I'm sure that's connected to the miscarriage isn't it? What if this is just empty and there's nothing there and nobody cares – they don't care? (B1:17/611-614).

Possibly, this fear was more present four years ago when I began the research and it felt as if I was travelling into a big empty void in my time machine. Now, as my research nears its completion, I do feel a sense of accomplishment but there are still fears and uncertainties. Etherington (2004, p.113) writes about “the fear that’s attached to not knowing” experienced by researchers and I can relate to her concerns expressed below:

“I had felt out of control: there was so much data, so many thoughts and images and no understanding of how it would all come together – and the fear that it might not” (p. 114).

Many PhD students will recognise these feelings but I suspect that when researching into a profound subject such as miscarriage they might come even more to the fore. Miscarriage is often unspoken about and can be a dark secret. It is therefore not surprising that these fears can be present in the researcher too. It is possible that women disenfranchise themselves by keeping silent about their experience of miscarriage and thus it becomes harder to undertake research on an almost forbidden topic. Perhaps it is not coincidental that there is so little research on the long- term effects of miscarriage on women as my Literature Review demonstrates. Layne (2003) describes this position eloquently when she writes:

“But by and large, in the realm of feminist scholarship the topic of pregnancy loss remains an orphan. It is time for feminists to move pregnancy loss from a ‘private space of shame’ to a public sphere of solidarity” (p. 239).

This idea of pregnancy loss being an “orphan” in feminist scholarship, and also I believe in the field of counselling and psychotherapy research, disturbs me. The use of the word “orphan” is resonant of a motherless baby and reminds me that after my miscarriage I really wanted my baby to know that it had a mother. This was important because I felt that my miscarriage had robbed me of my rights as a mother. At the time, I wrote a poem called ‘Not an orphan’ and I quote from it below:

Do you know you had a mother once?

Not an orphan you

But loved and missed

With an intensity

Beyond understanding...

I would have died to give you life.

You have refused me all my mother’s rights.

You came of age before you had a past

And thus your future was denied me too.

Oh yes, you had a mother once you know.

I feel as if the anger that is implicit in this poem has been channelled into my motivation to do this research. I do not want the topic of miscarriage to be motherless and it feels as if I have placed a burden of responsibility on myself to adopt this area of research. I want to play a part in opening up a space for a discussion in what I consider to be a neglected area but this requires me to share my own intimate experiences and this obligation sometimes fills me with dread. I explain this to Heather below:

This taps into my biggest fear...that people will say to me so you've had a miscarriage - okay get on with your life, get over it. It wasn't even a real baby- you were only pregnant for a few months – you've already got children (B1:17/630-635).

I believe strongly that miscarriage matters and that after miscarriage some women may find it difficult to express their sorrow or have it acknowledged. In this way their grief can become disenfranchised (Doka, 2002). I feel that by putting my grief into a more public sphere, I am giving myself permission to mourn and breaking the hold of marginalisation; yet paradoxically, underlying this is an anxiety that my grief is an indulgence and that I am making mountains out of molehills. This causes me to ask: How can research into miscarriage be valued if miscarriage is not viewed by society in general as an important issue? More than twenty years ago, nearer to the time when my participants had their miscarriages, Hey, Itzen, Saunders and Speakman (1989) wrote:

“It is particularly hard for women to assert their need to grieve without being accused of being weak, sentimental, over-emotional, selfish...It makes our loss an even greater tragedy when we have to fight for the right to mourn, as sadly many women do. We need our experience to be recognised as valid, even if it is not necessarily understood, and so we should not have to hold back from expressing our grief” (p. 119).

Sadly, I do not think that this attitude to miscarriage has changed much over the years and thus undertaking this research can feel like a dangerous and possibly a fruitless enterprise.

Running parallel to these concerns is my desire to have the solidarity of other women and to have our experience of miscarriage heard and validated. This is expressed when I say:

*I don't want to be alone. I want the solidarity of other women who can say to me
Lois you're not mad (B1:16/579).*

The fear of madness is connected to my struggle to accept the depth of my emotions following my miscarriage but there is also an underlying hope that other women might feel the same and I might discover this through undertaking research. However, this also means I have to confront the possibility that other women's experience of miscarriage might not be the same as mine. Significantly, by the time I had completed interviewing all my participants these fears were not so acute and I was more accepting of the multiplicity of experiences I had actually uncovered. This is illustrated in an extract from my second bracketing interview:

I want to embrace what I have found but I am not sure what it is. We all experience what appears to be the same thing differently. The loss and grief in all my participants' interviews is expressed differently. It has made me think that this idea of women not having a voice, of women being disenfranchised is not that straightforward because it is not just one thing. What has come up is very diverse. This is a group of middle aged women looking back over an important event in their lives and reflecting on how it has formed them. It is very unfocused. I am left with the idea that when women talk about their miscarriages they talk about their stillbirths, adoption, the possible impact of having a baby with Down's Syndrome on your family and that maybe it was all for the best. They say that a miscarriage can cause severe depression and a mental illness that still effects your family 15 years later. This experience feels fantastically huge (B2: March, 2011).

This brief account feels like an accurate summing up of the essence of my participants' experiences and what I have learnt so far about women's experiences of miscarriage through this research.

However, this process of learning has continued right up to the point where I thought, apart from some final revisions, my thesis was finished. Recently in August 2015, three years after this second bracketing interview, I became aware that I had argued for the taboo nature of miscarriage but that I had very little supporting evidence for this in my data. This realisation engendered some real anxiety and doubt and therefore discussing its implications fits well under this theme of “Wind-egg,” where I explore my fear of producing empty research. Below I include an extract from my most recent and final research diary entry where I contemplate this dilemma.

Research Diary 10th August 2015

I am now going to take an enormous risk and disclose a major issue with my thesis. When I began this research five years ago I was convinced that miscarriage was a taboo subject and I had no doubt that my participants would confirm this in their interviews. I undertook my analysis with this certainty in my mind and used the term quite freely when referring to my participants’ experiences, particularly in my first super-ordinate theme where I focus on the physical nature of miscarriage. Undertaking my literature view only confirmed me in my opinion because so many commentators begin their articles by commenting on the taboo nature of miscarriage and I have become accustomed to this point of view.

Yet, after I began the final revision of my Findings and Discussion Chapter and reviewed my first super-ordinate theme, a little seed of doubt began to grow in my mind. My supervisor had already questioned me about this and suggested that I needed more clarity so I looked more closely at what my participants were actually saying and, to my growing consternation, I could find very few direct quotes that would substantiate my claim.

However, I took the position that the taboo nature of miscarriage must be there, although perhaps not explicitly, and handed in my draft.

When we met again for supervision, my supervisor was more direct and said she did not think that I had demonstrated that miscarriage was taboo and where was my evidence.

This time I was more accepting of her criticism and went back to my transcripts with what I hoped were fresh eyes and an open mind. To my dismay, I had to admit to myself, that I couldn't see where my participants were explicitly saying miscarriage is taboo. In the light of this discovery, I revised my findings and re-wrote parts of my Findings and Discussion Chapter—certainly proof that qualitative research is an ongoing endeavour.

However, as I am currently reviewing my third super-ordinate theme once more, it is dawning on me that it is the need for recognition and validation that I feel most strongly about. Perhaps, I don't think miscarriage is taboo in the sense that it is shameful or offensive. However, I do feel that it is unrecognised sometimes as bereavement and the implication of this for women who have miscarriages is not always fully understood or appreciated. When I had my miscarriage, it was so easy to disenfranchise myself through buying into common beliefs about miscarriage. I told myself don't make a fuss; you're young and can try again for another baby. You've merely lost a bit of blood and it is only a collection of cells not a baby anyway so it is better if you keep it a secret. Nobody will understand how you feel. Go back to work and pretend it didn't happen. It was easy to keep my miscarriage hidden because of the convention that we keep pregnancy secret until after the first twelve weeks are safely over.

Three days ago I read a very moving article in the Daily Telegraph (Thursday 6th August 2015, pp. 21-22) by Louisa Pritchard with the title “I’d miscarried but I couldn’t tell anyone”. Here she comments on the bravery of Mark Zuckerberg (the founder of Facebook) and his wife for breaking the taboos surrounding the loss of their baby through miscarriage, and to my surprise (and private pleasure) she does use the word “taboo” because as her title suggests she found it impossible to tell the news to anyone. She writes:

“I hadn’t told anyone that I was expecting...meaning it was impossible to turn to my colleagues and say: ‘By the way, I was pregnant 10 minutes ago, but I’ve just had a miscarriage...It was- and still is one of the most physically and emotionally painful things that has ever happened to me.”

This article confirms me in my view that I have become accustomed to the idea that miscarriage is hard to talk about. It does make me feel vulnerable to share my experiences and I have to be brave to speak out in a climate where, I believe we have been conditioned to think that people don’t want to hear. Perhaps, this is what I mean by taboo. Yet I must admit sometimes when I do take the risk many people are very sympathetic and even begin to share their own experiences. The irony of course is that my research is paradoxical in that my participants have chosen to speak to me about miscarriage and are therefore breaking the silence of the taboo. Thus, perhaps it is not surprising that the taboo nature of miscarriage is only implied by my participants. Conceivably, I have been too cautious in my interpretation by not making this more explicit. Or perhaps I just have to acknowledge that I cannot presume something is there when it is not. However, I will move on from this, revise my themes where necessary and continue to trust in the reflexive process. However, I cannot help feeling a sense of disappointment and frustration with this outcome.

This experience illustrates that I am human and fallible and exemplifies how hard it is to set aside assumptions even when attempting to practise reflexivity to a high degree. Nevertheless, I hope that through a willingness to listen, a continuing commitment to reflexivity and by sharing this dilemma with my readers, I have added to the genuineness and sincerity of this research.

Creative Force

It has almost become a creative force you know – it's like a muse (B1: 22/788-789).

There is no doubt in my mind that my experience of miscarriage has been life changing and this is mirrored in my research. I have needed to find a way to make meaning from my miscarriage and to change what felt like a failure to create a new life into something more positive and fruitful. For the past five years, I have used my anger and creative energy to spur me on through a research process which has often felt challenging and at points interminable. I have discovered that I'm still learning about the extent of my own feelings and this is illustrated below:

I sometimes feel that I have let everything out that there is to let out and then I realise as I sit here talking to you that there is still more. It goes to infinity (B1: 6/181-183).

Even now, after twenty two years, I have tears inside. I am still frightened of being overwhelmed by my tears and I have a need to find ways of expressing my feelings in other ways. There is also a link here to my impetus for undertaking this research. I want to create something tangible from my loss. At the same time, I have come to an understanding that by holding on to my feelings, I have been trying to keep a connection to my pregnancy and my unborn child. I explore this with Heather when I say:

It's something to do with preserving the pregnancy. That somehow this is something that belongs to me...So this PhD is almost a hope and an end of this process. It is a bit of a shock to realise how much this is about my loss and my need to let go. I was going to say understand my loss but the understanding and the letting go, both those words are there. I sort of have a need to translate my loss into something. It's like something tangible which I didn't have before and that's what is so hard about having a miscarriage. For years I have felt as if I had flushed my baby down the toilet (B1: 6/190-252)

Over this five year period, I have come to believe that I have been gradually subsuming my grief into this research. Hopefully, I have found a creative way to make my voice heard and perhaps most importantly to create a memorial to my baby's brief existence and a testament to my sorrow. The poem ***Liminality***, reproduced just before the introduction to my thesis, is an attempt to get to the essence of these sentiments and express some of my emotions in words. It is the first time I have written a poem about my miscarriage for many years and it came to me just after I had written the poetic representation ***Giving Voice*** which is presented at the end of my Findings and Discussion Chapter.

By writing this research, I have found another way to integrate grief and loss into my life, which feels constructive. I am breaking my own taboos by allowing my hidden loss to come into a more public domain and my thesis has become '*a testament to my experience, which I didn't feel was heard*' (B1: 8: 269).

Shadow Child

In my mind there is this fantasy baby that almost sits inside me but running parallel to that is a shadow child (B1: 6/216-217).

This final theme ***Shadow Child***, is probably the most important in illustrating the impact of my own personal experience of miscarriage and for this reason I have saved it to last. Very early on after my miscarriage, I became aware of the presence of a fantasy baby in my life. This imaginary baby has a secret place tucked inside me. It will never grow or develop and will always be a part of me. I think of this internal presence as an insubstantial baby without a gender or a name. However, over the years since my miscarriage, I have gradually become aware of another manifestation of this baby whom I call my Shadow Child. My Shadow Child has been with me throughout the writing of my thesis and is very present in the research. In my Findings and Discussion Chapter, I explore through an extract from my Research Diary (3rd January 2012), how I view my Shadow Child in relationship to the theory of continuing bonds with the deceased (Klass et al., 1996). I discuss the difficulties of maintaining a relationship with a child who has never been born and yet, through the power of imagination, I appear to have found a way. My Shadow Child is a distinct presence from my fantasy baby and intriguingly in recent months, I have come to an important realisation that she is female. This is a new discovery because I have maintained for many years that my baby has no gender and no name. This is still true for my hidden fantasy baby but more and more I have found myself thinking of my Shadow Child as female. She continues to be an external presence that walks alongside me and grows and I feel she takes a very close interest in the progress of my research.

The story of my baby's blanket

Linked to this theme of my Shadow child is the story of my baby's blanket. I experience this story as emerging from one of the most profound and moving moments in my first bracketing interview. During the interview, I told Heather that when I first discovered I was pregnant, I went out and bought a blanket for the baby. After my miscarriage, I put this blanket in the top of the wardrobe and it sat there like a guilty secret. Very occasionally, I would allow myself an indulgent look but I never took it out of its wrappings. There was something very bitter sweet in allowing myself these snatched moments of grief. As I told this story to Heather, I was suddenly filled with emotion. It was at that moment, she offered me a gift; she suggested that I could wrap myself up in the blanket and this spoke to a really deep need inside me. I include the extract below:

Lois: *Yea but it feels like- and this might make me cry- it feels like a bit of a – I'm not very good at giving myself permission to cry. I don't think I am.*

Heather: *It's lovely for me in a way because for me the sense of a blanket is something you could be wrapped up in.*

Lois: *I've never done that before.*

Heather: *Yea, that's kind of what I feel I want to say. It's about wrapping you up in that blanket and saying actually all of these feelings I've had for all of these years it's okay. This matters and about giving yourself that...*

Lois: *Permission (B1: 21/755- 765).*

This was a very brief moment towards the end of the interview but from then on I was filled with a desire to go home, take the blanket and wrap it round me. The first thing I did

on arriving home was to rush upstairs to the wardrobe. I unwrapped the packaging and to my amazement inside were two baby blankets rather than the one I was expecting. I put the first blanket back carefully into the wardrobe and I have never looked at it since. This secret blanket symbolises for me my fantasy baby who remains hidden inside my body and whose blanket is tucked safely inside the wardrobe. I wrapped the second blanket around me and metaphorically it feels as if I have been wrapped in it ever since. It made me feel held; safe and secure enough to confront the horrors of my miscarriage again which I inevitably had to do if I was to undertake this research. As I look back now, I realise that this moment was the beginning of a further stage in understanding my grief and coming to terms with my miscarriage. This blanket now sits over the back of my chair as I write. It is an outward expression of my loss and represents the presence of my Shadow Child. I often wrap it round my shoulders and it brings me great comfort. This was a very profound experience. It marked the beginning of my PhD and also the beginning of a healing process that has continued throughout the progress of this research.

Keeping a reflexive research diary

From the very beginning, I have kept a diary in which I have chronicled my insights about the research process. Throughout this thesis, I have included extracts from my research diary as another way of making myself present in the research. Also, it has been essential to the audit trail necessary for trustworthy research and part of the transparent process that good qualitative research requires (Ahern, 1999; Etherington, 2004; Braun & Clarke, 2013). Therapeutically, it has been somewhere to record my darkest fears and secret hopes, even before it felt safe to share them with my supervisor. If I was experiencing writer's block, I wrote freely in my diary before attempting another stint of academic writing. For

all these reasons, keeping a reflexive research diary has been invaluable and a most precious and satisfying part of undertaking this research.

However, at this point, it is thought-provoking, to consider the similarities and differences between journaling reflexively and undertaking bracketing interviews. I have used both methods in a similar way to those suggested for reflexive journals by Ahern (1999) and Tufford and Newman (2012). For example, through writing reflexively and undertaking bracketing interviews, I have been able to clarify my assumptions around miscarriage and identify opinions that might have led to bias during my interviews and the analysis.

Through my discussions with Heather and by journaling, I have kept track of how my past feelings influence the present and how these have altered through the research process. I have monitored whether I have favoured a particular participant and noted surprises in my findings (Tufford & Newman, 2012). These insights have enabled me, when necessary, to go back and re-think my analysis and my procedures.

Yet, I think there is also substantial difference between the two approaches. I have written my reflexive diary continually throughout the research so it is a more intimate and constantly evolving expression of my reflexive process. Whereas, my bracketing interviews were facilitated at three major transitional phases in the research and thus could only reflect my feelings at these set points. Paley (1997) argues that reflexive bracketing is something that is best done by yourself as only the individual can understand their subjective experience. To a certain extent this has been the purpose of my research diary. Nonetheless, during my bracketing interviews, Heather helped me to evoke and stay with the deep emotions attached to my miscarriage in a way that I believe would have been impossible to do on my own. She helped me to access material at the edge of my awareness in a similar way to how I might use supervision for my counselling practice,

which is well documented in the literature (e.g. Dryden & Thorne, 1991; Creaner, 2013). Drew (2004), suggests that the role of the bracketing interviewer is to help a colleague “remain in touch with feeling” (p. 218). I believe that the success of this is reflected in the themes that emerged from my thematic analysis of my first bracketing interview and the depth of self-revelation that occurred in my subsequent interviews.

It is clear that bracketing interviews and reflexive journaling are complementary and utilising both has enabled me to be transparent about my own position in this research and to give my readers an insight into the core of my research process. I include below an extract from my research diary that illustrates how I have used journaling to explore my feelings about the benefits of taking part in a bracketing interview.

Research Diary 25th November 2010

I am feeling more unguarded, less defensive and more open to the endless possibilities for my research. I can approach my research with fewer fears, fewer assumptions, less need to validate my own experience and this is tremendously healing. Since my interview with Heather, I have less need to set aside assumptions and a greater ability to integrate all that I am experiencing, thoughts, feelings and conjectures into the work. Everything belongs and everything can find its place. The research grows round me. I become the research and the traditional view of bracketing in phenomenology feels rather paradoxical and a misnomer. If I replace the words “bracketing” with the word “embracing” I come nearer to the truth and nearer to the intimacy of the research process.

Yet most significantly, the perplexing issue of whether miscarriage is taboo came to my attention through dialogue with my supervisor and not through reflexive journaling or bracketing interviews. Therefore, it is also important to recognise the role of good

academic supervision in enhancing reflexivity. In my view, apart from a brief mention in Etherington (2004) and Finlay (2011), the necessity of an open and frank supervisory relationship for enhancing reflexivity is not much discussed in the literature.

Trip to Edinburgh May 2012

One of the most profound stories that my research diary contains is an account of my trip to Edinburgh for the British Association for Counselling and Psychotherapy (BACP) conference in May 2012. I have used the memories chronicled in my diary to recount this story as I feel it has become a very significant part of my reflexive process.

After I had a paper accepted at the BACP conference in 2012, I knew the agoraphobia I have experienced since my miscarriage would make travelling to Edinburgh a challenge. For many years, I have kept my difficulties with travel hidden even from my close friends so confiding this to my supervisor was painful. I did some intensive work with my therapist and armed with tiny anti-anxiety acupuncture needles in my ears, I did manage to travel with minimum stress, accompanied by my supervisor. This achievement alone is a triumph worth recording but whilst in Edinburgh I had a very special encounter.

A few weeks previously, out of the blue, an old friend got in touch because she had seen my name in the BACP conference abstract booklet. We had not seen each other for 18 years. She was also attending the conference and we agreed to meet. The following day she came to my paper ten minutes early and sat in the front row. It was then that I began to remember how she was one of my close friends who had comforted me during my miscarriage. Before I presented, she had time to tell me how impotent she had felt at the time and how much she knew it had affected me. During my paper, on the use of the bracketing interview in qualitative research, I told the story of my baby's blanket. At this

point I could see that my friend was in tears. I felt totally calm as if she was doing my crying for me. It was a genuinely cathartic experience and one that I will never fully understand. We discussed it later, and neither of us could quite believe that a quirk of fate or synchronicity had brought us together when I miscarried and then twenty years later at a conference where I was talking about miscarriage. This encounter continues to be both healing and unfathomable.

Conference presentations

Presenting papers at conferences has also been an important part of my reflexive process. Initially, I found presenting very difficult because I was fearful of public speaking. However, I have come to value these opportunities as a way of bringing the subject of miscarriage into a public arena. It was at a conference that I first told the story of my baby's blanket. Since then, I have shared recorded extracts from my second bracketing interview and read my poetic representation "*Giving voice*". When I take the floor at a conference, it feels for a moment as if I am liberated and granted permission to speak about the unspeakable. In these moments, I identify with the Ancient Mariner in Coleridge's poem and I am compelled to hold my audience with a 'glittering eye' and they 'cannot choose but hear'.

The challenges of reflexivity

I see the process of reflexivity as making me accountable for my decisions during the research and also as a valid way of having my experience of miscarriage recognised as a fundamental part of my research process. However, this approach to reflexivity can present the researcher with many challenges.

Macmillan (as cited in Finlay, 2002) argues that in attempting to show how a text is constructed, researchers are in affect weakening their argument as the reflexivity process

can then itself be deconstructed and the researcher is left spinning in what Finlay (2002, p. 542) describes as “infinite regress”. Certainly, I am aware of the dangers inherent in focusing too much on my own experience of miscarriage and how this may impact on the research. I sometimes feel like Banquo’s ghost, in *Macbeth*, holding up my mirror to self-reflection and declaiming “What will the line stretch out to th’ crack of doom” (Shakespeare, 1997, 4.1. 116). In this context, I can appreciate why some critics of the use of reflexivity in qualitative research argue that too much inward gazing may come across as self-indulgent and narcissistic (Etherington, 2004; Finlay & Gough, 2003). I am also conscious of the danger that in practising reflexivity, I might lose focus on my participants’ experience of miscarriage which needs to be the central focus of my research. Yet, this can feel difficult when my interpretation of another’s experience is so entwined with my own, and I agree with Finlay (2003) when she states, “hermeneutic revelation of the phenomenon and reflexive uncovering of the self are one” (p.118).

Perhaps one of the major challenges for a researcher using reflexivity lies in the fact that there is no clear method for how reflexivity should be approached and no well established guidelines to follow. In this sense, it is very dependent on the commitment and creativity of the researcher and demands high levels of self-awareness (Tufford & Newman, 2012). Yet, this level of scrutiny may leave the researcher feeling exposed and distressed. I know that sometimes I have battled with feelings of self-consciousness and an uncomfortable awareness that possibly, I am revealing too much and making myself vulnerable. Inevitably, this means I have had to make choices about what to include in this section, what to leave out (McLeod, 2011) and indeed when to stop holding up Banquo’s mirror. Yet I still believe that reflexivity should be embraced wholeheartedly and not just viewed

as additional “academic virtue” (Lynch, 2000, p. 26) or imbuing a project with added value (Etherington, 2004).

I am also aware that there are many ethical implications in practising reflexivity. I risk exploiting not only myself but my family, as they are mentioned in some of the extracts from my research diary and bracketing interviews included in this thesis. My husband and sons are aware that they are included here but I cannot offer them the same anonymity as my participants. It remains a continuing ethical dilemma to balance my own needs, the needs of my family and the demands of reflexivity for this research (Bond, 2004; Finlay, 2011).

However, despite these challenges, I remain committed to being a reflexive researcher. I believe that there is a liminal space, described by Etherington (2004) as being between objectivity and subjectivity, where through reflexivity, I can meet and forge a relationship with my readers because without them I have no one to listen to this story.

Summary

Finlay (2002, p. 544) describes “coming out” through being reflexive as a “political act” and suggests that when it is done well, “voicing the unspoken, can empower both researcher and participant”. This has certainly been my intention in this chapter and a wider aim throughout my whole research. Indeed, the need to voice the unspoken took on a new meaning when I had to revise my findings and admit that my participants were not talking about miscarriage as taboo during their interviews. This took courage but I hope will ultimately give my research a genuineness and truthfulness that it might have lacked had I decided not to reveal this dilemma.

Through the process of reflexivity, I feel that I have confronted my struggle with the tension between my personal experience of miscarriage and the more public aspect of me

as a researcher. By exploring the themes that emerged from my first bracketing interview, I have been candid about my own perceptions of miscarriage and its psychological consequences. It has been emotionally demanding to reveal I have agoraphobia and exposing to disclose the presence of my Shadow Child. Nonetheless, through 'time travelling,' I have arrived at a richer understanding of my own miscarriage and a deeper awareness of the beliefs and values I inevitably bring to my research. I believe that practising reflexivity has made me more open to, both my own, and my participants' experience. This has resulted in an authentic analysis and interpretation of the experience of miscarriage which, ultimately, is the main aim of this research.

There are also personal benefits. It is possible, that some of my guilt and sorrow has been allayed by engaging with reflexivity. Significantly, my three bracketing interviews, my trip to Edinburgh and my conference papers have been vital to my personal growth during the progress of my research. They are now woven into the fabric of who I am as researcher and as a woman who experienced miscarriage many years ago. I have never chosen to use the image of giving birth as an analogy for the creation of this research, even though it has sometimes been suggested to me. I do not feel that my PhD has become a substitute for my baby; that would be too simplistic. However, I do feel that my research has grown in parallel with my Shadow Child. When I first began this research she was nearly eighteen years old and getting ready to leave home. Now she is twenty two and as this thesis nears its completion, I sense with sorrow, and at the same time pride, that she will be leaving me very soon.

CHAPTER 3: LITERATURE REVIEW

“Although I have not discovered” how perinatal loss is” or “how perinatal loss can be mediated,” I have discovered how “ perinatal loss can be” and what has mediated perinatal loss for some.” And that has profound worth to me” (Malacrida, 1998, p.135).

This chapter is a historical/narrative review (McLeod, 2013, p. 68) in which I tell the story of how the research on miscarriage has been constructed during the past fifty years. Here, I aim to evaluate and give an overview of the literature on miscarriage that has informed my discussion in this thesis. Since the 1960s a substantial body of literature on miscarriage has been written; much of this based on quantitative research and written for and by the medical profession. However, in the last thirty years there has been a significant amount of qualitative research produced in which women have described and reflected on their experience of miscarriage. A considerable volume of this literature has been written by women who have experienced miscarriage themselves and who express a desire to bring the subject of miscarriage more into the public awareness. I have focused, where possible, on reviewing research into women’s early experience of miscarriage, defined by the National Institute for Health and Clinical Excellence (NICE, 2012) as the loss of a pregnancy up to twelve weeks of gestation, since this is the main emphasis of my own research. Yet, this has not always been possible as many studies that include early miscarriage also incorporate the whole spectrum of reproductive loss from early miscarriage to neonatal death. There is very little research undertaken specifically on women’s experience of miscarriage many years after the event.

My review begins by looking at the difficulties around defining miscarriage. I explore the controversies in the choice of terminology when writing about miscarriage and I have provided a glossary of terms at the beginning of this thesis. I then go on to set the research on miscarriage in its historical and cultural context. I give an overview of pre-twentieth century attitudes to miscarriage and explore how these began to change from the beginning of the twentieth century up to the 1940s. From there, I explore the growth of research into miscarriage through the 1960s and 1970s. I examine in more detail the different ways in which research advanced and developed throughout the 1980s and 1990s, the time in which the women in my study were having their miscarriages.

I then move on to reviewing the current literature that concentrates on the psychological consequences of miscarriage for women with an emphasis on depression, anxiety and trauma. Here the focus is often on the best early interventions for preventing psychological distress after miscarriage. This is followed by an exploration of the motivations of women to go on to have another child after a miscarriage and I review the literature on the psychological impact of miscarriage on subsequent pregnancies. Next, I examine the literature which explores why some women feel a sense of isolation after miscarriage and the role of family and friends in providing social support. Then, I look at the claim that Western society lack rituals to sustain women in coming to terms with the experience of miscarriage.

Next, I survey and evaluate the literature concerned with the attitudes of health care professionals to miscarriage. I consider how often there are incongruities and discrepancies between the perceptions of women experiencing miscarriage and the opinions of health professionals towards their treatment during and after miscarriage. I discuss the difficulties

facing healthcare professionals working with women who miscarry and how approaches and attitudes might be changed.

After this, I review the literature on miscarriage and bereavement and consider whether bereavement theory can illuminate our understanding of the long term impact of miscarriage for some women. I highlight the limited number of phenomenological studies on miscarriage and finally consider miscarriage from a feminist perspective. Here, I consider the dilemmas and controversies in the feminist literature on the personhood of the fetus and reflect on lesbian women's experience of miscarriage.

This review can inevitably provide only a brief outline of the research available in this field. Nevertheless, I hope that it will present the reader with a broad and illuminating account of how research pertaining to miscarriage has grown and developed from the 1960s to the present day.

Defining miscarriage

Defining the term miscarriage can be problematical because as Lovell (1997, p. 30) argues a definition of miscarriage cannot be based on fact because miscarriage is a “socially constructed” concept. In the UK a miscarriage is defined as the loss of a pregnancy up to 24 weeks gestation with The Royal College of Nursing (RCOG, 2006) and the National Institute for Health and Clinical Guidance (NICE, 2012) defining early pregnancy loss as a confirmed empty sac or sac with fetus with no fetal heart activity at less than 12 weeks gestation (Brier, 2008). However, the period of gestation that defines a miscarriage differs internationally. The World Health Organisation (WHO, 2001) defines miscarriage as the premature expulsion of an embryo or fetus from the uterus up to 23 weeks of pregnancy and weighing up to 500 grams. In Australia miscarriage is defined as “an unintended loss or interruption of the pregnancy in the first 20 weeks of gestation” (Frost & Condon, 1996)

and there is a legal requirement in the state of Victoria, Australia, that all births/deaths over 20 weeks' gestation be registered under the Births, Deaths, and Marriages Registration Act, 1996 (McLean & Flynn, 2012). Brier (2008), in his comprehensive review of the literature around grief following miscarriage, stipulates that although clinicians would consider pregnancies that spontaneously terminate before the 14th – 16th week as miscarriages, the time frames used in research studies have ranged normally from up to 20 weeks gestation to as much as 27 weeks gestation.

Inevitably, the definition of what constitute a miscarriage is linked to a definition of stillbirth but it can be hard to differentiate a late miscarriage from a stillbirth because of different interpretations regarding when a fetus is viable. In the United Kingdom in 1980 a stillbirth was defined as a child being born dead after the 28th week of pregnancy. However, due to medical advances in the treatment of neonates, under the Stillbirth Definition Act 1992, this was brought forward to 24 weeks (Lovell, 1997, p. 30). In some European countries, in Australia and New Zealand and many states in the USA, fetal death occurring after 20 weeks of gestation is termed as stillbirth (Adolfsson, 2004; Silver et al., 2007). Thus, the definition of when a fetus is viable is constantly changing.

The frequency rates for miscarriage have also changed over time because pregnancies can now be confirmed only a few days after conception with accurate home testing pregnancy kits. There is also increased use of ultra sound to confirm early pregnancy and miscarriages. No doubt, as medical advances continue and babies born prematurely survive at earlier ages, definitions will continue to change and develop. However, there is general agreement in the literature that miscarriage is a common event with up to 20% - 45% of all conceptions resulting in miscarriage and 80% of these occurring in the first 12 weeks (Cote- Arsenault & Morrison Breedy, 2001; Gerber-Epstein, Leichtentritt, & Benyamini,

2009; NICE, 2012). However, these statistics do not necessarily take into account miscarriages that go unreported (Lovell, 2001).

There are many different factors which cause miscarriage ranging from problems with the mother to problems with the fetus such as chromosomal abnormalities. However, the cause of the majority of miscarriages often goes unexplained (Christiansen, 1996).

Language and miscarriage

Spelling “foetus” or “fetus”?

Throughout this thesis, I will use the spelling “fetus” as opposed to “foetus” which, until recently, has been the standard British spelling in both technical and non-technical use. However, in technical usage, according to the Oxford English Dictionary, “fetus” is now the standard spelling throughout the English-speaking world (“Fetus”, 2015).

My choice of terminology

Finding a language to describe effectively the experience of miscarriage can be difficult. Throughout this research I have struggled to find a language, that in the words of Jonas-Simpson and McMahon (2005) importantly, “honors (sic) and affirms a baby who dies prior to birth, consistent with the parents’ meaning of this baby” (p. 130). Ultimately, I have decided to predominantly use the words spoken by the women in my research during their interviews. They consistently tell me that they lost a “baby” rather than use the word “fetus” or “embryo”. Therefore, I have chosen mainly to use the language that I feel my participants would be most comfortable reading. Nevertheless, I recognise that the language we use is often determined by the times in which we live. The women in my study had their miscarriages in the 1980s and 1990s and yet are talking to me about them in the 21st century and this may have some influence on the language they use. I also

recognise and respect the view that not all women who have experienced miscarriage or abortion will be comfortable with the language of “lost babies” and may prefer a more clinical language (Wong, Crawford, Gask & Grinyer, 2003). I will return to the debates around the clinical use of language to describe miscarriage a little later in this section.

As well as the terms “miscarriage,” “stillbirth” and “abortion” to describe my participants experiences, I use the expressions “reproductive loss”, “pregnancy loss” and “perinatal loss” when I want to refer to all losses during pregnancy or prior to birth, regardless of whether they might be medically termed abortion, miscarriage or stillbirth. Moreover, I have also used the word “fetus” and “products of conception” occasionally in my writing, particularly when referring to literature that uses these terms.

I am aware that I occasionally use the words “baby” and “lost baby” when I want to shock the reader a little and bring home the horror of miscarriage; yet at the same time I am very conscious of how my terminology may be perceived. Layne (2003) describes how women in pregnancy-loss support groups even dislike the use of the word “miscarriage” because it implies that a woman is unable to carry her baby safely in her womb. Therefore, it is clear that there is still work needed to find an acceptable language to talk about the loss of babies before birth that does not reinforce the stigma and guilt that some women feel after miscarriage.

Controversies around the use of clinical language

The clinical language used by health professionals to describe miscarriage is also controversial and may have potential for unintentional harm (Allen & Marks, 1993; Chalmers, 1992; Gesler, 1999; Jonas-Simpson & McMahon, 2005; Hutchon & Cooper, 1998; Mitchell & Bunkers, 2003; Moscrop, 2014).

The history of how clinical language applicable to early pregnancy loss has developed and changed throughout the twentieth century is described in detail by Moscrop (2014). He argues that the terms “miscarriage” and “abortion” had been used by doctors synonymously for many centuries. However, when Moscrop undertook a hand-search of indexed references to “miscarriage,” “abortion,” “spontaneous abortion” and “early pregnancy loss” in the *Lancet*, *BMJ* and *British Journal of Obstetrics and Gynaecology* between the years 1960 and 2010, along with ten seminal textbooks on obstetrics, gynaecology and midwifery 1917 to 1985, he discovered a subtle change in the use of this terminology over the last fifty years. Up to the 1970s the terms “spontaneous abortion” or “abortion”, were used to signify early pregnancy loss. Then in the 1980s Moscrop found there was an important shift to using the terms “miscarriage” and “spontaneous abortion” synonymously. By the 1990s, the term “miscarriage” had generally become the accepted term in medical literature.

Moscrop attributes this important linguistic movement partly to the 1967 Abortion Act when it was made legal to end an unwanted pregnancy under certain conditions up to 28 weeks gestation. Thus, it became necessary to differentiate between the spontaneous loss of a wanted pregnancy as in “miscarriage” and the elective loss of a pregnancy as in “abortion”. In the 1990s, because of technical advances in keeping premature neonates alive, the Human Fertilisation and Embryology Act was passed limiting abortion up to 24 weeks except for some narrow restrictions. Here the Act uses both the terms “termination” and “abortion”. However, it is not my remit here to get into the complex intricacies of the legal and ethical implications of this Act particularly when the writers Brazier and Cave (2011) point out that whilst attempting to accomplish this feat “the reader may be advised to apply a cold flannel to his or her head” (p. 396).

Furthermore, the development of ultra- sound technology in the 1980s made it much easier for doctors to confirm pregnancy loss very early. When I was pregnant with my sons in the 1980s I was not offered routine ultra-sound but in 1991 when I had my miscarriage it was confirmed by an ultrasound scan and this was my first experience of such a procedure. Previous to this technological advance, it had not always been possible to distinguish medically between a natural miscarriage and an illegally induced abortion and because of the criminal implications for women, doctors tended to avoid making these distinctions when a woman presented with bleeding in early pregnancy. However, this ability to make a clear and early diagnosis led to a growing awareness among the medical profession that some women found the use of the medical term “spontaneous abortion” offensive and preferred the term “miscarriage” to be used. This was confirmed by a Miscarriage Association, survey in 1985 that showed, 85% of women who miscarried felt strongly that the word “abortion” should be changed to “miscarriage” (Moscrop, 2014, p. 101). Now in the 21st century, there is a plea for unexpected pregnancy loss, diagnosed by ultra sound scan, to be termed “silent miscarriage” (Peel & Cain, 2012), so the deliberation around terminology continues.

Shift in medical terminology during the 1980s

Importantly, the 1980s was also a time of growth in the feminist movement. There was an increasing demand for a more person-centred approach to health care for women along with a growing acknowledgment of the emotional impact of miscarriage (Oakley, McPherson, & Roberts, 1984). This led inevitably to a demand for a less clinical vocabulary. In 1985, Professor Richard Beard wrote a letter to the Lancet urging doctors and health professional to use the more acceptable term “miscarriage” in their professional dealings with women patients. However, there was little recognition at this time of the

effect of the word “abortion” on women and how this might also impact on their sensitivities. Moscrop (2014) argues that it was this division between the terms “abortion” and “miscarriage” in the 1980s that has led to the ongoing struggles today to find a collective vocabulary that covers the wide range of diverse experience of pregnancy loss. I discuss this in more detail later in this review, when I consider the literature on miscarriage from a feminist perspective.

It is salutary that Moscrop (2014) ends his article by stating that in his opinion this shift in medical terminology did not necessarily signal a more empathic or women-centred approach to miscarriage by the medical profession. Certainly, throughout this review, I examine research in which women express some dissatisfaction with how they were treated during and after miscarriage by the medical profession. They comment on the insensitive language sometimes used during their medical treatment, in particular by doctors. Thus, sadly some of these concerns still appear ongoing and are reflected in the current literature (e.g. McLean & Flynn, 2012; Murphy & Merrell, 2009) which I discuss in more detail later.

In writing this thesis, I have become aware of how important it is to choose the right words to capture the quintessence of the experience of miscarriage. Paradoxically, this struggle may reinforce the silence around miscarriage. It is interesting to note in this context that I have chosen to call my poetic representation “*Giving Voice*.” I think this serves to illustrate the tension between the difficulties of finding the right words and the need to break the silences around miscarriage. At the same time it highlights for me the inadequacies of words. There is also a link here to the importance of finding the right terminology in the feminist and theological debates on miscarriage which I explore in more detail later. Personally, I feel that the experience of miscarriage can render words

inadequate and I have often talked about this in my own therapy when reflecting on the difficulties in writing my thesis.

Pre-twentieth century attitudes to miscarriage

Midwifery in the seventeenth century

Although there is little documented historically before the twentieth century on the impact of miscarriage, there is writing on women's experience of midwifery written from the midwives' point of view. One of these is a fascinating notebook written by the Frisian midwife Catherine Schrader (1656-1746) translated and edited by Marland, Kloosterman and van Lieburg (1987). Schrader gives chronological descriptions of all her deliveries over a period of 52 years at the turn of the 18th century. This was at a time when midwifery was being seen as no longer the sole preserve of women and the male dominated profession of obstetrics and gynaecology was starting to become established (Marland et al., 1987). Significantly, out of all the hundreds of detailed deliveries Schrader describes, there is very little mention of miscarriage in her notebooks. There is no recorded data on the duration of each pregnancy but there is mention of "small fruit of three months" (p. 36) in 25 cases which presumably refers to miscarriage. This is a low percentage out of more than 600 hundred deliveries and would seem to show that the majority of women did not ask for a midwife during a miscarriage. In 27 cases she mentions "fruit of 4, 5 or 6 months" but as Kloosterman (1987) argues, Schrader did not think much of these miscarriages "as none were considered significant enough to be included in her memoirs" (p. 36). Of course, I cannot presume from Schrader's attitude that there was not significant distress and suffering for some women at this time who miscarried but it suggests that generally miscarriage was considered insignificant, at least by midwives.

Miscarriage in eighteenth century England

During the eighteenth century in England there was a growing preoccupation with abortion as a criminal act and this was linked to a rising concern in society about the immorality of some women and their engaging in sex outside of marriage. Therefore, women would often hide the fact that they had a miscarriage in case they were accused of intentionally murdering their unborn child and similarly some women would cover up induced abortion by claiming that they had experienced a miscarriage. These cases would often come to court and relied very much on unreliable medical evidence from doctors on the viability of the child or whether it had been born alive which was difficult to establish at that time. If a woman could argue that she had only lost blood or tissue that bore no resemblance to a child then it was often considered inconsequential and of no more importance than menstruation. This would suggest that early miscarriage was not regarded as a noteworthy event (Jackson, 1996).

Throughout history, for most women, childbirth was painful and dangerous. It is shocking that in the nineteenth century women were 40 times more likely to die in childbirth than today (Chamberlain, 2010). Therefore, because of this high death rate, miscarriage may have been viewed by society as a blessing rather than as a sorrow and not always perceived as a particularly significant event. It is possible that miscarriage signalled one less pregnancy and birth to endure, particularly among the poor, who lacked knowledge about contraception (Chamberlain, 2010; Letherby, 1993; Oakley et al., 1984). Chamberlain suggests that most women did not consider it either immoral or illegal to abort a baby until it was felt moving, sometime between 16 -18 weeks gestation, at which time it was considered alive or to fail to revive a sickly baby after birth. Pointedly, she remarks:

“With infant mortality so high in the nineteenth and early twentieth century, few working -class women could afford to feel sentimental about a child who, even if born, might not survive anyway” (p. 106).

However, Sha (1990) argues in her book on customs and rituals of infertility and miscarriage that it is a misconception to argue that historically women did not mourn miscarriage deeply. She quotes from a book published in 1838 written for mothers on aspects of child rearing including miscarriage:

“The death of a babe, creates no common sorrow. Even the burial of one that has never breathed brings a keen pang to a parents’ heart...The scales in which a mother weighs her treasures, are not the same on which the man of the world weighs his silver and gold. A mothers’ grief is often most poignant for the youngest and faintest blossom” (p. 72).

She suggests that miscarriage may have been perceived as a non- event in previous centuries because women hid their pregnancies out of modesty and thus only successful births were announced. Therefore, I would suggest that attitudes to miscarriage have always been complex.

Miscarriage: the historical and cultural context from 1940 to 1990

Attitudes towards miscarriage begin to change

From the 1940s onwards miscarriage became less hidden. Articles about miscarriage first began to appear in women’s popular magazines from the 1940s onwards. However, they all, “assumed that miscarriage represented the loss of wanted children to married couples” (Reagan, 2003, p. 360). These magazines encouraged women to believe that miscarriage was often a blessing in disguise, in that a miscarriage usually indicated some form of fetal

abnormality but by taking an active medical approach all women could eventually have babies. By the 1950s, there was also a belief among the medical profession that women's anxieties caused miscarriages and that a competent doctor could prevent this. A range of treatments were offered from surgery to treat an incompetent cervix to vitamins and psychotherapy (Reagan, 2003).

Cecil (1996) found in her study of elderly women's recollections of pregnancy loss during the 1940s and 50s that:

“Their memories were made more poignant by the awareness that their loss had occurred at a time when the nature of what was lost was considered to be of little or no value” (p. 192).

This implies for me that when women are given permission for their voices to be heard about their experiences of reproductive loss then they do express feelings of loss and sadness as well as a sense of disenfranchisement from society. I would tentatively suggest that this has probably been the case throughout history.

Miscarriage in the 1960s

Significantly, it is only from the 1960s that the experience of miscarriage has been acknowledged in the literature as possibly having a psychological and emotional impact on women and their families, and that this reaction was something worthy of academic research. It is salutary to note that even then it came about in a serendipitous manner. Fifty years ago, Cain, Erickson, Fast and Vaughan (1964) undertook a clinical study into children under psychiatric care noting their disturbed reaction to their mothers' miscarriages and this study has become generally acknowledged as one of the first to recognise the psychological impact of miscarriage on women and their families (Klier,

Geller, & Ritsher, 2002; Wojnar, Swanson, & Adolfsson, 2011). In this respect, I believe it is probably not insignificant that the three co-researchers in the team led by Albert Cain in 1964 at the University of Michigan were women and I surmise that this was probably unusual at the time in American Universities.

At the time of writing, they commented on the fact that there was a dearth of research into the psychological impact of miscarriage on women considering its high incidence. Meaningfully, they noted that in the contemporary psychiatric literature there were many references to psychiatric disorders being the cause of miscarriage but very little investigation into the psychological consequences of miscarriage for women and their families. This accords with Oakley's (1980) view that:

“Infertility, habitual abortion and premature delivery have all been analysed as psychosomatic defences as a result of hostile identification with a woman's mother, as a rejection of the feminine role, as failure to achieve feminine maturity and as evidence of disturbed sexual relationships” (p. 48).

As a woman living in the 21st century this attitude seems unbelievable, yet it is within my lifetime. There are clearly many ways to interpret this focus on the causes of miscarriage from a feminine cultural perspective but I cannot help but hear a hollow ring of laughter echoing down through history, particularly from working class women suffering in childbirth or with the consequences of having yet another mouth to feed, if they were told they could psychologically affect the outcome of an unwanted pregnancy.

What is particularly striking in this study by Cain et al. (1964) is how far these results from the 1960s are in accord with the findings in the literature from the early 1990s onwards, for example those of Frost and Condon, (1996) and Letherby (1993). Cain et al.

remark on the possible trauma to women caused by the exposure to blood and fetal tissues during miscarriage. They note the feelings of guilt and loss experienced by many women after miscarriage, are dependent on the meaning they attribute to the pregnancy and comment on how the handling of the miscarriage by the medical profession may contribute to an adverse psychological reaction. Interestingly, they also consider men's response to miscarriage, an area described by Letherby (1993) as lacking research. The article ends with the hope that it will stimulate more interest in how women react to miscarriage and how they and their families can be supported in their ability to cope. I believe the final sentence still has resonance for researchers today:

“We would only insist now, quite simply, that miscarriages do not occur in the uterus, but in a woman; and that miscarriages do not occur solely in a woman but in a family” (p. 65).

Following on from this study, a body of literature looking at the impact of pregnancy loss on women slowly began to grow (Peppers & Knapp, 1980).

In 1969 Simon, Rothman, Goff and Spenturia compared related psychological factors in a group of women who had therapeutic abortion (an abortion which is induced to save the life or health - physical or mental - of a pregnant woman) with those who had spontaneous abortion (miscarriage). However, a difficulty with this study is that two thirds of the women interviewed already had a diagnosis of psychiatric illness before their therapeutic abortion. Nevertheless, they found that there was little psychological distress in those who had a spontaneous abortion compared to the women who had therapeutic abortions. They also commented that “spontaneous abortion itself may represent an alternative way of dealing with and acting out sadomasochistic impulses and conflicts around feminine

biological roles” (p. 805). This confirms the views of Oakley (1980) that doctors often blamed women’s psychological distress for causing miscarriage during this period.

In an adjunct to this article in the same journal, Dr. George Wolff criticises Simon et al. (1969) for trying to compare two dissimilar groups of patients. He argues that those having therapeutic abortions were choosing to destroy a potentially healthy fetus, whilst those having spontaneous abortions usually had warning signs that something was going wrong and could therefore be reassured that they were probably losing a fetus that was damaged in some way. Thus, these women could eventually come to terms with the desirability of their miscarriage. Simon et al., in a further adjunct to this debate, refute this conclusion and argue that from a psychological point of view:

“Sometimes the most important thing for the women is not actually how the pregnancy was lost but the fact that the pregnancy was lost, and what the meaning of the pregnancy was to her in the first place” (p. 808).

This attitude more closely resonates with the views of pro-choice, feminist writers 20 years later when they argue that the extent and meaning of the relationship with the unborn baby is determined by the mother herself (Letherby, 1993; Layne, 2003; Parsons, 2010).

Miscarriage in the 1970s

Throughout the 1970s, there appeared to be a growing recognition in the literature that late miscarriage was a bereavement with the associated grieving process after the loss. Initially, the grief reaction after stillbirth or late miscarriage was studied. Wolff, Nielson and Schiller (1970) conducted a study of 50 women who had lost a baby at or shortly after birth. Forty of these women were followed up and interviewed for three years to determine their emotional reaction after the loss. All were said to have responded to their stillbirth

with “a typical grief reaction” (p. 73). A typical reaction is not defined but I presume it means that these women did not appear to develop any psychiatric difficulties and their grief was considered to be normal and appropriate for their loss. This is in contrast to a study by Corney and Horton (1974) who describe the case study of a woman who appears to have experienced what the writers call “pathological grief” (p. 825) after her miscarriage. They define normal grief, rather vaguely, as “emotional suffering after the death of a loved one” (p. 825) and suggest that after a miscarriage the period of grief is usually of a relatively short duration resolving within a period of several weeks to months. The writers acknowledge that there is often some psychological distress in women after a miscarriage and cite research by Freundt (1964) where 15% of women studied, reported some psychological effects following their miscarriage. However, they bluntly state: “For most these feelings were transient, lasting for only a few days to a week” (p. 825). I was so shocked by these statistics, I initially thought I had misunderstood them because I could not believe that this was so readily accepted or the significance of the loss after a miscarriage so summarily dismissed.

In this context, it is not surprising they consider a woman still grieving for her miscarriage several months later as suffering from “delayed and distorted grief” (p. 825). This woman underwent brief psychotherapy where she grieved her loss and appeared to recover well, prompting Corney and Horton (1974) to speculate that perhaps pathological grief after miscarriage is the same as that after any death. At the end of this research, there was still conjecture around why miscarriage may cause unresolved grief and if there were psychological reasons for the miscarriage such as an ambivalent attitude to the pregnancy. Nevertheless, there does appear to be a growing recognition in the literature of this period that stillbirth and certainly late miscarriage cause grief responses in some women.

Miscarriage in the 1980s

Remarkably, it was only from the beginning of the 1980s that miscarriage began to be truly recognised as a source of bereavement (Frost, Bradley, Levitas, Smith & Garcia, 2007) and from the early 1980s the interest in studying maternal grief reactions after reproductive loss continued to develop. One of the most significant pieces of research in this period was undertaken by Peppers and Knapp (1980). Their study focused on whether there were differences in grief reactions between mothers that had experienced miscarriage, stillbirth and the loss of a neonate. For this study 65 women were interviewed and completed a questionnaire which included responses to a grief scale developed by Kennel, Slyter and Klaus in 1970. The period of their loss ranged from six months to thirty six years and the average age of the women was 25 years. Controversially, compared to research in the 1970s, they found that “the reaction to a loss appears to be as great in the case of early miscarriage or stillbirth as it is in the loss of a neonate” (p. 157). This data led to speculation that parental attachment to pregnancy may occur very early on and that the closeness of the relationship is not dependent on the length of time invested in it.

Significantly for my study, during the 1980s Rosenblatt and Burns (1986) were the first to research into the long-term effect of perinatal loss on parents. Here they suggested that it might have a lasting impact for many years after the event which has implications for my own research into the long term effects on women of miscarriage. I discuss this research later in this review, when I explore in more detail retrospective studies on the experience of reproductive loss.

Miscarriage as a crisis needing medical intervention

During the 1980s pregnancy and childbirth were becoming more medicalised and miscarriage was often perceived as a medical crisis (Layne, 2003; Letherby, 1993; Oakley, 1980). During this time, although medical advances had led to greater reproductive control for women through readily available contraception and more access to abortion, there was also a greater reliance on technology and hospitals for safer births along with monitoring of pregnancy through ultra sound scans (Peel & Cain, 2012). Paradoxically, although this might have led to a greater awareness of miscarriage and its statistical frequency (Letherby, 1993), there was also a growing desire for a more women centred approach to childbirth with less medical and technological interference. This was made manifest during the early 1980s which saw the lengthy Savage inquiry (Savage, 1986). The arguments here centred on who controls childbirth, the powerful obstetricians, who were mainly men or whether women should be given a greater say in the management of their own pregnancies and more individual care during labour. This was the practice of Wendy Savage, a controversial and much maligned female obstetrician, who was accused in 1984 of malpractice and later exonerated after a lengthy legal battle for offering her patients this more personalised approach. There was also a growing acceptance that some women experienced psychological distress after miscarriage and research began into appropriate psychological interventions to support them as I discuss below.

Grief scales

In this climate of a growing recognition that miscarriage had psychological consequences for some women and that it might be experienced as a bereavement came the development of the perinatal grief scale by Toedeter, Lasker and Alhadeff (1988). This was in response to a demand within Psychology, Sociology and particularly in the nursing field for more

systematic and better designed research into outcome measures (Toedter, Lasker, & Janssen, 2001). Thus, the peri-natal grief scale (PGS) was developed to assess the factors which might affect the resolution of grief following spontaneous abortion, fetal or neonatal death, or ectopic pregnancy. The factors measured were the overall physical health of the mother, the gestational age at the time of the loss, the quality of the marital relationship and the state of a woman's mental health before the loss. Accordingly, it was hoped that using these measurement would help doctors predict which women might be vulnerable to psychological distress after a reproductive loss in order to introduce appropriate interventions.

Toedter et al. (2001) examined 22 studies from four countries that used the PGS with a total of 2485 participants and found evidence that it had very high internal consistency reliability. They suggest that although it would be useful to have more diverse samples from non- European countries and to compare samples from different cultures, it is considered a valuable measure in both clinical practice and research. This PGS still continues to be used internationally in many studies of pregnancy loss.

I believe that the variables causing grief after perinatal loss may be very individual and difficult to measure on a scale. In this study, no account seems to be taken of whether a woman has experienced previous reproductive loss, which is found by Adolfsson (2010) and Klier et al. (2002) to have an impact on a woman's level of distress after miscarriage. Likewise, a woman's attachment to the pregnancy should also be considered, which is documented in the literature for example by Letherby (1993) and Parsons (2010), although this might be problematic to quantify. However, the development of this PGS does represent progress in acknowledging that women might experience grief after reproductive loss.

Miscarriage and nursing studies

Kristen Swansen-Kauffman published one of the first descriptive phenomenological studies of miscarriage in 1986 (Wojnar et al., 2011), researching into the most effective interventions and management strategies for women who have experienced miscarriage. One of the main conclusions from this project was that a woman's feeling about miscarriage "could be understood only in the context of what being pregnant and having a miscarriage meant to her" (Swansen, 1999, p. 339). This appears to be an innovative finding as it is stressing the importance of the individual experience rather than attempting a more generalised approach through the development of grief scales described above.

Swansen's subsequent research was a phenomenological study of 20 women with the specific aims of attempting to describe the human experience of miscarriage and to describe the meaning of caring as perceived by women who miscarried. Two models were developed from this study, the Meaning of Miscarriage Model and the Caring Model (Swansen- Kauffman, 1986; Swansen, 1999). The meaning of miscarriage model themed six common challenges faced by the women she had interviewed: i) coming to know, ii) losing and gaining, iii) sharing the loss, iv) going public, v) getting through and vi) trying again. These challenges are similar to those reported by the participants in my own study. Swansen (1999) described this model as a useful framework for predicting what might be a woman's response to miscarriage. Thus, women could be cared for more effectively through early intervention and any psychological disturbance reduced. Subsequently, there have been further qualitative studies researching into supportive intervention for women after miscarriage that have used the Meaning of Miscarriage Model as their theoretical base (e.g. Adolfsson, Bertero & Larsson, 2006; Wojnar et al., 2011).

I feel a certain apathy towards research that seeks to create models from women's attitudes to miscarriage, as in my view it negates the individual experience, and the purpose of phenomenological research. However, I can understand how this was a positive step and of its time. Swanson was innovatively combining qualitative and quantitative research methods in a medical climate where most research was quantitative with a focus on measuring and outcomes. It was an improvement to have a framework that validated women's experiences of miscarriage and raised awareness in health professional of the challenges faced by women undergoing miscarriage. Also, there seemed to be a false perception, however well meaning, that if the levels of grief a woman might experience after a miscarriage could be predicted and suitable interventions put in place to mitigate this grief, then miscarriage could be tidied up, perhaps in an attempt to make it more acceptable for researchers and the medical profession.

Swanson's findings in 1986 culminated in the research by Stirtzinger and Robinson (1989) where they examined the psychological effects on women of "spontaneous abortion". I am deducing they are writing here about late miscarriage or what might be termed now as stillbirth, although this is not particularly clear from the terminology used in the article. Significantly, they suggest that after a "spontaneous abortion" or late miscarriage, women may experience a similar grief reaction to that felt by women who lose a baby after birth and conclude that these feelings are normal and not a pathological reaction, which is in agreement with the earlier findings of Peppers and Knapp (1980). They go on to suggest how health professionals might mitigate these feelings of grief through acknowledging the extent of the loss and by providing women with clear cut explanations for what happened in order to minimise feelings of guilt and self-blame.

It is difficult to accept, from a twenty-first century perspective, that late miscarriage or stillbirth was not always viewed as a loss resulting in grief for some women even in the 1980s. However, these studies do mark progress in the understanding of the psychological distress and bereavement caused by reproductive loss and there is a desire to understand and offer interventions to support women. In this respect research by Leppart and Pahlka (1984) is influential because it studied the grieving characteristics of women after late miscarriage and recognised counselling as an appropriate intervention. Here counselling sessions were offered to women twice in a 15 month period after their miscarriages. They found that all of the 22 women in the study were suffering from severe emotional reactions and grief and concluded that counselling should be offered as part of obstetric care after late miscarriage which feels like progress. Significantly, there are still current debates thirty years later, about whether counselling is a suitable intervention for women experiencing psychological distress after miscarriage (e.g. Murphy, Lipp & Powles, 2012), and I return to this discussion further on in this review.

Women's voices in the 1980s.

Thus, the 1980s saw growing understanding of the nature of grief and the development of bereavement theory which I discuss later in this review. Three major strands of research were discernible by the end of the 1980s on miscarriage. The first two recognised miscarriage as having psychological consequences for some women and miscarriage was being acknowledged as bereavement. Emphasis was then placed on looking for interventions that could minimise these psychological effects. It was hoped that by screening women for psychological problems those most at risk could be helped more effectively.

The third strand was being written by female academics who themselves had experienced miscarriage. In 1984 Ann Oakley, Ann McPherson and Helen Roberts wrote a sociological book on miscarriage which is described in their introduction as “the first British book on the subject” (p. 2). A revised edition was published in 1990. They expressed astonishment at how little there was written on women’s experience of miscarriage and in particular on their emotional reactions, a sentiment that continues to be expressed in much of the literature up to the present day. For the purpose of the book, they sent out questionnaires to women asking them to recount their miscarriage experience, making this one of the earliest studies in which the voices of women were central. These voices were interwoven between information on the causes of miscarriage, its medical treatment, the attitudes of medical professionals and finally advice on facing the future after a miscarriage. Revealingly, a scan of the reference section for the book shows that the majority of the literature at this time relates to the causes and treatment of miscarriage from a medical perspective and there are only a handful of articles that consider the psychological consequences of miscarriage on women.

A few years later Hey et al. (1989) produced a very similar book “Hidden Losses” now in its second edition (1995). Again, this was a book based on the first- hand accounts of women who had miscarried and their stories are told concurrently with information on miscarriage. The aim of the book was to break the silence around miscarriage and to have it recognised as bereavement. It includes a seminal chapter, written by Hey that explores miscarriage from a feminist perspective. Her argument influenced substantially the thinking of later researchers such as Letherby (1993) and Layne (1997) as I discuss later in my review.

Although both books produced by Oakley et al. (1984) and Hey et al. (1989) were written by women who had experienced miscarriage, for women who had miscarried, they are not self-help books in the conventional sense. They are based on scholarship and research as well as personal accounts and in this sense were quite ground breaking in this field. I suspect these books were aimed at well educated women and at the medical professionals who treated them. Nevertheless, they continue to make an important contribution to the research literature on miscarriage. From a historical perspective, it is notable that this research was taking place during the beginning of the pregnancy- loss movement founded in America. Women who had experienced miscarriage were sharing their feelings of loss and grief, making it more acceptable for miscarriage to be openly mourned and acknowledged in Western society as a genuine bereavement (Layne, 2003).

This movement was organised by predominately white middle class women, who were encouraging women to compare miscarrying with losing a child and to grieve accordingly. Reagan (2003) describes them as “the new mourning movement” because they focused on women’s grief and the emphasis was on miscarriage as “a personal tragedy” (p. 365). Mourning rituals such as candlelight ceremonies and naming lost babies were encouraged and very often no distinction was made between early miscarriages, stillbirths and neonatal death (Allen & Marks, 1993; Layne, 2003). A new sensitivity towards the feelings of women and their partners after miscarriage was developing and there was a growth of hospital chaplains performing memorial services and funerals, particularly after stillbirths (Lovell, 2001). Reagan (2003) argues that the influence of these new outlooks is seen in the self-help literature and the attitudes of miscarriage support groups today, which in her view tend to have a bias against the pro-choice movement. I discuss this view more fully later in this chapter under the heading ‘The feminist perspective on miscarriage’. She

points out that in this environment “the overwhelming grief experienced by some is projected on to all” (Reagan, 2003, p. 367). This is a needful reminder that miscarriage is not a significant loss for all women.

Miscarriage in the 1990s

A plea for a sense of proportion

Paradoxically, by the 1990s Bourne and Lewis (1991), two consultant psychotherapists, were writing to the BMJ urging a sense of proportion in the management of early pregnancy loss and stating that the number of papers on the topic has gone from a trickle in the 1960s to a “flood” (p. 1167). They were sympathetic to the recent developments in supporting women after stillbirth but stated that “People should not be pushed into magnifying miscarriage (common in one in three or four pregnancies) into a tragedy” (p. 1168). They warned that too much emphasis on emotional distress after miscarriage might interfere with a women’s natural resilience and her ability to get over the event without becoming psychologically disturbed and they challenged the research that suggested grief was unrelated to the duration of a failed pregnancy. In my opinion, they are implying that psychotherapy should be reserved for those who are experiencing severe unresolved or complicated grief. This leaves me wondering whether it is this type of attitude that is partly the cause for the dearth of literature on the psychological consequences for women who experience miscarriage in the field of counselling and psychotherapy.

The contribution to the debate by Gayle Letherby

One of the articles written in this period that has had a substantial influence on my own research is by Gayle Letherby (1993). I identify with the fact that she is a researcher with personal experience of miscarriage and significantly, I had my own miscarriage in 1993.

Equally, I feel that her findings accord closely with my own personal experience of miscarriage. This is a comprehensive and wide ranging article written from a sociological and feminist perspective and clearly influenced by the earlier work of Hey et al. (1989). Letherby suggests that the meaning of miscarriage is very much determined by the woman's own perception of the event. She gives prominence to how traumatic miscarriage can be and suggests that for some women it is a painful bereavement that may last for many years. She implies, but does not overtly state, that the feminist movement has ignored or neglected the experiences of women suffering miscarriage. She calls for more debate from a feminist perspective around the impact on women of reproductive loss, with a focus on recognising difference between women such as class, race and disability. In this context, I find it puzzling that Letherby's work is not cited in Layne (2003) or in other feminist writing on miscarriage such as Parsons (2010). This causes me to wonder whether this neglect is because Letherby is critical of the feminist position on miscarriage which I explore more fully later in this chapter.

Christine Moulder's book was first published in 1990 with the support of the Miscarriage Association, and it continued the debate in the style of Hey et al. (1989) and Oakley (1980). Moulder's book has now been published in three editions (1990, 1995 and 2001) and it is interesting to compare the introductions to each book and to note how her concerns have changed over time. For the purpose of her first edition, 350 women recruited by the Miscarriage Association completed a survey, and 30 women were interviewed on their experience of miscarriage. The research culminated in a set of guidelines being developed for good practice by health care professionals in dealing with women experiencing miscarriage. In her subsequent introduction in 1995 she was still urging that these guidelines be followed and that good training for health practitioners in dealing with

miscarriage was essential. By 2001 she was commenting that there had been a major shift in health culture; that women were offered more choice in their care after a miscarriage and that there was better information available and more openness generally about miscarriage. However, I think she was being overly optimistic in her assessment because during the ten years following these claims there has been a substantial body of research still calling for just such reforms (e.g. Simmons, Singh, Maconochie, Doyle, & Green, 2006; Murphy & Merrell, 2009; McLean & Flynn, 2012).

It seems clear that throughout the 1990s the themes that dominated the 1980s persisted. There was still an interest in the psychological impact on women of miscarriage (Frost & Condon, 1996; Letherby, 1993) and a developing interest in miscarriage as a traumatic event (Lee & Slade, 1996). Debate around whether miscarriage caused depression and how symptoms of depression could be differentiated from grief reactions also continued (Beutal, Deckardt, von Rad, & Weiner, 1995) and there was still emphasis on medical intervention during and after miscarriage (Zaccardi, Abbot, & Koziol-McLain, 1993). New attitudes to bereavement were emerging (Rando, 1985) and discussion round their relevance to reproductive loss (Malacrida, 1998). In this context, Lee and Slade argued (1996) that early miscarriage was increasingly being described as perinatal bereavement (p. 239). At the same time there was a growing body of research into health professionals' attitudes towards reproductive loss (Prettyman & Cordle, 1992).

Having set the scene through a broad review of the literature on miscarriage up to the end of the 1990s, I will now explore how these individual themes grew and developed from the 1990s onwards to the present day.

Research into the psychological consequences of miscarriage from the 1990s onwards

From the 1990s there is a general consensus in the literature that pregnancy loss is a stressful life event with psychological consequences for some women. Research shows that it may even increase the risk of suicide (Klier et al., 2002). Saraiya et al. (1999) found that between 1981 and 1991 sixty two women in the USA killed themselves after a miscarriage and in a Finnish study between 1984 and 1987 the mean annual rate for suicide one year after a miscarriage was significantly higher than for women after birth and for those in the general population (Gissler, Hemminki, & Lonnqvist, 1996).

Frost and Condon (1996) in their critical review of the literature on the psychological sequelae of miscarriage stated that research into the psychological consequences of miscarriage for women has lagged behind research into the impact of perinatal bereavement and they conclude that this afforded it a lowly status by researchers. It is certainly the case that perinatal bereavement was being examined by Rosenblatt and Burns (1986) ten years earlier and the longer term effects of miscarriage noted. They reported that the psychological consequences of miscarriage for women could be severe, ranging from grief and guilt to feelings of loss of identity and lack of understanding from family and the medical profession and these might lead to the development of depression and post-traumatic stress. Nevertheless, they criticised contemporary research in this area for its methodological problems such as: too many subjective and anecdotal accounts; the lack of standardised measures of grief; the use of use of small samples, and no control groups meaning the studies were not generalisable.

Depression

Through the 1990s into the 2000s, a body of literature continued to grow looking at the connection between miscarriage and depression. There was debate around whether women

were describing depression, anxiety or grief after miscarriage and whether these could be separated and delineated because the research findings in this area were ambiguous (e.g. Brier, 2008; Lee & Slade, 1996).

Neugebauer et al. (1992) claimed that their systematic study on the determinants of depressive symptoms in the early weeks after miscarriage confirmed for the first time, that miscarriage causes depression in the first few weeks after the loss. They stated that this should be seen as “a public health concern” (p. 1338). They found that women who had miscarried showed greater symptoms of depression than women who were pregnant or in the community and these symptoms were “unrelated to the women’s attitude towards the pregnancy” (p. 1337). Childless women were particularly distressed and those who experienced both early and late miscarriages were equally affected which accords with earlier findings (e.g. Peppers & Knapp, 1980; Lepper & Pahlka, 1984).

In a later controlled study Neugebauer et al. (1997) found that women who miscarry have an increased tendency to bouts of depression and those women who have already experienced major depression are at an increased risk after a miscarriage. Similarly, Klier et al. (2002), contrary to Frost and Condon’s (2006) criticism above, argue that many well designed studies had been performed over the past 10 years which showed that miscarriage could have long lasting consequences for women including depression (p. 145). They claimed that 5.2% of women experienced minor depression after miscarriage compared with 1.0% in the community.

Contrary to these findings, Maker and Ogden (2003) revealed in their qualitative study that depression was not an emotion commonly described by their participants. They argued that this might be because of the different language used by the women in their study where sadness might previously have been interpreted as depression in previous research.

Miscarriage and grief

There is much debate in the literature around whether women experience grief or depression after miscarriage and how these psychological consequences might be delineated and measured (e.g. Beutal, et al. 1995; Brier, 2008; Carter, Misri, & Tomfour, 2007; Frost & Condon, 1996; Klier et al., 2002; Lee & Slade 1996; Nikcevic, Kuczmierczyk, & Nicolaides, 2007; Stirtzinger & Robinson, 1989). In this context, Brier (2008) defines grief as, “the affective, physiological reactions to the loss of an emotionally important figure and typically includes severe and prolonged distress” (p. 452).

In his comprehensive view of the literature on grief following early miscarriage, Brier (2008) states that the empirical literature in this area is “extremely sparse” (p. 460). He argues this is because of difficulties in defining grief, problems with the validity of scales used to measure grief in various studies and the problems that arise when comparing studies that measure grief immediately after miscarriage with those that measure it retrospectively. He also comments on the fact that so many studies on pregnancy loss fail to distinguish between early and late miscarriages, ectopic pregnancies, stillbirths and neonatal deaths which cloud the findings.

Brier (2008) found that the available literature seemed to indicate that grief reaction after a miscarriage was common and similar to the grief experienced after other forms of bereavement. However it did have unique traits. Women dwelt more on the loss of hope for the future and their yearning for the lost baby was based on an imaginary relationship rather than one based on past experience (p. 460) and this resonates with my experience. He asserts that there are too many variables to determine what impacts particularly on the intensity and duration of grief after miscarriage but it is suggested in the literature that the

importance and desire for the pregnancy, the absence of other children and a propensity to previous psychiatric symptoms, may predict the levels of grief a woman might experience.

In a controlled study by Beutal, et al. (1995), 125 women were assessed shortly after their miscarriage and then again six months later using a grief scale. They found both depression and grief reactions were present immediately after miscarriage. These grief reactions were self-limiting lasting up to six months but depressive reactions were still present after twelve months. From this finding, Beutal, et al. argue that it is important to discriminate between grief and depressive reactions after miscarriage in order to determine who might benefit from psychological support for depression. However, they could not find conclusive evidence as to why some women experienced depression, whilst others responded with grief and other women experienced both emotional reactions.

Significantly, this study also showed that a large minority of women reported no negative emotional reaction after miscarriage. They also reported relatives and friends having more empathy for women who experienced grief reactions whereas depressed women caused feelings of irritation and distance in observers (p. 525). This finding might explain a little why some women perceive they are unheard and misunderstood by friends, family and health professionals after a miscarriage.

I believe that this inability to define precisely what the emotional reaction after miscarriage might be, may lead to women experiencing disenfranchised grief as defined by Doka (2002) and I discuss this later in this chapter. However, as a qualitative researcher and a counsellor in this field, my view is that the many varied and moving accounts of women who have experienced miscarriage over the last 30 years is sufficiently convincing to leave me in no doubt of the psychological impact of miscarriage on some women. It is important that these feelings are recognised and validated but it is not so essential to attempt to make

subtle distinctions in diagnosis between depression and grief as I believe they are often concurrent and as Maker and Ogden (2003) argue difficult to delineate.

Anxiety

Research also demonstrates that there is a link with depressive symptoms and anxiety after miscarriage (e.g. Geller, Kerns, & Klier, 2004) and controlled studies have shown that anxiety levels are often raised for up to six months after the loss, for example Thaper and Thaper (1992) and Beutal et al. (1995). Geller et al. (2004) state, in their review of the literature, that it is only relatively recently that research into whether miscarriage causes anxiety has received much attention and indeed Prettyman, Cordon and Cook (1993) argue that anxiety is the predominant psychological response to miscarriage rather than depression. They go on to argue that more research is needed into the stress and anxiety that miscarriage places on the whole family as Cain et al. (1964) were recognising 40 years earlier.

There is also evidence that the experience of miscarriage may increase the risk for developing an anxiety disorder such as obsessive compulsive disorder (OCD) (Neziroglu, Anemone, & Yaryura-Tobias, 1992) or a panic disorder (Klein, Skrobala, & Garfmkel, 1995). Miscarriage has not been found to increase the risk for agoraphobia but more research is needed in this area (Geller, Klier, & Neugebauer, 2002). Certainly, I believe that the development of my own symptoms of agoraphobia and anxiety were triggered by my miscarriage. There is also evidence that anxiety following a miscarriage may influence decisions regarding further pregnancies (e.g. Bergner, Beyer, Klapp, & Rauchfuss, 2008; Cote-Arsenault & Morrison-Breedy, 2001; Firtl, Bergner, Reinhard, Burghard, & Klapp, 2009; Lee & Slade, 1996) which I discuss later in this review.

Trauma

For some women miscarriage is experienced as physically distressing and they have to face the unexpected horrors of blood loss and sometimes the sight of decaying fetal tissue.

Thus, miscarriage can be a painful, unforeseen and frightening experience and its traumatic nature has in recent times been well documented in the literature (e.g. Abboud & Liamputtong, 2005; Gerber-Epstein et al., (2009); Leichtentritt, & Benyamini, 2009; Lee & Slade, 1996; Letherby, 2003; Malacrida, 1998).

Tedeschi and Calhoun (1995) state that difficult life crises are traumatic when they are sudden and unexpected and perceived by the individual to be out of control. They are out of the ordinary events which create long-lasting problems for the sufferers and for which they can find no one else to blame, occurring at critical moments in the life cycle.

Malacrida (1998) argues that reproductive loss fulfils all six of these criteria. Thus it is clear, that for some women, miscarriage is experienced as traumatic.

Engelhard, van den, & Arnoud (2001) investigated the prevalence of posttraumatic stress disorder (PTSD) one and four months after an early pregnancy loss, i.e. within twenty weeks, in 113 women using the Posttraumatic Symptom Scale. They found that 25% of the participants met the criteria for PTSD diagnosis one month after their miscarriage and that 13% could be regarded as having mild to severe depression. This is not surprising when I consider my own fear and horror experienced during the physical process of my miscarriage. They also established that the gestational length of the pregnancy was linked to the severity of PTSD symptoms and in particular the experiencing of intrusive recollections. I go on to explore this theme in more detail in the discussion on my first super-ordinate theme *Memories of the Initial Impact Miscarriage* later in this thesis.

This finding is significant as it appears to contradict earlier findings that psychological distress after miscarriage is not linked to the length of the pregnancy (e.g. Peppers & Knapp, 1980; Stirtzinger & Robinson, 1989). However, from a personal perspective, it seems obvious that losing a baby in later pregnancy might lead to the experience of pain and stress similar to child birth. Similarly, the horror associated with delivering a well-developed dead fetus could well be traumatic and lead to the development of PTSD and flashbacks, even more so than in early miscarriage.

The trauma of miscarriage may also be exacerbated through mismanagement by medical professionals (Moulder, 2001; Simmons et al., 2006) and by the lack of understanding from family and friends (Conway, 1995; Cote- Arsenault, 2003; Letherby, 1993; Rajan & Oakley, 1993; Rowlands & Lee, 2010) and I review the literature in these areas later in this chapter.

The theory of post-traumatic growth

Following on from the concept of trauma is the theory of traumatic growth developed by Calhoun and Tedeschi (2006). In the past twenty years there have been systematic attempts in Psychology to focus on the phenomenon of post-traumatic growth both through qualitative and quantitative research methods and to explore whether positive transformation and psychological growth can develop from experiencing a traumatic event (e.g. Linley & Joseph, 2004; Tedeschi, Calhoun, & Cann, 2007). There has also been research into the development of traumatic growth after the loss of a child (e.g. Engelmeyer & Marwit, 2010; Polatinsky & Esprey, 2000). There is no literature applying the concept of post-traumatic growth directly to miscarriage and I go on to discuss this area in more detail later in my Discussion Chapter under the theme *Miscarriage as a life changing experience*.

Debates about psychological intervention after miscarriage

Throughout this review of the research showing miscarriage can have a psychological impact on women, many researchers have concluded that there is a need for psychological intervention or psychological follow up after miscarriage and that it is effective (e.g. Adolfsson et al., 2006; Lee & Slade, 1996; Leppart & Pahlka, 1984; Prettyman & Cordle, 1992; Stirtzinger & Robinson, 1989; Swansen- Kauffman, 1986; Swansen, 1999; Wojnar et al., 2011). Suggested interventions may range from informal conversations with health professionals, to the offering of advice and literature, through to formal counselling for an agreed number of sessions.

Therefore, it is surprising that in the recent Cochrane review, Murphy et al. (2012) state that the evidence for the effectiveness of psychological support, such as counselling after miscarriage, is inconclusive. They argue that although the United Kingdom Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (2006) suggest that counselling for women after early pregnancy loss can have a positive effect on psychological wellbeing, conversely research also suggests that there is insufficient evidence that interventions are helpful (e.g. Stratton & Lloyd, 2008) and a lack of evidence to show which type of interventions may be most effective (e.g. Flenady & Wilson, 2005). For the purpose of the review they analysed six randomised controlled trials based on research by Adolfsson et al., 2006; Lee & Slade, 1996; Lok Hung, 2006; Nikevic, 2007; Swanson 1999a, involving 1001 women. In these studies the interventions mainly consisted of one or a number of counselling sessions using recognised counselling methods. The outcomes were measured using validated tools such as the Perinatal Grief Scale developed by Toedter, Lasker and Alhadeff (1988) and the Impact of Miscarriage scale developed by Swanson (1999b). In their conclusion they state:

“This review has found a lack of evidence to show that psychological follow-up is beneficial for women following miscarriage. However, some women may benefit from psychological follow-up and the review authors recommend that any service already in place should continue taking into account women’s preference pending further evidence” (p. 13).

In my opinion, these findings show the limitations of attempting to quantify the impact of miscarriage or measure the effect of psychological intervention as they appear to contradict the qualitative evidence that women want support. As a counsellor, I am encouraged by the research referenced above that finds counselling after miscarriage is considered better than no counselling and which suggests women’s preferences should be the dominant factor in determining whether counselling is offered to women. There is a body of research which finds that many women favour and request counselling and other psychological interventions after miscarriage (e.g. Adolfsson, Larsson, Wijma, & Bertero 2004; Brier, 1999; Murphy & Merrell, 2009; Neugebauer et al., 1992; Prettyman & Cordle, 1992; Simmons et al., 2006; Murphy & Merrell, 2009; Wong et al., 2003). Thus, I hope that the rather insubstantial evidence from certain aspects of six randomised controlled trials will not be used to stifle the voices of the myriad of women clamouring for counselling interventions.

Current provision for women who experience miscarriage

In the NICE (2012) guidelines for medical professionals dealing with women who experience ectopic pregnancy and miscarriage it states that:

- An opportunity should be given to ask any questions she may have about the causes and consequences of miscarriage.

- Discuss how she is coping and offer information about where to access support and counselling where appropriate.
- Be aware that grief, anxiety, and depression are common following miscarriage (1.5 & 1.6).

These guidelines are rather vague and do not specify what they mean by “support” other than counselling. They also appear to partly contradict the findings of Lipp and Powles (2012) in the Cochrane Report described above. They seem to be more in accord with research I have reviewed that demonstrates women want to have more information about miscarriage and access to counselling if necessary. However, it is doubtful whether these recommendations are always implemented.

Denis Cambell (2012), the Health Correspondent from the Guardian newspaper, claimed that despite these guidelines, there was still a need for better healthcare for women experiencing ectopic pregnancy and miscarriage. His critique was followed up on the internet by 62 women posting comments generally expressing dissatisfaction with how their miscarriages had been dealt with by the NHS. In a very recent article, on provision for women who have suffered an early miscarriage, Robinson (2014) is still calling for better trained health professionals and improved information and support systems for women who miscarry.

Whilst writing this review, I have been struck by the wide variety of research that has been done over the past thirty years, both quantitative and qualitative, into what women say they want after a miscarriage from the health systems and health professionals that are there to care for them and from society in general. It seems obvious to me that there is plenty of evidence already in the public sphere to support the necessary reforms required and I am

bewildered as to why these reforms consistently fail to materialise. All that seems to happen is that there are more unflinching calls for further research.

Miscarriage in the counselling literature

As a counsellor, I am also astonished at the complete lack of response to women's concerns after miscarriage in the counselling literature. In the psychotherapy literature there is some research by Margaret Field (2007) on the effect of miscarriage on women and on their children subsequently born after miscarriage. However, there is very little written about counselling women specifically after miscarriage and no attempt to engage in the debates around counselling efficacy. In Mick Cooper's book (2009) "Essential research findings in counselling and psychotherapy," which is considered indispensable reading on most counselling and psychotherapy training courses, there is not one mention of any research into counselling for infertility or reproductive loss during pregnancy. To date, I have found two papers that specifically mention counselling and miscarriage. The first is by Anthea Hayton (1995) where the main focus is on the trauma after abortion rather than miscarriage. The second by Rinehart and Kiselica (2010) examines the implications for psychotherapeutic work with men after their partners experience miscarriage. There is no reference in this paper to any research into counselling for women. Significantly, to date in "Therapy Today," the journal read widely by counselling and psychotherapy professionals, Hayton's (1995) commentary is the only article it has published which considers the impact of miscarriage on women from a counselling perspective, over a period of nearly twenty years.

In 2001, Valerie Vreede wrote an article for the *Counselling and Psychotherapy Journal* (CPJ) in which she describes her work as a counsellor in a maternity unit dealing with

women who experience miscarriage. The article is concerned with the loneliness and isolation she felt undertaking this type of counselling work and how the staff on the unit did not want to deal with the painful side of pregnancy loss leaving it to the counsellor. She writes, "Counselling was like the shadow side of the service and they wanted to leave the shadow in the dark" (p. 9). In my view it will not be brought into the light until more is written in the counselling literature about the impact of miscarriage on some women and indeed on the effect on counsellors offering this service to women and their partners.

It is clear that for many women miscarriage has psychological repercussions such as depression, anxiety and trauma. Yet, I can only speculate why this area remains so neglected in the counselling literature. Conceivably, in the past the majority of counselling research was produced by men and thus perhaps issues related to reproductive loss were not commonly in their awareness. Fairhurst (1999), writing in the preface to her edited collection of "Women writing in the person-centred approach" informs the readers that whilst 85% of trainees on person-centred counselling courses are women, the majority of books and papers on counselling are written by men. However, in my experience as a counsellor and counsellor trainer, over the last ten years there are many more women writing and researching in the counselling field. Possibly, a more mundane answer might be that counsellors are working on a daily basis with women and their families who are distressed after perinatal loss and they are fully aware of its psychological impact. In this sense, they do not need further research to enlighten them. However, I would suggest that this best places counsellors to write and research into the emotional needs of women who miscarry. Perhaps by encouraging more research in this area, the impact of perinatal loss for some women can be brought out of the private space of the counselling room and more into the public domain. This might result in health professionals and the general public

deepening their understanding of how best to help and support women who experience miscarriage.

Miscarriage and subsequent pregnancies

After a miscarriage it is common for women to become pregnant again. According to Lamb (2002) 50% – 60 % of women become pregnant again within the first year after a reproductive loss and Swanson (1999a) states that 50% -89% of women go on to conceive a subsequent pregnancy after such a loss. I can find no statistics that show how many actually went on to have successful ensuing pregnancies. Yet, this subsequent pregnancy is often over shadowed by uncertainty and anxiety because of the fear that miscarriage may happen again. Cordle and Prettyman (1994) in their investigations around psychological morbidity after miscarriage asked 65 women who had been recruited previously after an early miscarriage to complete a follow up questionnaire and a Hospital Anxiety and Depression scale; 68% of these women reported still feeling upset by their miscarriage two years later, 64% reported that their miscarriage had affected their subsequent decision to become pregnant and 16% decided never to become pregnant again.

Motivations to have another child

Thus, statistics show that most women become pregnant again after a miscarriage and this was the experience of four out of five of my participants. However, there is little research into why women are motivated to have another child and to face the possible risk of further reproductive loss. Morgan and King (2001) challenge the position of behavioural genetics that human beings are predisposed to childbearing because sex and parenthood is pleasurable (Kohler, Rogers, & Kristenson. 1999). They ask rhetorically, why do we have children at all in the twenty first century when modern contraception and the availability of abortion have removed the connection between sexual activity and childbirth? I would also

suggest that current fertility treatment such as IVF, donor insemination and the freezing of embryos may also play a part in separating sexual pleasure from pregnancy. Foster (2000) suggests that small scale qualitative studies asking women about their motivations might be the place to start answering this question because although demographic data sources can tell us about differences in fertility over time and the relationship between reproductive behaviour and socio-economic factors, it can tell us nothing about why women decide to have children or what influences their decision making. However, she does propose a biosocial model of fertility motivations which includes:

“A genetic pre-disposition to nurture, normative pressures, and hormonal and environmental influences from previous pregnancies and children” (Foster, 2000, cited in Rotkirch, 2007, p. 91).

Rotkirch (2007) develops this further by proposing that “a desire for babies may appear as a result of psychophysical changes” (p. 92). He suggests that the:

“Longing for a baby can develop as a by- product of hormonal changes that evolved to prepare the women for motherhood” (p. 92).

Whilst these psycho-sexual changes were initially proposed to describe the natural longing for a baby in a woman who has not had reproductive failure, I feel that they can equally apply to a woman who has experienced miscarriage and I would suggest that they may even be magnified as a result of her loss.

Although it is clear that more empirical research is needed in this area, I find the notion of hormonal changes playing a part in the desire to have another baby convincing. Rotkirch (2007) found that in his own research, based on 106 stories written by women in Finland, some of the triggers for a yearning for a baby included, facing challenging circumstances

around “reproductive health” (p. 97) and “miscarriage” (p. 100). I know from my own experience that after reproductive loss a woman’s body can take a long time to return to its natural state pre-conception and it seems highly likely that there may be hormonal influences driving the longing to become pregnant again for some women. This might explain why some women, despite all the distress occasioned by their miscarriages, are determined to try again for another baby.

Levinson (1986), in his seminal work on life-course studies, views becoming a parent as a development task of adulthood. Therefore, if there is a failure in completing this task a woman may feel that she has failed in her ability to become an adult with subsequent feelings of inadequacy and loss of status in society. A woman may believe that the only way to overcome these feelings is to continue to try to have a child. Jaffe and Diamond (2010) call this development task of reproduction “the reproductive journey” (p. 17). They suggest that our family history and ethnic and religious background may affect the desire to have children. Similarly, they stress the importance of cultural influences on the need to reproduce, including societal norms which assume that as adults we will marry and have children and that family and friends becoming pregnant can stimulate in those close to them a similar desire to have a baby.

The psychological impact of miscarriage on subsequent pregnancies

As I demonstrate earlier in this review, over the past thirty years or more there has been a growing interest in researching the psychological consequences on women after suffering a miscarriage but only in the last 10 years has there been much research on how the experience of miscarriage impacts on subsequent pregnancies (e.g. Lamb, 2002). It is consistently noted in the literature that women who become pregnant after miscarriage report high levels of anxiety because of fear they might miscarry again, particularly in the

first few months (e.g. Armstrong, 2004; Bergner et al., 2008; Cote- Arsenault & Morrison-Breedy, 2001; Firtl et al., 2009; Geller et al., 2004). Sadly, this fear may become a reality because findings show that after a first miscarriage there is an elevated risk of suffering another (Firtl et al., 2009).

In a longitudinal study of 342 women, Bergner et al. (2008) found that women with a history of miscarriage suffered more anxiety related to the pregnancy than women with no prior miscarriage history. They concluded that after an early miscarriage, women are particularly at risk of having psychological problems during a subsequent pregnancy. These findings are concomitant with other research (e.g. Armstrong, 2004; Geller et al., 2004; Firtl et al., 2009).

Similarly, Firtl et al. (2009) found that in a study of 143 pregnant women who had experienced a miscarriage, their levels of anxiety and pregnancy related fear were higher than for women in control groups who had no previous history of pregnancy loss. Significantly, this high level of anxiety did not abate as the pregnancy progressed but continued for some women up to the 24th week of gestation. After this time, the level of anxiety dropped nearer to the levels reported by pregnant women without a history of miscarriage; perhaps because these women felt that their pregnancy was now more viable. They conclude that women who miscarry may become sensitised to the risks during pregnancy and experience increased fear of never having a child or another child, and that their anxiety is exacerbated by the additional problem of an increased attachment to the subsequent pregnancy (p. 26). They conclude their findings by recommending that medical professionals receive more training in allaying these fears, and women and their partners would benefit from short term therapy to help reduce anxiety (p. 27).

Contrary to the research findings above which shows evidence of increased attachment to the pregnancy after a miscarriage, there is also evidence that after a reproductive loss some parents avoid forming a relationship with their unborn child out of fear that they will also lose the subsequent pregnancy (e.g. Armstrong, 2004; Cote-Arsenault & Morrison Breedy, 2000, 2001). There is a possibility that these high levels of anxiety may cause women to be more anxious in their relationship with subsequent children born after a miscarriage but it is clear that more research is needed in this area (Lamb, 2002). Although, as with most qualitative research findings in this review, these results may only reflect the experiences of those parents who volunteered for the studies and possibly were most affected by their experiences and keen to share their stories (Armstrong, 2004, p. 771).

Miscarriage, family and social support

Cecil (1996) states, in her anthropological study, that miscarriage occurs within a family context:

“The baby who is lost through miscarriage would not only have been the child of its father, as well as its mother, but also the sibling of any existing children, and a grandchild, a niece, a nephew and so on” (p. 1415).

Much of the literature on the effects of reproductive loss on parental relationships focuses mainly on stillbirth and perinatal death (e.g. Turton, Evans, & Hughes, 2009). However, in the first national study on the effects of miscarriage and stillbirth on parental relationships in America, Gold, Sen, and Hayward (2010) found that as well as stillbirth, women who had a miscarriage also had a greater risk of their relationship ending than those who experienced a live birth (p. 1202). They concluded that given the high frequency rate of pregnancy loss this may have implications for society and family life.

Thus, miscarriage can have a profound effect on family life and may cause strain between partners and difficulties in relationships with children. After a miscarriage, there is often poor social support and little understanding from friends and family and sometimes parents feel that they cannot be open and honest about the emotional and psychological effects they are experiencing (Conway, 1995; Cote- Arsenault, 2003; Letherby, 1993; De Montigny, Beaudet, & Dumas, 1999; Rajan & Oakley, 1993; Rowlands & Lee, 2010).

Social isolation

Parents may feel unable to talk about the lost child (De Montigny et al., 1999) and there may be pressure from family and friends and indeed the medical profession, for women to move on, and to become pregnant again quickly (Leppart & Pahlka, 1984; Letherby, 1993). Rajan and Oakley (1993) found that women felt isolated after a reproductive loss because of the absence of traditional mourning rituals, a lack of understanding from family and friends in the long term and differences in the way male partners expressed their grief. Throughout the research, women voiced a need to have their loss validated and recognised. When midwives provided this social support women reported much better emotional health at 6 months and 12 months after their miscarriage. Similarly, Kavanaugh, Trier and Korzec (2004) argue that health care professionals need to be much more aware of parents' need for social support after the experience of miscarriage and that there needs to be more research into how families could gain an understanding of the best ways to help and support each other after a miscarriage

In an in-depth analysis conducted by De Montigny et al. (1999), 20 parents responded to written questionnaires consisting of 23 open-ended questions “concerning the impact of the death of a child on the family’s functioning and structure” (p. 152). They found that parents described strained relationships with members of their extended families after

perinatal loss. There was avoidance around talking about the baby and insensitive comments from other people which sometimes resulted in parents feeling isolated and unable to communicate their needs or express their feelings. These parents felt that miscarriage was not perceived as a “real loss” (p. 153), particularly by friends and work colleagues, and this led to an expectation that they would recover quickly, resulting in parents feeling marginalised. This is supported by Hazan (2003) who found that both “grief in the work place and perinatal loss are disenfranchised” (p. 163). However, if women are offered support by managers and colleagues it could be affirming and healing.

Yet, De Montigny et al. (1999) discovered that for some parents their relationships with the extended family were improved after reproductive loss and they felt able to express their grief within the family more freely. The researchers expected to find that attitudes of friends and colleagues might be influenced by the type of loss, such as miscarriage versus stillbirth but this was not found to be the case. They concluded by identifying the importance of supportive networks for bereaved families and the necessity for medical professionals to use interventions that might help maintain these where possible. These differences in experience demonstrate the complexity of researching in this area.

Rituals and commemoration

In a recent study, Rowlands and Lee (2010) used semi-structured, qualitative interviews with nine Australian women to explore how the responses of others to miscarriage affect women who have experienced miscarriage. They suggest that it is important for women to have their loss acknowledged and that some women felt having some kind of ritual or ceremony was helpful as was naming the baby in order to provide a form of public recognition for their loss.

There is also poignant research by Cote- Arsenault (2003) into how women weave their lost babies into the fabric of the family. Here, she used textual data from four of her previous qualitative studies and themed these using thematic analysis. Data was collected through questionnaires, interviews, focus groups and participant observations. This resulted in the identification of five themes: rituals, symbols, visible presence, holding a place in the family and life- long impressions, illustrating the various ways women in these studies had found to keep their baby's memories alive and integrated into their family story (p. 27). Many of her participants expressed their gratitude at being given the opportunity to take part in the research and stated that being able to talk about their experiences felt like a part of their grieving process. The ending of this article especially speaks to me through the imagery of weaving, as I sit with my back against my baby's blanket draped over my computer chair:

‘Despite dying at very early stages of their lives, these lost babies remain important threads in the family fabric, and remembering them helps parents and siblings mend the tear in their lives’ (p. 36).

There appears to be a constant refrain in the literature that Western society or culture does not provide women and their families with appropriate rituals or ways to remember babies lost through miscarriage (e.g. Allen & Marks, 1993; Letherby, 1993; Layne, 2003; Seftel, 2006; Rajan & Oakley, 1993; Rowlands & Lee, 2010).

However, as Seftel, (2006) argues, if this need to have losses recognised and legitimised by Western society is not met then women will find their own ways of remembering often through the creative arts and poetry. In more recent times, the internet has become a place where women can create memorials and develop rituals to remember their babies (Sejourne, Callahan, & Chabrol, 2010). There are numerous websites and blogs in which

women share and recount their experiences of miscarriages. There are websites where women can buy jewellery and mementos to remind them of their lost baby. I can personally testify to the comfort these symbolic articles can bring after miscarriage as I own a tiny bronze statue of an angel holding a little baby in her arms which I purchased from the internet many years after my miscarriage. I find consolation in its solidity and weight when I occasionally hold it in the palm of my hand.

A contemporary way of remembering is to have a tattoo. In a recent trawl of web sites (e.g Miscarriage Tattoos, no date) I found many suggestions for tattoos such as a sleeping angel, the baby's name and date of loss or a quote that tells the world you'll never forget such as "For love is as strong as death". There are also poignant websites where women discuss how to announce the news of their miscarriages on face book when sonograms have been uploaded and pregnancy status updated (e.g. Jezebel, no date). Although, these can be painful to read, perhaps the stigma around discussing miscarriage is slowly being eroded through discussions on the internet.

Attitudes of the healthcare profession to miscarriage

Early miscarriage causes approximately 50,000 hospital admissions per year (NICE, 2012). However, research shows that women's trauma may well be intensified by their stay in hospital and in their interactions with medical staff during and after a miscarriage. Current research establishes that health professionals have a key role in reducing the traumatic impact on women after miscarriage but sadly this does not always happen and there is certainly room for improvement (Moulder, 2001; Simmons et al., 2006; Tsatsara, 2002).

There has been a growing awareness from the 1990s onwards, reflected in the literature, that women's needs were not being met by those caring for them when they miscarried and that medical professionals sometimes viewed miscarriage as a minor medical disorder and

therefore ignored the psychological impact (Malacrida, 1998; Adolfsson et al., 2004; Murphy & Merrell, 2009; Evans, 2012). Adolfsson et al. (2004) sum this up when they write that after miscarriage women may feel “abandoned with their feelings by the health professionals” (p. 558).

What women want from their healthcare professionals during miscarriage

Many health professional are perceived to be deficient in good communication skills and to lack sensitivity towards women who have miscarried (Frost et al., 2007; Rowlands & Lee, 2010). In response to this, there is an ever growing body of literature exploring what women want from their health professionals, including the need for more follow up appointments and counselling (e.g. Adolfsson et al., 2004; Brier, 1999; Murphy & Merrell, 2009; Nikcevic et al., 2007; Prettyman & Cordle, 1992; Simmons et al., 2006; Murphy & Merrell, 2009; Wong et al., 2003). Therefore, I can only give a snapshot in this section of the wide range of literature in this area.

Data from the National Women’s Health Study (NWHHS, 2006), a national representative survey, seems to support the view that care from medical staff after miscarriage in the UK is inconsistent and that women desire more emotional support. Simmons et al. (2006) produced a thematic analysis of 172 women’s stories of their miscarriages from this study’s qualitative data. Their clearest finding was a divergence between what women felt were their priorities in their treatment after miscarriage compared to the main concerns of the medical professionals. Women wanted more emotional support and follow up after miscarriage. They felt that staff did not know how to offer this support and it was dependent on the individual professionals to offer what they could. There were no formal procedures in place for follow up appointments or counselling and information on miscarriage was not readily available. In general women felt there was a lack of “sympathy

and compassion from professionals involved in miscarriage care” (p. 1942). However, there were some positive stories and midwives and health visitors were often praised for their help and support.

International studies

Significantly, problems with attitudes of health professionals do not seem to be confined to the UK alone. They also appear to be an international problem. McLean and Flynn (2012) recently undertook a study in Australia from a social work perspective. Using semi-structured interviews and thematic analysis they investigated how a small sample of women who attended hospital for miscarriage in the first 20 weeks of pregnancy experienced their treatment. They found women reported feeling little compassion from medical staff and that they were given poor information. They conclude that the medicalisation of miscarriage has ignored the possible emotional and psychological effects on some women which is consistent with previous literature discussed in this review. However, they do argue for an improved system based on provision similar to the Early Pregnancy Units (EPUs), developed in the UK, which provide a more women-centred model which is encouraging for women in this country (Condous, 2008, cited in McLean & Flynn, 2012). Similarly, Sejourne et al. (2010), in a French study based on an internet questionnaire of 350 women, found that the majority specified a desire for more help and support after miscarriage. In particular they wanted help with psychological problems and more information regarding medical issues.

In a North American study, Wojnar et al. (2011) found, in line with other research, that only some women experienced compassion and caring from health practitioners. They suggest that health providers need to offer women “realistic optimism” (p. 555) after miscarriage by supporting them in their own decision making and self-care. They suggest

that this can be done through referrals to counselling, recommending self-help books and helping women to voice out loud what they personally feel they have lost. I refer to this research again when I explore longer term studies on the experience of reproductive loss.

Miscarriage from different perspectives

Wong et al. (2003) and Murphy and Merrell (2009) compare the experiences of women who miscarry with that of health professionals dealing with miscarriage. Wong et al. undertook a qualitative study to explore how best the primary health care team might identify psychological problems in women after miscarriage. There were two strands to the research. The data on a 100 women who had experienced miscarriage was collected through interviews, and qualitative questionnaires. Data was also obtained from healthcare professionals such as general practitioners, health visitors, midwives, counsellors and district nurses who took part in three focus groups, each with 5 to 6 participants, in order to discuss their personal and professional views on miscarriage (p. 698). The women in the study identified a need for more formal follow up plans after miscarriage; they wanted more explanation, and information from their health professionals and they felt that the care they had received from health professionals was very variable. Significantly, for the purpose of this section of my review, they found that, “A number of differences have been identified in the attitudes and expectations of patients and healthcare professionals with regard to care provision after miscarriage” (p. 698). The focus group of health professionals recognised that in an attempt to normalise miscarriage for women they often portrayed it as an “unremarkable life event” and a common occurrence statistically which some women interpreted as a lack of empathy (p. 700). This meant that sometimes women who were experiencing psychological difficulties were overlooked. Healthcare workers were also aware of their own “lack of experience and vulnerability” (p. 701) when dealing

with miscarriage and there was a general agreement that they needed more training in this area.

Murphy and Merrell (2009) pursued an exploration of women's experience of miscarriage in a hospital gynaecological unit in the UK, through a qualitative, ethnographic study. The participants were eight women who had early miscarriage and sixteen health professionals working in the unit (p. 1583). Staff saw their main role as seeing a woman safely through the physical process of miscarriage, whereas the women's perceptions were different. The researchers found that being cared for in a busy gynaecological unit meant that women's physical needs were met at the expense of their emotional needs and that women having treatment for miscarriage were not considered a priority in a setting that was geared up for acute gynaecological emergencies (p. 1587). Nurses expressed frustration that they could not care for women emotionally because of time and financial constraints and felt that they needed more skills training in this area. However, they found that not all women or medical staff viewed miscarriage as a bereavement. They suggest that viewing miscarriage through a transition model marked by "phases of separation, transition and incorporation" (p. 1590) may provide a wider perspective on what is a complex life- event and I discuss this proposal in more detail later in my review and in subsequent chapters.

The difficulties for health professionals working with miscarriage

However, the stresses and difficulties of working as a medical professional in the area of reproductive loss must not be forgotten. Corbet-Owen and Cruger, (2001) comment that health professionals can "powerfully influence how women experience pregnancy loss" (p. 411). They also stress that training medical professionals in how to communicate and work with women who experience pregnancy loss is one of the most neglected areas in professional training. Similarly, health professionals are given very little training in how to

handle their own feelings when dealing with this type of loss (Johnson, 1996, cited in Corbet-Owen & Cruger, 2001, p. 421). Jonas-Simpson and McMahon (2005) suggest the possibility that healthcare professionals use objectifying language “to distance themselves from the pain and reality that an infant has died (p. 127) and because they fear death. Yet these are the people who are going to bear the brunt of a woman’s initial distress after a reproductive loss and they are expected to cope.

Listening to a woman whose baby has died before birth and witnessing her pain takes courage. Yet, according to Jonas-Simpson and McMahon, (2005) it can be one of the most helpful things that a health professional can offer; although it may come at an emotional cost. Reader (1995) describes her difficulties as a female doctor in this area below:

“I also found my involvement with miscarriage led to feelings of resentment about women requesting abortion counselling and dampened the joy I used to share with women giving birth successfully. Thus, like a pendulum, I swung back to a middle-of-the-road approach so that I could work with each women individually, keeping myself more detached from the grief but at the same time still caring” (p. 98).

This account sums up the personal dilemma and strain involved for professionals dealing with reproductive loss every day. They may have to face the challenge of treating women, who for various reasons do not wish to be related to with a “loss” model of care, whilst at the same time relating to women who are mourning their loss.

The nursing perspective

In a review of the literature on miscarriage from a nursing perspective, Evans (2012) describes the demands placed on nurses who work in obstetrics and gynaecology. She states that coming into contact with dead fetuses daily can cause continuing stress and grief

and nurses are not always provided with the skills and training that this sort of emotional work demands. Significantly, Read, Stewart, Cartwright and Meigh (2003) stress the need for good education of doctors and nurses, the importance of collaborative working and good professional practice, when working in this challenging field. Correspondingly, Bolton (2005) in her article on the world of the gynaecological nurse describes eloquently how their work is perceived as “women’s work,” “tainted,” and “dirty” (p. 169). She writes:

“It is physically tainted due to its association with the body, death and abnormality; socially tainted through the regular contact with unmentionable topics such as the termination of pregnancy, incontinence, infertility and sexually transmitted disease, and morally tainted because what should remain private and invisible is made public and rendered visible” (p. 176).

Perhaps there is an expectation for nurses, who are generally female, to be more understanding towards women who are experiencing a reproductive loss and a belief that they are capable of better empathy than their male colleagues. Yet, in my view, working in an area that is stigmatised must at times feel overwhelming. This might explain why even female doctors and nurses occasionally seem to distance themselves emotionally from patients. Therefore, it is not surprising that sometimes they can be perceived as cold and aloof.

It may be that women working in gynaecology can feel as disenfranchised as some of the miscarrying women they are treating as they both labour in the stigmatised and liminal space between the private and the public perceptions of miscarriage. However, DeFrain, Milspaugh and Xie (1996) found that when women were asked to rank the quality of care provided by professionals in the community after miscarriage, nurses were ranked the

highest (3.8 on a five point scale) and physicians ranked second with a score of 3.7. These statistics suggest that women often do feel supported by both female and male health professionals and this is more encouraging.

Although a review of the above literature does present the medical profession's interactions with women who have miscarried in rather a negative light, there are also examples in the literature of women experiencing good care from health professionals (e.g. DeFrain, Milspaugh, & Xie, 1996; McLean & Flynn, 2012; Rowlands & Lee, 2010; Wong et al., 2003). It is clear that when women do feel listened to and supported this is perceived as helpful and is remembered. Although, it must be emphasised when health professionals get things wrong it can exacerbate the trauma for women who are miscarrying and may similarly be remembered for many years after the event (Brewin, 2007; Frost et al, 2007; McNally, 2003).

Radically, Layne (2003) suggests a further source for this lack of support for women who miscarry. She blames both the more conventional and alternative women- centred healthcare providers for focusing on pregnancy as a joyful, natural event with a happy ending and ignoring the statistics on miscarriage that show for many women this is not the case. She claims this is also evident in most of the educational materials available for women on pregnancy and childbirth and in childbirth classes (p. 71-72). Thus, she argues that women are deluding themselves that pregnancy always has a positive outcome and in this way continuing the silence around the issues of reproductive loss. I believe that there is certainly an argument to be made for educating pregnant women and raising awareness of the possibility of miscarriage. Conceivably, a requirement for better education about the possibility of miscarriage before it occurs should be in the NICE guidelines (2012).

Although this might be distressing for some, it might lessen the shock and trauma if women were more prepared for this eventuality and more aware of its high incidence.

It is clear from my review of the substantial body of literature in this area from 1989 to 2014, that women know what they want during and after medical treatment for reproductive loss. Women require the medical professionals dealing with them to have good communication skills and to show sensitivity. They want health professional to suspend their own assumptions and to focus on what the loss means for each individual woman. There is a demand for more information on miscarriage and its psychological effects and the provision for more follow up appointments and counselling in situations where women are experiencing psychological difficulties. Likewise, health professionals are aware that they need more training and more time to attend to emotional needs as well as offering physical treatment.

Therefore, it is disappointing that over the past twenty five years, researchers have consistently commented on what needs to happen to improve women's experience within the health system and yet nothing substantially appears to change. Perhaps, a lack of services is one of the reasons why more women appear to be turning to the internet for the help and support they need after a miscarriage. However, I feel it also important to once again stress at this point that not all women will be negatively affected by miscarriage (Corbett- Owen & Kruger, 2001).

Long term studies on perinatal loss

There are a limited number of long term studies in the literature that look at women's experience of perinatal loss (e.g. Cecil, 1996; Malacrida, 1998; Smart, 2003; Peppers & Knapp, 1980; Rosenblatt & Burns, 1986; Wojnar at al., (2011)). In this context, perinatal loss refers to miscarriage, abortion, stillbirth, and postnatal death.

One of the first studies to consider the long-term effects of perinatal loss on parents was undertaken by Rosenblatt and Burns in 1986. In a qualitative study, 34 adults who had experienced perinatal loss were interviewed, in order to explore the personal meaning they ascribed to their loss and how they remembered dealing with it. For the 55 losses reported “the median time since the loss occurred was 24 years, with a range of 2 years to 46 years” (p. 241). Significantly, they found that pregnancy loss, for some adults, brought a life-time of grieving, which is in stark contrast to the many studies in this review that report grief after depression to be self-limiting for example Beutal, et al. (1995).

They found that often parents did not just grieve for the child but for the many other associated losses such as the fear of childlessness, the feeling that the world is no longer a safe place and their loss of faith in the medical profession which has resonances for my study. However, they clearly stated that not all adults experienced perinatal loss in this way and that their reaction was dependent on how they personally defined the loss. This is concomitant with many of the findings in subsequent qualitative research written from a more women-centred and feminist perspective (e.g. Letherby, 1993; Parsons, 2010).

Only Wojnar et al. (2011) have undertaken research which focuses specifically on the long term experience of miscarriage. In this study, 42 women were involved from the United States, Canada and Sweden and they had experienced miscarriage over a period of 25 years. They used data from a series of phenomenological studies by Adolfsson et al., (2004); Swanson, Connor, Jolley, Pettinato and Wang, (2007); Swanson-Kauffman, (1986) and Wojnar, (2005/ 2007). From this data they created a conceptual model of miscarriage which they named, “Miscarriage: Confronting the Inevitable”. Here they describe features of miscarriage common to all their participants, whilst stressing every woman experiences these in an unique way. The model depicts six common events related to miscarriage:

getting pregnant, bleeding and cramping, scooping it up, feeling empty, making memories and resuming menses. These are presented alongside six common experiences that accompanied these events: *losing and gaining, sharing the loss, going public, getting through and trying again.* The overarching theme was “*We are not in control*” (p. 544).

Wojner et al. anticipate that this model might be useful for practitioners and as a guide for “research and clinical practice” in the hope that it might change society’s views about the “legitimacy of grieving after miscarriage” (p. 556).

In my opinion, this is an accurate and helpful model and I am struck by its similarity to the themes I describe under my first super-ordinate theme ***Memories of the Initial Impact of Miscarriage.*** However, my research demonstrates that the impact of miscarriage does not stop once a woman begins to try again for another baby. Its influence can persist through subsequent pregnancies and continue to shape family life and relationships. For some women the effect may last a lifetime. This omission confirms my view that the long term effect of miscarriage is a neglected area in the literature.

Malacrida (1998) has produced a comprehensive study into 25 parents’ experience of perinatal loss. The perinatal losses of her respondents ranged from within six months previous to the study up to 29 years after their loss (p. 148). The data was collected through a mixture of qualitative interviews and focus groups. Smart (2003) takes a life course approach in a similar qualitative retrospective study of infant death from 1926-55. Here she examines the reproductive loss stories of 16 elderly women and 3 men and concludes that, “considerable variation was seen in older individual’s perceptions and expressions of feelings generated by child-bearing related loss” (p. 89).

I have been struck by how far the findings in these two different studies are similar and accord with my findings in this research. There is emphasis on the vivid memories of the physical pain and distresses of miscarriage, even after many years; although participants report not dwelling on their miscarriage very often. Similarly, respondents fail to remember the exact time and dates of the miscarriage despite its obvious impact. There are also parallels with participants' fears that mourning the miscarriage may diminish the worth of a living child and by the lack of mementos for their miscarriages. Malacrida (1998) concludes with an elegiac and inspiring message which I quote at the beginning of this chapter. As a qualitative researcher, it speaks to me of the difficulties and rewards in trying to understand and convey the complexities of the long term effects of miscarriage.

Traditional grief models and bereavement theory

From the literature reviewed above, it is clear that there is a lack of research into the long term effects of miscarriage. This has led me to consider whether traditional models of bereavement might explain how women and their families come to make sense of their miscarriages over long periods of time.

It seems incomprehensible that miscarriage only began to be recognised as a legitimate bereavement in the literature from the 1980s onwards (Frost et al., 2007). However, over the past 20 years, including the time period in which I had my miscarriage, there have been many changes and developments in understanding and beliefs about bereavement. Theories regarding stages of grief and the necessity of grief work have been challenged (e.g. Machin, 2008; Rothaupt & Becker, 2007). Likewise, theories around what encompasses complicated grief have also been disputed (e.g. Silverman & Klass, 1996; Rothaupt & Becker, 2007) and Doka (2002) developed the concept of disenfranchised grief.

Stage theories of grief

Traditionally, from the 1970s, stage theories of grief have been dominated by the classic models of bereavement such as Parkes' (1972/1996) Process Model and Worden's (1983/2010) Tasks of Mourning. I offer here only a brief synthesis. These models built on the works of Freud who believed, that for mourning to be ultimately successful, there needed to be an emotional detachment from the deceased. However, if this resolution failed to occur, because of some ambivalence in the relationship with the deceased, then pathological or unresolved mourning might result (Machin, 2008; Rothaupt & Becker, 2007).

Drawing on the work of Bowlby (1965) and attachment theory, Parkes (1972/1996) developed a four phases of mourning model of bereavement. According to this theory, we react to loss and bereavement as a small child might cope with enforced separation from its mother. There are four stages that the bereaved must pass through before they can ultimately, "let go of their attachment to the lost person and move on to review their basic assumptions about the world" (p. 3). These stages are: numbness, yearning and pining, disorganisation and despair and finally, reorganisation or recovery. This process is not linear and the bereaved person is not expected to pass through the phases in any particular sequence.

Worden (1983) describes his model as linked to Parkes' model, the main difference being that the bereaved person actively engages in the tasks associated with mourning. He views the tasks of bereavement almost like the developmental stages of childhood and describes four tasks that have to be undertaken to avoid, "incomplete healing of the wound" (p. 27). These tasks are: to accept the reality of the loss, to work through pain and grief, to adjust to an environment in which the deceased is missing and to emotionally relocate the deceased

and move on with life. Again these tasks are not linear but “can be reworked and revisited over time” (p. 37).

The Dual Process Model

The Stroebe and Shut (1999) Dual Process Model (DPM), unlike Parkes’ model, does not focus on the grieving process but describes how we learn to cope with the death of a loved one. They suggest that during a bereavement people undertake concurrently, “loss and restoration- orientated coping.” However this is done in “varying proportions according to individual and cultural variations” and does not occupy all of the bereaved person’s time (Stroebe & Shut, 1999, p. 8). In loss orientation, where the emphasis is on the loss experience itself, it is similar to Parkes’ four phase model. However, in restoration-orientated coping the emphasis is on the additional sources of stress after bereavement and is thus comparable to Worden’s task of mourning.

Stroebe & Shut argue that we oscillate between loss and restoration-orientated coping in order to avoid the different stressors associated with bereavement and this is a “dynamic, back and forth process” (1999, p. 10). In my view, this is a useful model in that it highlights both problem focused and emotional focused ways of coping and most importantly emphasises that the grieving process need not be relentless. It suggests a way of finding balance through the process of grieving and the more practical tasks associated with getting on with life. Maker and Ogden (2003) argue that “rather than be considered a trigger to psychological morbidity miscarriage should be understood as a process which involves shifting emotions and active coping” (p. 414). This is in accord with the Stroebe and Shut model and is similar to the methods describes in studies by Swanson, Conner, et al. (2007) and Van (2001).

It is unlikely that traditional grief models will help to explain all of the problematical processes that a woman may go through after a miscarriage. Although, it is important to acknowledge that this might be the case for any bereavement. Following a miscarriage, the absence of a visible dead body can make accepting the reality of the loss difficult (Letherby, 1993; Layne, 2003; Moulder, 2001). This may make Worden's model problematical because accepting the reality of the loss is the first task. In my experience, it is often hard to determine what has been lost after a miscarriage, since the loss can feel greater than just the coming away of blood and products of conception. There are so many losses associated with miscarriage. These may range from the loss of the pregnancy itself, the loss of future dreams and possibilities, to feelings about the loss of motherhood and the loss of a woman's identity and role in society (Exley & Letherby, 2001; Frost et al., 2007; Parsons, 2010). Yet sadly, these losses may sometimes be unrecognised.

Disenfranchised grief

Possibly, it is partly this inability to define exactly what has been lost after a miscarriage and to fully explain the emotional reaction of some women to the loss which may cause it to become disenfranchised. Doka (2002, p. 5) states that disenfranchised grief can occur in a person who has experienced a loss but whose grief is not "openly acknowledged, socially validated, or publicly observed". He argues that if losses occur outside "society's grieving rules" then the grief may go unrecognised by others. In relation to miscarriage, this is well evidenced in the literature (e.g. Leask, 2005; Letherby, 1993; Layne, 2003; Murphy & Merrell, 2009; Wojnar et al., 2011). Leask (2005) sums up disenfranchised grief in the context of miscarriage poignantly when she writes:

“The loss of pregnancy or death of an infant causes profound grief, yet society has long minimised or ignored this grief, which is among the most painful of bereavement experiences” (p. 389).

It is salutary to note that in the fifty year span of this Literature Review, from Cain et al. (1964) to Robinson (2014), including this study, the distress associated with miscarriage continues to be described as marginalised and unacknowledged for some women.

I believe that there is also a link between what Doka (2002) terms disenfranchised grief and Worden (1983) describes as “complicated mourning” (p. 83). In this model “complicated mourning” occurs when the griever is unable to progress through the traditional stages of grief where mourners are expected to give up their old attachments and readjust to a new life without the deceased. The phases that relate to expressing grief and remembering the lost relationship are particularly difficult after miscarriage. It can be hard for a woman to define the relationship she had with her baby and thus to fully articulate and explain what she has lost. I believe that my own experience led to me developing a form of complicated grief that perhaps I am still working through. There is also expectation from society generally, and from women themselves, that miscarriage is kept secret and not talked about. In this sense, perhaps women disenfranchise themselves after miscarriage.

Continuing the bonds

Rando (1985), in her research on parental bereavement, challenged the prevailing beliefs around complicated mourning and the need to detach after the loss of a child. She argued that unresolved grief was part of the normal experience of bereaved parents and that they not only grieved for the child but for all their lost hopes and dreams (Rothaupt & Becker,

2007), conceivably for a lifetime. Although the research was not initially around miscarriage, the findings that some women grieve after a miscarriage, possibly throughout their lives, seem in accordance with my experience and those of other women in the miscarriage literature (e.g. Arnold & Buschman, 2008; Hey, 1995; Letherby, 1993; Malacrida, 1998). Following Rando's (1985) research, new bereavement theories were developed that encouraged the bereaved to integrate memories of the deceased. Klass et al, (1996, p. 39) describe this as the bereaved assimilating an "inner representation" of the lost loved one into their lives and possibly continuing the bond forever. Over time, the notion of continuing bonds has become an accepted and mainstream way of explaining behaviour after bereavement (Klass et al, 1996; Machin, 2008). I discuss how this theory might further apply to miscarriage in my Findings and Discussion Chapter under the heading ***Complications and contradictions in coming to terms with the loss***. I also relate this theory to my own miscarriage experience in my Reflexivity Chapter.

I agree with Ingram, Hunt and Robson (2000) when they observe that bereavement theory "simplifies a very complex and rich experience" (p. 71). However, as a bereavement counsellor, I also feel that models of grief can be helpful. They can validate and normalise the grieving process because they illustrate common progression through phases of grieving towards a process of integration and coming to terms with a loss. Nevertheless, it does concern me that if this resolution does not happen within an indeterminate but socially imposed period of time, a person may be considered to have unresolved grief (Rothaupt & Becker, 2007). There are commonly held assumptions in Western society about how long we should grieve and variations from these expectations can be challenging. Research shows that women can feel pressure from friends, family and health professional to recover from their miscarriages quite quickly and to move on with life (e.g.

De Montigny et al., 1999 & Leppart & Pahlka, 1984). This may arise from the belief that a woman can become pregnant again quickly and move on from her miscarriage. There might also be a fear that lengthy periods of grief signify a mental health problem.

However, my research shows that although a woman's life may be changed by miscarriage, she invariably can move on and grow from the experience but this may take time.

Transition models

Another way of explaining the experience of miscarriage is to use transition models.

Murphy and Merrell (2009) argue that not all women view their miscarriage as the loss of a baby but more as a significant life event. They dispute the prevailing view in the literature that miscarriage is bereavement and that after miscarriage women experience grief in various degrees (e.g. Moulder 2001; Maker & Ogden, 2003; Adolfsson et al., 2004).

Similarly, they challenge the traditional models of grief (Parkes, 1972/1996; Worden, 1983/2010). Their transition model offers an alternative view that miscarriage is a process of change for women marked by phases of "separation, transition and incorporation" (p. 1590). However, it could be argued that this is just another form of bereavement model.

Phenomenological studies

There is a growing body of phenomenological research focussing on women's lived experience of miscarriage (e.g. Abboud & Liamputtong, 2005; Adolfsson et al., 2004; Adolfsson, 2010; Cote-Arsenault & Morrison Breedy, 2001; Gerber-Epstein et al., 2009; Maker & Ogden, 2003; Tsartsara, & Johnson, 2002). In these studies importance is given to women's individual and distinct voices. There is recognition that women's experience of miscarriage is dependent on many factors, ranging from the personal circumstances of each woman to the wider social and cultural context in which they live.

In particular, I want to review briefly the research of Adolfsson (2010), as this study has important resonances with my own research. Adolfsson argues that women's experience of miscarriage can only be explained by examining it through the lens of Heidegger's interpretive phenomenology. In this sense the focus is on the totality of experience through the past, present and future. In her research, she undertook 13 in-depth interviews with women on their experience of early miscarriage. Words or phrases were then selected from the interviews that were interpreted as having the most meaning in the context of the whole interview in an attempt to identify and clarify the "essence" of the experience (p. 77). However, the process of data analysis is not made very clear.

She found that a woman's feelings after miscarriage were influenced by her past experiences of pregnancy and reproductive loss; that a woman's current relationships, work and living conditions, contribute to how she perceives the experience and that miscarriage can alter her hopes for the future. Meaningfully, she states that the women in her study believe that only those women who have experienced miscarriage are fully able to understand this complex experience and its effects. To a certain extent, I believe this is true. However, I also think that effective qualitative research can bring a deeper understanding of the phenomenon of miscarriage to the reader.

Adolfsson's (2010) findings have close links to the three super-ordinate themes in my research: **Memories of the Initial Impact of Miscarriage**, **The Longer Term Consequences of Miscarriage** and **Making Sense of Miscarriage in the Present**. Both studies illustrate how the experience of miscarriages has impacted on the temporality of the lives of our participants. This becomes more significant when I consider that my participants are reflecting back on miscarriages that happened over twenty years ago.

Research using IPA

The only studies using (IPA) (Smith et al., 2009) that specifically focuses on the experience of early miscarriage are by Maker and Ogden (2003) and Tsartsara and Johnson (2002). In the first study by Maker and Ogden, 13 women who had experienced miscarriage within the first 14 weeks of their pregnancy were interviewed on average five weeks after their miscarriage. This data was then analysed using IPA. From this emerged a range of themes that were categorised into three stages labelled “turmoil, adjustment and resolution” (p. 407). There are similarities here to the transitional model by Murphy and Merrell (2009) described above.

However, research suggests that there is a link with the extent of a woman’s grief and the meaning she attributes to her pregnancy (Letherby, 1993; Layne, 2003; Parsons 2010). Therefore, I wonder if women who were in deep grief after their miscarriages would refuse to take part in a study five weeks after their miscarriage. This might explain why the respondents in this research describe completing a transition process over 5 weeks that is taking me a lifetime to work through. Maker and Ogden suggest that many quantitative studies on research miss the “subtle development and dynamic nature” of the change in feelings as a woman moves towards a process of resolution after miscarriage (p. 413). I agree but at the same time I want to acknowledge that for some women this progression may take a much longer period and possibly a lifetime.

The study by Tsartsara and Johnson (2002) aimed to evaluate from women’s own perception the care they received after a miscarriage in a large General Hospital in the Midlands. They interviewed six women, who had been treated in an Early Pregnancy Assessment Unit and analysed the data using IPA. Five themes emerged from this data which revealed the advantages and disadvantages of the miscarriage provision in the

hospital. These were 1) At the antenatal clinic: comparing self with other pregnant women, 2) EPAU: a special place to go, 3) D & C: why am I left on my own? 4) Need for explanation, 5) Need for sensitive after care services. The researchers concluded from this study that a more “patient orientated” (p. 55) approach would be beneficial for women experiencing miscarriage. These findings are concomitant with the research I reviewed earlier in the section *Attitudes of the healthcare profession to miscarriage*.

The feminist perspective on miscarriage

From the late 1980s and early 1990s feminist writers were emphasising the need to bring the impact of early miscarriage into the open (Hey et al., 1989; Letherby, 1993). Yet, there is agreement in the literature that feminist writers have been reluctant to write about pregnancy loss and in particular about early miscarriage (Hey et al., 1989; Hey, 1995; Letherby, 1993; Layne, 1997; Parsons, 2010). Hey, writing in 1995, expressed her disappointment that many pro-choice feminists did not identify with the idea that the unborn child has personhood. She maintained that this position allowed the pro-life arguments to be more appealing to women who had experienced miscarriage.

Two years later, Layne (1997) began researching into the growth of the pregnancy-loss support groups in America. These groups were attempting to confront the perceived taboos and silences about miscarriage and the apparent denial in Western culture that miscarriage can have a long lasting effect on women and their partners. They were fighting for the rights of women to have their grief after miscarriage acknowledged and for informed choice in their care during pregnancy. Although these were noble aims, writers such as Hey (1995) and Reagan (2003) argued that the language used by the pregnancy loss movement was adopted from the Catholic Church’s pro-life position on reproduction which was based on the sanctity of life and motherhood. The pregnancy loss movement

urged parents to acknowledge the personhood of their lost child after miscarriage. They referred to a “baby” rather than an “embryo” or “fetus” and encouraged parents to consider naming their child (Allen & Marks, 1993).

This was contrary to the feminist philosophy that did not accept that miscarriage was the loss of a child and according to Reagan (2003) there was fear that imbuing a fetus with personhood might give ammunition to the anti-choice and anti-abortion movement. Thus, Reagan argues that the feminist perspective was not heard on reproductive loss and paradoxically this vacuum was filled by the pro-life movement which resulted in their beliefs and attitudes becoming more main stream. However, as Hey (1995) points out, it is possible to be pro-choice without actually being strongly pro-abortion. Yet, this position was never powerfully claimed, leaving women who did not feel that their miscarriages were particularly significant as disenfranchised as women who felt their losses were not sufficiently recognised.

A relational model

In my view, during the 1990s, the moderate position that recognised the importance of each woman’s relationship with her unborn child (Layne, 2003) in determining a women’s level of distress after miscarriage was neglected. It fell down the chasm between the polarised positions of the pro-life and pro-abortion movements. Feminist writers on miscarriage such as Hey (1995) argued that if the notion of personhood as a cultural construct was acknowledged, then the process of imbuing personhood to some embryos and not others could be recognised and the belief accepted that some women form a close relationship with a wanted child during pregnancy. However, it is clear from this review, that the feminist movement did not hear the moderate voices of these feminist writers, many of whom had experienced miscarriage and were struggling to re-evaluate their

beliefs and make meaning from the experience in line with their feminist philosophy (Hey et al., 1989, 1995; Layne, 1997, 2003; Letherby 1993).

More than fifteen years later, Parsons (2010) a feminist writer who experiences miscarriage, presents the view that the way forward in this debate is to advocate a “relational model”. She writes:

“One can conceptualise, name, and define a woman and her embryo/fetus as physically connected to each other, while still recognising the variability in women’s emotional and intellectual connection to their foetuses. We can conceptualise a woman and her embryo/ fetus as interrelated on a physical level, while still recognising the severability of that relationship, attaching as little or as much emotional significance to the relationship as each woman deems fit” (p. 12).

She goes on to suggest that this relationship may remain fluid, changing and adapting to the different circumstances a woman might be presented with as her pregnancy progresses. However, this is not a unique concept. It is significant to note in this context, that researchers in the 1960s from Cain et al. (1964) and Simon et al. (1969) through to researchers in the 1990s such as Letherby (1993) and Swanson (1999a), have all stressed that the meaning of the relationship a woman has with her unborn child during pregnancy is important in determining how far she feels attached to her pregnancy. This perspective is summed up clearly by Allen and Marks (1993, p. 10) when they write, “Whether we feel our miscarriages are deaths or blessings, both or something else together, our feelings are okay.”

Parsons (2010) also reminds the reader that miscarriage is not just about losing a baby; that there are other losses associated with it. She suggests that during a miscarriage a woman

loses parts of her own body such as blood and tissue and in particular she feels a loss of control over what is happening to her. There are also losses associated with her plans and dreams for the future. Layne (2003) advocates that feminists should work towards developing “feminist rituals of pregnancy loss” (p. 247) which might provide “scripted ways for friends, relatives, and colleagues to offer support, acknowledge her loss, her connections to others, and her sense of belonging and identity” (p. 247). However, she does not go so far as to suggest ways in which this might be done. I suspect that most women will continue to struggle to find their own ways to manage their feelings after miscarriage including the writing of a PhD thesis.

Lesbian women’s experience of miscarriage

In the context of reviewing the literature on miscarriage from a feminist standpoint, it is also important to consider miscarriage from the perspective of lesbian and bi-sexual women. Peel and Cain (2012) point out that very little is written in feminist scholarship on pregnancy loss from the perspective of lesbian women. They argue that, “placing marginalised experience and non-normative groups of women more firmly within pregnancy loss scholarship promises to significantly augment critical, feminist and social scientific theorising” (p. 79). As this review demonstrates, the experience of pregnancy loss and in particular early miscarriage is very individual and therefore it is important not to neglect the experiences of diverse groups of women.

Peel and Cain (2012) argue that pregnancy loss is already often a disenfranchised form of bereavement and therefore in the context of lesbian relationships it can be even more complicated. Fewer lesbian women have children, nevertheless it is estimated that roughly one third of British lesbians are mothers (Golombok et al., 2003, cited in Peel & Cain, 2012). However, there is an absence of literature on lesbian and bisexual women’s

experience of pregnancy loss and similarly little research has been done into the psychological implications of miscarriage for non-heterosexual women (Peel & Cain, 2012).

One of the few empirical studies on lesbian women's experience of miscarriage is by Wojnar (2007) where 10 white American, lesbian couples who had experience of miscarriage were interviewed. Wojnar argues that in order to understand the impact of miscarriage on lesbian couples it is necessary to first appreciate the difficult conditions in which conception takes place. These range from confronting homophobic attitudes from within the family, negotiating which partner is to become the biological mother, finding donor sperm, dealing with prejudice from health professionals and living with the uncertainty before the non-biological mother can legally adopt the child. The overarching theme in her study is "We are not in control" and two subthemes were identified, "We work so hard to get a baby" and "It hurts so bad: The sorrow of miscarriage". Overall, Wojnar concludes that because of the challenges for lesbian couples in becoming pregnant, the pregnancies were generally wanted and much was invested in them. Therefore, the loss of the pregnancy was particularly devastating.

Following on from this research Peel (2010) undertook an online qualitative survey of 60 non-heterosexual women, mostly lesbians, from the UK, Canada and Australia in order to explore their experience of miscarriage, stillbirth and neonatal death. Three themes were identified, '*processes and practices for conception*', '*amplification of loss*' and '*healthcare and heterosexism*' (p. 726) which appear similar to those identified by Wojnar (2007) above. Peel goes on to claim that:

"Based both on the complex processes, practices and often lengthy time period involved in achieving pregnancy, and the emotional and material investment these

women made in impending motherhood, the experience of loss is amplified for lesbian and bisexual women” (p. 724).

She argues for a more sensitive approach from health professional to lesbian women and in particular their partners after miscarriage and stresses that there is a need for health professionals to recognise the challenges faced by lesbian women in becoming pregnant. Finally, she states that there needs to be more research into lesbian women’s experience of reproductive loss and that it should not be assumed or implied that it will be the same as for heterosexual women.

Whilst I am in no doubt that miscarriage can be devastating for lesbian women, I feel that the circumstances presented here could be equally applicable to heterosexual women, particularly if they are undergoing IVF. I can see no benefit in creating a hierarchy of distress after miscarriage. I feel it is more important to stress that many women may find themselves marginalised after miscarriage and set aside from the normative route of a healthy pregnancy resulting in a live birth. I would argue that what is needed is an approach that recognises the diversity of the experience of miscarriage for all women.

The challenges presented by ultra-sound diagnosis of miscarriage

Within the context of the feminist attitude to pregnancy and pregnancy loss the use of ultra-sound technology has been controversial, particularly with regard to the concept of personhood and the unborn fetus. Peel and Cain (2012) write:

“It is hard to locate pregnancy loss in the lexicon of feminism: Feminists have been well taught to mistrust the concept of the ‘pre-born child’, the now ubiquitous foetal image which threatens to take over the mother’s subjectivity and agency (Petchesky 2007)” (p. 87).

Peel and Cain (2012), in their research into lesbian women's experience of having their miscarriages diagnosed by ultra- sound, describe this type of miscarriage as "silent" (p. 80). They define a "silent miscarriage" as occurring when "the foetus dies *in utero* and is discovered by ultrasound scan before the foetus is expelled" (p. 80). In this case the pregnant woman is unaware that anything is wrong with her pregnancy until she undertakes a routine scan. They argue that an unintended consequence of this technology is that the pregnant woman has had time to bond and form a relationship with her unborn baby, whilst being oblivious to the fact that the embryo was no longer viable. This news can be shocking and devastating for all involved. Both authors of this research had this experience, one whilst in a lesbian relationship and a planned pregnancy, the other whilst in a heterosexual marriage with an unplanned pregnancy. In their research they undertook a critical evaluation of both experiences to determine how being in a different-sex relationship might impact on the diagnosis of a "silent miscarriage".

Both reported inadequate medical care and poor understanding from medical staff of the psychological consequences of miscarriage for both women and their partners. They were offered few options and very little information. Both women believed that their losses were unrecognised by society in general and that it was unacceptable to grieve for a loss occurring early in pregnancy. These are all similar to experiences reported by women after miscarriage consistently throughout this review. They state that, "pregnancy loss adds another dimension of 'ghostliness' to the abject construction of reproduction and maternity in Western societies" (p. 88). Thus, in their view, contemporary society perceives a woman who has experienced pregnancy loss as a shadowy figure on the margins of maternity or as Hey (1995) so eloquently puts it thrown out of the "secret club of maternity" (p. 131) until she becomes pregnant again.

However, Peel and Cain point out that this marginalisation can be worse for lesbian women. Even though they are not deliberately excluded from the little support that is available such as web based support boards and organisations like The Miscarriage Association and SANDS these tend to be dominated by heterosexual women and their partners. They remind the reader that it is particularly difficult and complex for lesbian women to just “try again” for another baby and conclude by pointing out the need for sensitivity from the medical profession towards the unique concerns of lesbian couples and their particular difficulties in conceiving. Finally, they also call for cultural shifts in how pregnancy loss is perceived generally in society which is again a recurring theme in this review.

There is a general consensus in the feminist literature, written by women who have experienced miscarriage, that more needs to be done from a feminist perspective to support women who miscarry (e.g. Hey, 1995; Layne, 2003; Parsons 2010; Peel & Cain, 2012). These writers argue that women should be encouraged not to collude in their own silence; that miscarriage needs to be talked about more openly and the stigma surrounding it dispelled. They suggest that this can be done by producing more accessible information for women about the possibility of miscarriage in early pregnancy and the risk that miscarriage may be discovered during routine ultra- sound procedures. They suggest that feminists need to continue the campaign for a more women centred approach by the medical profession and for the use of less alienating language used to talk about miscarriage.

Writers such as Hey (1995) point out that the anomalies in society’s attitude to both abortion and miscarriage need to be addressed when women who have abortions are reminded about the right to life and yet those who miscarry are encouraged to view it as God’s will or a blessing and to get over it quickly. They also want feminism to

acknowledge that miscarriage can make women feel that they have lost control over their bodies and this can be very challenging. Layne (2003) suggests that feminists need to help create models for supporting women who experience reproductive loss. This may be done through creating rituals and symbols that are meaningful to women and which might help creatively with the process of transition after such a loss.

Finally, many of these writers end with a plea for more feminist philosophical work to be done on early miscarriage otherwise there is a danger that the feminist position will continue to be weakened and undermined by the pro-life activist movement. My sense is that some feminist writers may fear that if they acknowledge the distress caused by miscarriage for some women they may be viewed as not supporting the pro-choice cause. Tentatively, I would also suggest that in presenting a more moderate view on the effect of miscarriage researchers may be thought of as pro-life and linked to the anti-abortion movement. I believe that amongst women there is a need for wider acceptance of diverse opinions and a more collaborative approach, if the important issue of the impact of miscarriage on some women is to be heard.

Summary

As this review shows, attitudes towards miscarriage have changed over time (Lovell, 1997; Reagan, 2003). Reagan (2003) sums up these changes succinctly when she writes that during the twentieth century attitudes to reproductive loss moved from “hazard to blessing to tragedy” (p. 359). Improved access to contraception and abortion from the middle of the twentieth century onwards had put women more in control of their reproductive lives resulting in women having fewer children (Chamberlain, 2010). More recently, technological advances in reproductive medicine have caused pregnancy and childbirth to become much safer for women (Letherby, 1993; Layne, 2003). However, as the research

reviewed here shows, this often means that when women experience reproductive failure such as miscarriage it comes as a profound shock to discover that modern medicine has very little to offer. There is also an expectation that a wanted pregnancy ends with the birth of a healthy child and when this fails to occur, a woman can be left with a myriad of complicated emotions ranging from trauma, anxiety, fear and guilt to anger, feelings of isolation and disenfranchisement (Adolfsson, 2010; Frost et al., 2007; Hey et al., 1997).

Miscarriage is also problematical because of the inconsistent attitudes towards it in contemporary Western society. Often it is shrouded in silence and kept secret. This may be because of its associations with women's intimate bodily functions, society's fear of death and a general desire to avoid facing blighted hopes and expectations. At the same time, it is viewed as a common occurrence, a minor medical inconvenience which is easily recovered from and simply resolved by a subsequent successful pregnancy. Therefore, it is not surprising, that research shows many women feel confused after a miscarriage and unprepared to cope with their complex feelings (e.g. Wong et al., 2003). Similarly, these ambivalent attitudes in society may also cause health professionals to feel challenged and ill -equipped to deal with women who miscarry (McLean & Flynn, 2012).

Throughout the twentieth century, pregnancy and childbirth have become more medicalised (Hey, 1995; Oakley et al., 1984). From the 1950s onwards the medical profession has been more involved in pregnancy and more women have had their babies in hospital. Thus, miscarriage has come to be regarded by doctors as a medical crisis and initially debates in the medical literature ranged around the best way to treat women physically who were miscarrying, although there was very little to be done to prevent it (Layne, 2003; Letherby, 1993). However, from the 1960s, with a mounting awareness generally of the links between psychology and health, there was growing interest in health

professionals researching into the psychological implications for women of miscarriage. This led to a gradual understanding that miscarriage may cause grief responses in some women (Brier, 2008). These concerns instigated debates around the nature of grief and depression and the difficulties of diagnosing these conditions in women who had experienced miscarriage (e.g. Brier, 2008; Frost & Condon, 1996; Nikcevic et al., 2007). From the 1990s there was also a growing interest in other psychological effects of miscarriage on women such as anxiety and trauma (e.g. Abboud & Liamputong, 2005; Geller et al., 2004; Gerber-Epstein et al., 2009).

At the same time that medical research was acknowledging a link between grief and miscarriage, contemporary bereavement theory was moving away from the stage theories of grief, developed by Parkes (1972/1996) and Worden (1983/2010), towards a greater recognition that for some people, and particularly parents who experienced perinatal loss, grief after bereavement may last a lifetime (Rando, 1985; Rosenblatt & Burns, 1986). Later, Klass et al. (1996) introduced their theory of “continuing bonds” in which the bereaved were encouraged to find ways of maintaining their relationship with the deceased throughout their life and this approach to bereavement has become accepted as a normal and healthy way to manage grief (Machin, 2008). Notably, there was also a growing acceptance in the literature that miscarriage may cause a grief response. The development of these theories overlapped with the emergence of the pregnancy-loss movement in America, which encouraged women who had experienced reproductive loss to maintain a relationship with their unborn babies (Allen & Marks, 1993; Layne, 2003).

Alongside debates on whether miscarriage results in psychological consequences for women and whether miscarriage should be viewed as bereavement, there has been constant deliberation on what are the best interventions for women after miscarriage (e.g. Simmons

et al., 2006; Murphy & Merrell, 2009; Wong et al., 2003). This is still continuing to the present day (e.g. Robinson, 2014). From the 1980s onwards, study after study, recommends better training for health professionals working with women who have miscarried. There are calls from women and health professionals for more holistic and women centred approaches and a plea for more readily available support and counselling for those who require it. Yet nothing appears to change. There is also a strange discordance in the demand for more counselling and psychological interventions for women after miscarriage and a lack of any research in this area by the counselling profession.

Particularly striking in this review is the fact that the majority of the pioneers writing and researching on the experiences of women who miscarry are women who have personal experience of miscarriage (e.g. Layne, 2003; Hey et al., 1993; Letherby, 1993; Malacrida, 1998; Oakley, 1980; Parsons, 2010; Reagan, 2003). I speculate on the reasons for this. From the 1980s onwards research into areas of specific interest to women and female experience has grown in the fields of Sociology, Anthropology, Health Psychology and Nursing studies and particularly in qualitative research (Letherby, 2003). However, the feminist movement and the academic community seem to have avoided engaging in much philosophical debate around the issue of reproductive loss (Parsons, 2010). This could be out of wariness that any recognition of the personhood of the fetus might cloud the pro-choice, pro-abortion arguments (Hey, 1995; Parson, 2010). Thus feminist writers only seem to engage with the topic after personally experiencing miscarriage (e.g. Reagan, 2003; Parsons, 2010). In my experience, a woman who miscarries may feel compelled to confront the philosophical and ethical debates around reproductive loss. If she is an academic and finds there is a lack of appropriate literature in the area, possibly her next step is undertake the research herself.

Disappointingly, there is an absence of men undertaking qualitative research on the theme of miscarriage. As this review shows, there is a large body of literature on miscarriage, written from a more medical perspective by health professionals for the medical profession. Much of this is written by men, although increasingly women in the nursing field are producing qualitative research on reproductive loss (e.g. Adolfsson, 2010; Evans, 2012; Wojnar et al, 2011). However, I can find no academic research written by men on their personal experience of miscarriage, although there is a growing body of research on the grief response of men whose partners miscarry produced by women (e.g. Johnson & Puddifoot, 1996; Murphy, 1998; Rinehart & Kiselica, 2010). Letherby (2009) argues that more research is needed into the male experience of reproductive loss but currently this important task is being undertaken mainly by female researchers. Certainly, research into reproductive loss would be enhanced by more qualitative research and first person accounts produced by men.

I agree with Reagan (2003) when she argues that it is damaging to believe that one's own experience is universal and it is important to remember that our experiences of miscarriage are formed by our history and the culture in which we live. Yet, this does not explain the apparent schism in attitudes to miscarriage between the feminist movement and the pro-life movement which has developed almost synchronistically within Western society. In my opinion, this has rendered theoretical discussion on reproductive loss very difficult and emotive. Possibly, if more academic writers, both men and women, were to research the experience of miscarriage from a diversity of positions the arguments would become less polarised and impassioned.

Finally, as I conclude this chapter, it is important to note for the purpose of my research that apart from the retrospective studies on reproductive loss already reviewed (e.g. Cecil,

1996; Malacrida, 1998; Smart, 2003; Peppers & Knapp, 1980; Rosenblatt & Burns, 1986; Wojnar et al, 2011), there is very little literature specifically on women's experience of miscarriage many years after the event.

Ultimately, as this review demonstrates, miscarriage will always be multifaceted and confounding. It is common place and yet disenfranchised; much researched and yet still misunderstood. Death before birth is inexplicable and it will always be the case that "there remains no script for death when there was only one for life" (Earle, Komaromy, Foley, & Lloyd, 2008, p. 90).

CHAPTER 4: METHODOLOGY

SECTION 1: THEORETICAL FOUNDATIONS

A decade into the beginning of the 21st century it no longer seems necessary to justify why I am using a qualitative research method as opposed to a quantitative approach. There are many researchers in all disciplinary fields now using qualitative methods and it has long been accepted and legitimised as an approach, particularly when researching into the subjective realms of human experience such as women's perceptions of miscarriage (Smith et al., 2009; Finlay, 2011; Harper & Thompson, 2012). However, different qualitative research methods come from different philosophical traditions and therefore it is important that I make my philosophical stance clear and that my choice of methodology corresponds with my philosophical position and enables me to answer my research question (Lowse & Prowse, 2001; Harper, 2012).

Harper (2012) describes the three main epistemological categories that fit with qualitative research as “realism, phenomenology and social constructionism” (p. 87). He divides realism into “Direct realism” where it is expected that data reflects reality and “Critical realism” where data tells us about reality but not directly because other influences beyond the text, such as cultural expectations, distort the evidence (p. 89). He locates thematic analysis and some forms of grounded theory here. He describes social constructionists as being more interested in research methods that focus on “language and the cultural and social availability of ways of seeing and talking about the world” (p. 90). Positioned here would be discourse analysis and some constructionist versions of grounded theory. Finally, I come to phenomenologists who focus on “subjective experience” (p. 89) from the standpoint of the participant and this is where I situate my philosophical position and my research methodology, Interpretative Phenomenological Analysis (IPA).

Interpretative phenomenological analysis

IPA is a qualitative approach developed specifically within psychology. However, it is now widely used by researchers in health, clinical and sociological psychology. In health psychology particularly, it is important to understand how patients interpret their bodily experience (Howitt, 2010). Therefore, since miscarriage can be very visceral, it seems an appropriate methodology for this research. IPA attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event. Thus, it is a suitable method for exploring how women perceive miscarriage many years after experiencing it (Smith et al., 2009). I have found a limited number of studies using IPA that specifically focus on women's experience of early miscarriage and I describe these in my Literature Review (e.g. Maker & Ogden, 2003; Tsartsara & Johnson, 2002).

In IPA the researcher is concerned with trying to understand how participants make sense of their own experiences. However, IPA acknowledges that one can never do this completely; access is always dependent on the researcher's own interpretation of another's personal world (Smith et al., 2009). Thus, IPA is also underpinned by hermeneutics or the theory of interpretation. Here the researcher uses intuition in an attempt to offer significant insights into the deeper meaning of their data. Smith et al. describe this process as learning afresh from the past in the "light of the present" (p. 27). This approach seems particularly pertinent to my research where I ask my participants to think about how an experience of miscarriage from the past has affected their present life and ultimately how they face the future. I find this methodology particularly attractive because as a counsellor, I feel there are analogies here to how I relate to a client through the changing dynamics of a counselling session using interpretation and meaning-making (Finlay, 2011).

The Founding Fathers of Phenomenology

Phenomenology is “the study of human experience and the way in which things are perceived as they appear to consciousness” (Langridge, 2007, p. 10). It engages with existential issues that reflect what it is like to be human and comes from rich philosophical roots (Finlay, 2011), which I explore here briefly.

Edmund Husserl (1859-1938)

Edmund Husserl is acknowledged to be the founding father of phenomenology (Smith et al., 2009). In very simple terms, for Husserl, phenomenology was about examining closely the essence of human experience and finding a way whereby we might come to know our own experience more deeply right down to its very essence. He developed a phenomenological method which involved stepping outside of our “natural attitude”, putting to one side or “bracketing” preconceptions or beliefs, a process also known as “reduction” or epoché (Smith et al., 2009; Lowes & Prowse, 2001; Gearing, 2004). Husserl’s phenomenological method involved progressing through a series of reductions, leading the inquirer closer to the essence of an experience in an attempt to arrive at “the content of conscious experience” (Smith et al., 2009, p.14). Ultimately, this was a first person experience; Husserl was conducting a phenomenological inquiry in order to arrive at as full a description as possible of his own experience (Smith et al., 2009). In this reductive attitude, Husserl expected phenomenologists to bracket or set aside their assumptions about the phenomenon and to immerse themselves fully in the new experience as it unfolded. This is a reflective process and, particularly for descriptive phenomenologists, the epoché or bracketing has become an important part of the research method (Finlay, 2011). Modern phenomenology is now mainly concerned with an attempt to understand the human

condition; “to describe the lived world of everyday experience” (Finlay, 2012, p. 10), such as women’s experience of miscarriage.

Martin Heidegger (1889-1967)

Heidegger moved this work on from a descriptive position to a focus on “being in the world” or “Dasein” in relationship with others (Finlay, 2011, p. 50). Here, understanding experience comes through interpretation. Heidegger did not separate understanding from language and thus theorised that we can only understand what our “being in the world” means through interpretation (Finlay, 2011). However in order to make an interpretation we bring prior experiences and assumptions to the encounter. Yet, as Smith et al. (2009) point out, we may not know what our pre-understandings are until we engage with the research phenomenon. This has implications for the notion of using bracketing as part of a reflexive process, which I have considered more fully in my Reflexivity Chapter.

Maurice Merleau- Ponty (1908-1961)

Merleau- Ponty developed the work of Husserl and Heidegger further, moving away from Husserl’s more transcendental and descriptive position to one which perceives the person as “embedded in the world” (Smith et al., 2009, p. 21). Merleau- Ponty expresses this beautifully when he writes:

“Where are we to put the limit between the body and the world since the world is flesh?...The world seen is not “in” my body, and my body is not “in “ the world...A participation in and kinship with the invisible...There is a reciprocal intertwining of one in the other’ (Merleau- Ponty, cited in Finlay, 2011, p. 57).

The phenomenological belief that the body and the world are interrelated has resonance for a study looking at pregnancy loss and an apparent failure of the body. It is significant to

consider from this perspective how women connect to and perceive their bodies during a pregnancy and particularly after a reproductive loss.

Hermeneutics

Gadamar (1900-2002), focused on the importance of history and tradition in interpretation. His belief was that we can never fully understand what the original author of an historical text, for example the bible, intended from a modern point of view because we are influenced by our own cultural prejudices. He suggests that the only way to attempt to understand meaning is through language which is central to qualitative research methods (Finlay, 2011; Smith et al., 2009). However, whilst attempting to make sense and interpret the language used by participants in their research, qualitative researchers need to be continually questioning their assumptions and remain open to the answers being revealed in a new way. He writes:

“The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meaning” (cited in Finlay, 2011, p. 60).

In order to achieve this, the researcher using IPA engages with the “hermeneutic circle” (Finlay, 2011; Smith et al., 2009). Smith et al. describe the hermeneutic circle as a basic principle in IPA because the researcher needs to have an ever changing relationship with the data and the interpretations she makes. Here, she continually attempts to come to an understanding of the parts and then the whole of her research, engaging in an oscillating process. Initial understandings are challenged, in order to reach a new understanding, which in turn is challenged and the cycle repeats itself. I particularly like the way Finlay (2011) describes this process as:

“Coming to understand the being of something” (be it a ‘text’ or the ‘phenomenon’ or ‘participant’ in the research context) through moving iteratively between the whole and parts and back again to the whole” (p. 115).

This broad and inclusive description resonates with me as a powerful account of the process of undertaking qualitative research. Throughout my research, I have been aware of this process. One moment I am exploring the meaning of a particular word or phrase for a single participant. The next I am considering how this is linked to all my participants’ experiences of miscarriage and then I am interpreting this in relation to a whole body of literature. I may then return again to the meaning of a single word or phrase in a transcript. Intertwined through this is a conscious awareness of how my own personal experience of miscarriage is influencing this process above. I see an analogy here to how I might weave a tapestry. Initially, I focus on choosing different coloured threads and the importance of each individual stitch and how and where they are placed in the canvas. At intervals, I step back and examine how well the new picture is emerging. I then resume the choosing of threads and the focus on each individual stitch. Eventually, a brand new picture will emerge but a closer examination will still reveal each of the stitches. Ultimately the weaver moves beyond the importance of each stitch and the qualitative researcher beyond the words in the text as something new and vital is created in its own right. As a researcher, this process never fails to fill me with wonder.

Idiography

The importance of the idiographic in IPA makes it an appropriate methodology for exploring my research question. I am attracted to its focus on paying attention to the “lived experience” of the individual, coupled with its emphasis on reflective interpretation by the researcher (Reid, Flowers & Larkin, 2005). According to Finlay (2011), it is this

concentration on the individual that separates IPA from other hermeneutic approaches (p. 140). In IPA, understanding is obtained through focusing on individual accounts. Each participant's account is explored in- depth and the analysis is based closely on the meaning of experience for that particular person. Only when this is done are the accounts put together and a more general description and interpretation of the phenomenon offered to the reader (Smith et al., 2009). The focus that IPA places on both the unique experience of participants' and their more common experiences resonates with me as a person- centred therapist because it reminds me of the words of Carl Rogers (1967, p. 11-12), "What is most personal is most universal". I hope that in this research I have been able to capture some of this apparent paradox so that my readers will gain insight into each of my participant's individual experience of miscarriage as well as a deeper understanding of their broader and more collective experience of miscarriage.

Evaluation of IPA as a research method

Since its inception in 1996, IPA has become one of the most popular qualitative research methods used in Psychology (Brocki & Weardon, 2006; Shaw, 2011; Smith, 2011).

Conceivably, this was because during the 1990s, Jonathan Smith was motivated to provide Psychology with a qualitative, experiential methodology that would have at its core an emphasis on personal experience. In this sense, he wanted it to be markedly different from discourse analysis, which was becoming very popular in Psychology at the time (Smith, 2011). Since then, Smith and his colleagues have provided very clear guidelines for researchers wanting to use IPA in their detailed and comprehensive book (Smith et al. 2009). The momentum and popularity of IPA has continued and because of the clear guidelines which continue to be published (Smith, 2010) and many training sessions on how to employ the method held at British Universities every year, it has become attractive

to novice researchers and researchers who are new to qualitative methods (Chamberlain, 2011).

The strengths and weaknesses of IPA

However, Smith's continuing promotion of IPA and his guidelines on what makes good IPA (Smith, 2010) has led to much debate in the literature about the nature of IPA as a methodology and how it compares to other qualitative methodologies (Brocki & Weardon, 2006; Chamberlain, 2011; Todorova, 2011; Willig, 2013). Carla Willig (2013) explores the limitations of IPA under four headings, "The role of language", "Suitability of accounts", "Explanation versus description" and finally she poses the question "Is there a place for cognition in phenomenology?" These concerns have been addressed in the comprehensive book by Smith et al. (2009) and in recent articles (Smith, 2010, 2011). I explore briefly here, some of these controversies and debates about IPA.

The skills of the researcher

Attempting to define IPA can sometimes feel like standing on shifting sands.

Commentators have used various complimentary epithets to describe IPA ranging from "flexible and rigorous" to "accessible" "convincing" and having "straight forward guidelines" (Braun & Clarke, 2013, p. 183; McLeod, 2011, p. 151). However, these claims of accessibility and ease of use, particularly for novice researchers, make it vulnerable to assertions that it lacks substance and sophistication in its approach (e.g. Braun & Clarke, 2013; Parker, 2005). Yet paradoxically, Smith et al. (2009) stress a need for the researcher using IPA, to be creative and not confined by the conventions of the methodology.

Furthermore, they place emphasis on the researcher having "rigour and interpretative flair" (p. 23). There is also the requirement, during the analysis, to move beyond the literal meaning of the participants' words towards a deep psychological interpretation, which

relies very much on the researcher's intuition (Smith et al., 2009). Thus, in my view, the demands placed on the researcher using IPA are considerable because the quality of the research is very much determined by the skills of the researcher, both in the interview and data analysis process and these skills cannot be learnt from text books alone, however comprehensive.

The role of language and the suitability of accounts

Willig (2013) sees IPA as having limitations because it does not fully recognise the important role that language plays in qualitative research. She suggests that phenomenologists have disregarded how far thoughts and feelings are defined and confined by language. She argues that experiences described by participants are not just realistic accounts accessed through thinking and feeling but constructed through language. However, Smith et al. (2009) address this criticism and argue that "our interpretations of experience are always shaped, limited and enabled by language" (p. 194) and this is consistently recognised by IPA.

Nevertheless, it is clear that some people will be unable to translate thoughts and feelings into words that appropriately communicate the depth and richness of experience required by good IPA (Willig, 2013). Yet, I believe that although this requirement does mean that some participants might be excluded from this type of research, the ability to use language should not be underestimated. If a researcher chooses their participants wisely and facilitates the interviews well, then it is possible to obtain rich and insightful data from participants from all types of background. This is illustrated in an idiographic study using IPA by Eatough and Smith (2006). Here the female participant makes meaning of her aggression and anger through the use of evocative imagery and metaphor. For example, she uses the redolent expression, "I feel like scrambled egg in my head" (p. 119), despite

being described as having left school at 16 years of age and working in a variety of unskilled jobs.

Convergence and divergence

Collins and Nicholson (2002) criticise IPA for its emphasis on a need to present convergence and divergence within themes. They suggest that this may result in a weakening of the idiographic focus during the process of theming and interpretative analysis because the narrative sequence in an individual interview may be lost. This issue has been a concern in my research. I understand the importance for the reader of being able to follow each participant's individual story as well as grasping the super-ordinate and sub-ordinate themes which attempt to capture the essence of my participant's overall experience of miscarriage. Indeed, Smith, Jarman, & Osborne (1999) warn the researcher using IPA of the danger that the individual experience of participants' may become lost in the detail of analysis. However, they offer the expectation that in good IPA the unique nature of the individual will hopefully re-emerge during the refining of the writing up process. This awareness played a part in my decision to order my super-ordinate themes in a sequential and linear way and I discuss this procedure later in this chapter. I have also consistently included references to my participants' individual stories and unique experience throughout my Findings and Discussion Chapter.

Ultimately, I see it as a strength that I have been able to emphasise where there is a divergence in my findings. I agree with McLure (2013) that there can be an obsession with sameness in this type of research. I believe that by acknowledging the differences in my participants' accounts, I am ensuring that my findings are trustworthy and dependable because it is evident that I have stayed focused on the importance of idiography in my

analysis. Ultimately, this serves to highlight the depth and variety of my participants' experience of miscarriage.

Social and cultural contexts

A further criticism of IPA is that the social and cultural context in which participants make meaning of their experience is neglected (Braun & Clarke, 2013; Todorova, 2011; Willig 2013). Todorova (2011) argues that IPA has a coherence of approach which focuses on personal experience and meaning making which is also sensitive to language. Yet she expresses concern about whether IPA's focus on the phenomenological is consistent with an analysis which also wishes to be sympathetic to the social and cultural world of participants. However, she concedes that IPA does offer "epistemological flexibility" to allow this exploration and she articulates the hope that as IPA becomes further established, it will be able to draw more on "constructionist ideas" and integrate these into its methodology (p. 36).

She writes:

"Sensitivity to socio-cultural context in an IPA analysis is consistent with its coherent epistemological and theoretical framework, since we can identify the social meanings which are entwined with the personal meanings and resources for people's sense-making in health and illness" (p. 36).

I agree with Smith et al. (2009, p. 195) when they state that for the researcher using IPA the focus will be "hermeneutic, idiographic and contextual" and in my view this triad is inextricably linked. In the case of my own research, I feel that an understanding of social and historical context is particularly important when the research is partly retrospective and I have addressed this in my Literature Review.

Explanation versus description

Another criticism levelled against IPA is that there are too many examples of research where the focus on describing experience is predominant and where interpretation is often neglected or done superficially (Willig, 2012). In his article on what makes good IPA, Smith (2010) asserts forcibly that IPA should be interpretative and not just descriptive (p. 24). He states that a rigorous IPA study should include a wide range of extracts to illustrate the theme and following each extract there should be “an interpretative commentary” so that the researcher is engaging in “the double hermeneutic” (p. 24). Inevitably, there will be published research using IPA that is perceived to have been done badly or has not fulfilled all the necessary requirements (Brocki & Weardon, 2006; Smith, 2010). Yet, these arguments could be made against any qualitative research approach. Significantly, in his evaluation, Smith (2010) considers that 82% of the 51 papers he reviewed are acceptable or good examples of IPA research.

Willig (2013) argues that because phenomenology is focused on describing the experience of being in the world, it does not tend to ask questions about why these experiences happen and why individuals may perceive them differently. She suggests this limits understanding of a phenomenon (p. 95). However, in my view, it is understandable that in wanting to give voice to marginalised and disenfranchised groups, some researchers using IPA may choose to focus on the more descriptive accounts of their participants’ experiences in order to honour and prize these.

Is there a place for cognition in phenomenology?

Both Langridge (2007) and Willig (2013, p. 95) ask, “Is there a place for cognition in phenomenology” (p. 95). Smith et al. (2009) give a comprehensive answer to this question

in their discussion on the relationship between IPA and other approaches. They maintain that in IPA:

“Cognition occurs within the informal, intuitive domain of reflective activity, in the natural attitude. It is dynamic, multi- dimensional, affective, embodied and intricately connected with our engagement with the world, and we would therefore argue that this cognition is at the heart of the phenomenological project” (p. 191).

They contend that thinking and reflecting are an aspect of being in the world and we can access these indirectly through listening to how people make meaning through the language of their stories and accounts. Smith et al. (2009, p. 189) discuss this process in their detailed account of “Layers of reflection,” where they consider the four stages an individual may go through in attempting to make sense of a significant experience. Here there is an explanation of the growing consciousness of being aware that may be experienced in everyday life before we engage in the deliberate reflection on something important to us. They describe these four stages as “*Pre-reflective reflexivity*”; “*The reflective ‘glancing at’ a pre-reflective experience*”; “*Attention on the pre-reflective*” and the “*Deliberate controlled reflection*”. They argue that for the IPA researcher, cognition is about “sense making” and “meaning making” and these are the foundations for learning about how people relate to the world (p. 194). I suggest that these are also the processes that a reflective researcher engages in when undertaking the interpretative element of IPA and in particular the deliberately controlled reflection.

Relationship between IPA and Thematic analysis (TA)

There is debate in the literature about whether IPA can be clearly distinguished from other research methods and in particular from thematic analysis (TA) (Braun & Clarke, 2013; Chamberlain, 2011). If I had not selected IPA as my preferred methodology, I may have

chosen to work with TA. Therefore, it is appropriate to look more closely at what I believe to be the similarities and differences between these methods. Personally, I find that the lack of differentiation between TA and IPA can be perplexing and I do perceive it as a weakness in my methodology. In his recent evaluation of IPA, Smith (2010) proposes an emphasis on the number of themes that should be included in a study. It is possible that this focus on specific criteria might result in encouraging less flexibility and inventiveness in IPA (Todorova, 2011), ultimately, causing it to become even less distinguishable from thematic analysis (Chamberlain, 2011; Todorova, 2011). Yet Braun and Clarke (2013, p. 183) argue that IPA has always, from its very beginnings, lacked substance and flexibility compared to TA. They argue that the strength of TA is due to the fact that it is one of the few qualitative methods that does not have a prescribed way of data collecting or a required epistemological or ontological foundation. They state boldly, “It really is ‘just a method’” (p. 178).

However, there is a set of guidelines produced by Braun and Clarke (2006) which describe clearly how to undertake thematic analysis and which has lead, perhaps paradoxically, to TA becoming more and more a methodology in its own right (Joffe, 2012). In my view, it is the chameleon nature of thematic analysis that may make it attractive to researchers. Thematic analysis can be applied to many different and varied theoretical approaches, whereas IPA is a distinct methodology underpinned by philosophical roots in phenomenology and hermeneutics (Smith et al., 2009).

Nonetheless, if the researcher chooses to use thematic analysis in an interpretative way, then from my own observation it can be difficult to distinguish it from IPA. Frith and Gleeson (2012) set out what they consider to be the differences between an inductive thematic analysis (ITA) and IPA. They suggest that although the steps in the data analysis

are similar, IPA generally has a smaller sample size. This means that the focus of IPA remains idiographic and concentrates on describing the phenomenological world of the participants and the interpretation of what is said happens later in the analysis. Whereas in ITA the common themes across the data set are developed from the very beginning. They also make the point that this difference in approach begins during the interview process. The researcher using IPA needs to interpret and ask questions during the interview in order to understand the individual participant's meaning well enough to make interpretations later in the analysis. Whereas, the researcher using ITA needs to avoid generating too much idiosyncratic interview material in order to find sufficient commonality across the themes during the analysis. Yet, I would argue that TA could still be undertaken in an interpretative phenomenological manner and therefore it is only the philosophical underpinnings of IPA that would distinguish it from thematic analysis. This remains an inherent struggle as I attempt to explicate my chosen methodology.

Nevertheless, I am confident that it is IPA's clear theoretical foundation that allows me to be innovative and creative in my research but at the same time assured that I am using a sound methodology, rooted in an appropriate philosophical tradition and one that is applicable to my research question (Lowse & Prowse, 2001; Harper, 2012).

From the beginning of this research, it has been important for me to find a methodology that focuses on my participants' individual voices whilst allowing me to interpret the data and make my perceptions transparent to the reader. IPA makes this possible because it allows me, "to stand alongside the participant, to take a look at them from a different angle, ask questions and puzzle over things they are saying" (Smith et al., 2009, p. 36). However, I fully acknowledge the complexities of this approach and I look at the ethics of interpretation later in this chapter.

In summary, I have chosen IPA, despite its inevitable limitations, and in preference to TA, because as Smith (2010) puts it so eloquently: “IPA believes in a chain of connection between embodied experience, talk about that experience and a participant’s making sense of, and emotional reaction to, that experience” (p. 10). Thus, I am confident that this is the methodology that can best allow me to honour and distil the essence of my participants’ individual experiences of miscarriage, whilst coming to some conclusions about the psychological impact of this event many years later and exploring how my participants have learnt to incorporate this experience into their lives.

SECTION 2: THE INITIAL RESEARCH PROCESS

In this section of my Methodology Chapter, I explain the procedures I undertook during my initial research process. These include the recruitment of my participants, the research interviews, my own bracketing interviews and the ethical implications of undertaking sensitive research.

Ethical procedures

McLeod (2011, p. 66) makes a distinction between the “ethical procedures” undertaken in qualitative research, such as obtaining informed consent from participants and permission from ethical bodies and “ethical practice” which is an awareness of ethical issues as they arise throughout the course of the research. In this section, I particularly address the ethical procedures I undertook during my research and I discuss other ethical issues as they emerge.

The first key ethical issue to be addressed, whilst undertaking research as a practising counsellor, is to have an adequate knowledge of the BACP Ethical Framework (2013). I

have endeavoured to be true to the principles set out in this framework throughout my research.

I obtained permission to undertake this research from Keele University's Ethical Review Panel in January 2010. A copy of this permission can be found as appendix E. Throughout my research I have abided by the Keele University's Code of Good Research Practice and I have followed the BACP Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004) under the five headings below:

- i. Ethical orientation
- ii. Risk
- iii. Relationship with research participants
- iv. Research integrity
- v. Research governance

I have quoted from these sections where relevant throughout this chapter.

I have also abided by the BACP (2013) Ethical Framework for Good Practice in Counselling and Psychotherapy and its guidelines for undertaking research are summarised below:

1. The right to give or withhold consent to participate in research is a basic human and civil right.
2. Confidentiality is a major ethical concern when conducting research.
3. Careful consideration must be given to adequately protect personally sensitive information and to obtain consent.

4. All research is likely to involve the researcher looking through the lens of his or her personal values at the experiences of others that may be shaped by different values. We must be aware of social and cultural diversity.
5. Researchers have responsibilities to themselves to ensure personal safety and an entitlement to be treated ethically.

Recruitment of my participants

Five women agreed to take part in this study. All of the women were between the ages of 47 and 65 and had at least one miscarriage between 14 and 28 years ago. Between these five women they have experienced 10 miscarriages, two stillbirths and one abortion. This is a striking number of reproductive losses for a small sample and I was not aware of the extent of this until I had completed the interview process. Initially, each woman who volunteered to take part in this research told me she had experienced a miscarriage. All five women were recruited as a result of my own contacts and through self-referral. Two referred themselves after hearing me speak at a conference on my research project and three volunteered to take part after learning informally about my research.

The women in this study

All the women in this study have been given pseudonyms and I have used brief contextual detail in order to protect their anonymity.

Janet, at the time of the interview was 54 years old, married and working in a science related profession. Janet had been married for ten years before she had her first pregnancy loss. This was a stillborn daughter, who died in the womb two days before her due date. Janet then suffered two miscarriages; the first approximately 28 years ago and the second a year later. She subsequently went on to have three successful pregnancies.

Dee was 65 years old when interviewed, married and working as a counsellor. Dee's miscarriage occurred 23 years ago when her three children were all in their teens. Tests showed that if her baby had gone full term there was a strong possibility it would have suffered from a chromosomal abnormality.

Lucy when interviewed was 47 years old, married and working as a health professional. After the birth of her son, she experienced three miscarriages in quite quick succession, the first 14 years ago. The second miscarriage caused her to have quite severe mental health problems. A few years later she adopted a 19th month old child.

Susan was 57 years old and divorced at the time of the interview. She worked in further education. At 18 years of age she had an abortion, followed a few years later by a stillbirth. Her daughter was still born at 30 weeks gestation. Susan had a miscarriage 28 years ago when her eldest child was 10 months old. She had another successful pregnancy after this miscarriage.

Tess was 53 years old when interviewed, married and working in higher education. She had two children followed by three miscarriages between 15 and 18 years ago. After medical treatment, she went on to have another successful pregnancy and her youngest child is now 14 years old.

Informed consent

"The right to give or withhold consent to participate in research is a basic human right."

(Bond, 2004, p. 6)

Once my participants had accepted the invitation to take part in the research I gave them an information sheet in which I laid out clearly the aims of my research and the procedures

that I would be following when recording interviews, transcribing and theming. A copy of this can be found as appendix C.

I assured my participants of anonymity, informed them that they would not be identified by name and that the information from the interview would be stored on a password protected computer. Only my supervisors and I would have access to the raw data and that it would be destroyed once the research was completed and examined.

I encouraged them to consider carefully whether they wanted to take part and to discuss their decision with friends and relatives. They were informed where the research would take place and what would happen during the interview. I apprised them of the benefits I hoped would result from the research such as wanting to gain a deeper understanding of how women perceive their miscarriages many years after the event and that this knowledge might be helpful for counsellors and those that work in the Health Service. My participants were given my contact number at Keele University and my supervisor's contact details. They were also told whom to contact at the university if they wished to make a complaint. I provided them with details of The Miscarriage Association and the British Association of Counselling and Psychotherapy (BACP) if they wished to access counselling or support after the interviews. Once they were fully informed and had agreed to take part in my research, my participants signed the consent form, a copy of which can be found as appendix D.

However, there are ethical issues around whether participants can give fully informed consent at the beginning of an exploratory qualitative interview (Duncomb & Jessop, 2012) and I discuss this more fully when I explore the ethical issues in undertaking sensitive research below. A research interview on a sensitive topic such as miscarriage can be unpredictable and disturbing and the researcher cannot anticipate the direction of the

interview and what might be revealed. Thus, it is important to monitor consent from participants throughout the interview process. I continued to re-visit informed consent with my participants, checking that they were still happy to be involved in the research both at the beginning and at the end of the interviews (Smith et al, 2009; Finlay, 2011). Yet, I was aware that even though they could withdraw during or at the end of the interview, the fact that they might reveal distressing material during the interview process was unavoidable.

Gathering the data

At the beginning of a piece of qualitative research one of the dilemmas confronting the researcher is how many participants to include in the study and thus how many qualitative interviews to undertake. The answer is often dependent on the research question, the researcher's methodological and epistemological approach, ethical considerations and pragmatic concerns such as the time and resources available and the method used to recruit participants. Qualitative research is often exploratory and tentative and it is difficult to determine at the initial stages how much data will be required or how it will be used (Eatough & Smith, 2008).

Sample size

I chose to include five participants in this study, in line with IPA's orientation towards an idiographic approach, which requires a fairly small, homogenous and purposive sample (Smith et al., 2009). My sample is homogenous in the sense that all five participants experienced pregnancy loss at least 14 years ago.

IPA has been used to research both single case studies and larger data sets of up to 42 participants (Smith et al., 1997; Smith et al., 2009). In their review of published IPA studies Brocki and Weardon (2006) found there was a wide variation in sample sizes

ranging from one (e.g. Robson, 2002) to 30 (e.g. Collins & Nicholson, 2002). Therefore, there appears to be no defining principle for sample size in IPA. Braun and Clarke (2013) suggest that three to six interviews will generate sufficient data for an IPA study. Smith et al. (2009) also specify this number and emphasise that because of the focus on individual experience in IPA, the requirement is to produce quality of analysis rather than quantity and therefore IPA generally benefits from small samples and indeed case studies. Significantly, Smith et al. (2009) observe that as IPA develops and further studies are published, smaller samples are becoming the norm. Recently, Smith (2010), in his evaluation of what makes good IPA concentrates more on sufficient sampling to evidence themes within research projects, rather than on the number of participants interviewed. Nevertheless, a small sample size does raise questions about generalizability. However, IPA is not concerned with making claims for large groups of people or for generating theory about human behaviour. In IPA, the researcher is committed to understanding the individual perspective and aims to produce an in-depth account of the essence of each participant's experience (Smith et al., 2009). This requires time consuming, close and systematic analysis. Thus, interviewing a small sample of five women gave me the time and opportunity to explore the richness of each woman's individual perception of pregnancy loss. Miscarriage is a complex and sensitive topic and I felt that every woman's account deserved in-depth and rigorous attention to the uniqueness of their experience. As well as observing and distilling convergence across the accounts, a small sample allowed me to take note of divergence as this is also an important aspect of a well- produced IPA study (Brocki & Weardon, 2006; Eatough & Smith, 2008; Smith, 2010). Throughout my Findings and Discussion Chapter, I have given particular attention to aspects of my participants' account where there has been significant divergence. Overall, I feel using a

small sample in my research has resulted in a full and moving account of the phenomena of pregnancy loss many years after the event and I address further the issue of what makes good qualitative research later in this chapter.

Bracketing interview procedures

Before I undertook the process of interviewing my participants, I took part in my first bracketing interview (Rolls & Relf, 2006; Tufford & Newman 2012). The rationale for undertaking bracketing interviews has already been described in my Reflexivity Chapter. Therefore, my focus in this section is on the procedures I used in undertaking the bracketing interviews and theming the transcript from my first bracketing interview.

The first bracketing interview process

The role of the facilitator

As I described earlier in my Reflexivity Chapter, my first bracketing interview took place in February 2010 facilitated by Heather, a colleague from the Counselling Psychology group at Keele University. Tufford and Newman (2012, p. 86) see this role as creating an “interface between the researcher and the research data.” In this context, Drew (1989) views the responsibility of the interviewer as using her own intuitions to help the researcher move away from rationally thinking about the research, allowing her to engage with it on a deeper emotional level and bringing her feelings more fully into awareness. Since Heather is an experienced counsellor, supervisor and researcher, she had all the necessary skills to fulfil this complex role. We were both familiar and comfortable with the role of counsellor supervisor and this role seemed similar. However, I trusted that Heather would prevent the interview slipping into a therapy session or academic supervision (Rolls & Relf, 2006). Also I was confident that she would avoid collusion and be able to set aside

her own beliefs about miscarriage and thoughts about undertaking research during the interview. However, I was aware that she would inevitably bring another level of interpretation to the interview. Yet, rather than being a limitation, I saw this as adding additional layers to the richness of the experience.

We met in a designated interview room in the University's School of Psychology and agreed that the issues discussed in the session would be confidential. As we were both familiar with the therapeutic hour it seemed an appropriate period of time to talk, bearing in mind the need to transcribe the interview. We began by setting similar boundaries to a counselling session and we decided that since the interview was being both recorded on a digital audio recorder and filmed we could stop at any time if either of us felt uncomfortable.

I initially gave Heather a list of questions she could use in the interview but stressed that these were fluid and that the focus of the session could change as we went along. I asked her to help me articulate my thoughts around the following:

1. Where am I now as I start this process?
2. Why do I want to do this study?
3. What do I think/believe about miscarriage?
4. What do I want to find in this research?
5. What are my fears?
6. What might get in the way?

Heather read through the questions but did not refer to the sheet again during the interview as we discovered that these issues arose naturally in our discussion.

After an hour, we had a short period of reflection where we both gave our feedback on the process; this was also recorded. We arranged that I would transcribe the whole recorded interview and do a basic thematic analysis on the transcript (Braun & Clarke, 2006). We contracted that I would make the results available as a data set in my thesis and I was given permission to use quotations from Heather's interventions during the interview. An account of how I used this thematic analysis is given in my Reflexivity Chapter. Finally, we discussed the possibility of undertaking further bracketing interviews later in the research.

Data analysis of my first bracketing interview

I decided that I wanted to include an analysis of my first bracketing interview as another data set in my research for a number of reasons. I was inspired by the two stage process model described by Rolls and Relf (2006) for the social construction of knowledge. In this sense, a bracketing interview would allow me to engage in both a "narrative form" through my interview with Heather and a "textual form" that could be thematically analysed (p. 304). The interview would be part of my audit trail, illustrating my deepening understanding of my perception of miscarriage and the thematic analysis would illustrate clearly the quintessence of this experience. I also saw my thematic analysis as part of my reflexivity and as an original way to have my voice heard at the heart of this study. This aspect is discussed more fully in my Reflexivity Chapter.

Thematic analysis

I chose to theme my bracketing interview using thematic analysis (TA). I felt it was a suitable approach to use within an interpretative phenomenological study as it can be used to examine how a person describes and makes meaning of an experience as well as

exploring social contexts (Braun & Clarke, 2006). From a pragmatic point of view, I wanted a method that allowed me to do a basic search for themes within a limited period of time but still provide a relatively rich description of my experience and allow a reflexive process. I also wanted an approach that would support a single case study and one where it was appropriate to relate my findings to the relevant Literature after the data analysis. Overall, I would describe my approach as an inductive thematic analysis at a latent level as it is data led and I make an attempt to explore the underlying assumptions of what I say and their broader meanings (Braun & Clarke, 2006; Howitt, 2010).

Data analysis of my first bracketing interview

My data set consisted of the transcript of my bracketing interview and the short period of reflection and discussion on the process afterwards. I analysed the data making use of Braun and Clarke's (2006) six phases method described below. Before I transcribed the interview, I divided the page on the computer into three columns. The first column I named *Themes*, the second *The transcript* and the third *Initial codings*. After I had transcribed the interview verbatim into the middle column, I read it through whilst watching the video recording, which enabled me to study the finer nuances of the interview in greater detail. After this familiarisation with the transcript, I then printed out the transcript and columns described above. I began generating the initial codes by making detailed notes in the right hand column by hand in blue ink, searching for as many patterns and initial themes as possible line by line. I then went through the data again by hand, refining these themes by making notes in red ink. When all of these sub-themes had been codified, I collated these on my computer under thirteen main themes. I continued to refine these themes, matching them to relevant data extracts. At this point I was confident that I had eight key themes that suitably mapped the essence of my experience of miscarriage and my role as researcher.

During the fifth phase I refined these down to four: *Time Travelling*, *Wind-Egg*, *Creative Forces* and *Shadow Child*. The sixth phase described by Braun and Clarke (2006) is the writing up of the report and I present a detailed account of these themes in my Reflexivity Chapter.

Evaluation of TA

Unlike IPA, one of the perceived weaknesses of TA is that there is no one recognised way of approaching the analysis, although Braun and Clarke (2006) have set down some stringent guidelines which I have attempted to follow. Whereas TA does give the researcher flexibility, it can appear to be a too broad and unfocused method unless the researcher adopts a rigorous approach to the analysis making it absolutely clear and transparent how they approached the data and undertook the analysis. In a similar way to IPA, TA relies on the intuition of the researcher to develop themes and unless this process is made transparent than perhaps it is too easy to make the data fit into a set of preconceived themes. However, I would argue that this is less of a problem if the researcher allows the emerging themes to be data led. I have written a detailed evaluation of TA in relation to IPA earlier in this chapter.

The second and third bracketing interview

I undertook the second bracketing interview in March 2011 after the research interview process was finished and the third in February 2012 after I had completed the initial theming of my transcripts. The basic procedure for undertaking these interviews remained the same as for my first bracketing interview described above. However, in these subsequent interviews, I did not use a list of interview questions but I asked Heather to

help me talk about the progress of my research, the ways in which my attitudes to the research were changing and developing and what I was learning from the research.

After each interview was completed, I repeatedly listened to the recording and then I made a list of resonant quotations from the interview in a word document and noted the timings so I could return to the place in my digital audio recorder easily if required. I felt that there was no need to fully transcribe or analyse these interviews because I wanted them purely for reflexive purposes rather than as another data set in the research. Pragmatically, I was also aware that undertaking two further sets of thematic analysis would be time consuming. I have used quotations from the second and third bracketing interview at appropriate points throughout this research.

Ethical issues in undertaking a bracketing interview

Inevitably, undertaking bracketing interviews on the sensitive topic of my experience of miscarriage and my motivations as a researcher, presented me with some ethical issues and I have discussed these more fully in my Reflexivity Chapter. In attempting to explore my own experience of miscarriage I am compelled to share some personal and private moments and at times this has made me feel vulnerable. As McLeod (2001) states, “The normal ethical procedures of informed consent seems inadequate in relation to the possible consequences of publishing personal narratives” (p. 198). I have attempted to deal with the emotional effects by discussing them with my personal therapist and with my supervisor and exploring them in my research diary. I agree with Etherington (2004) when she comments:

“Writing about our lives can become a healing endeavour (whether for research purposes or otherwise) that strengthens our connections with our body, mind and

spirit through sharing our experiences and newly discovered self-knowledge” (p. 145).

I would suggest that talking about our lives can also be healing and perhaps the bracketing interview can play an important role in this for the researcher. Carrying out a bracketing interview and completing a thematic analysis on the transcript has sometimes been sad but at the same time affirming. I feel I have made my voice heard, both as a woman who has experienced a miscarriage and as a researcher coming to terms with my motivations for such personal research. In presenting an authentic account of my experience of miscarriage, I hope I have come closer to understanding my own experience and thus making myself more open to the experience of my participants.

Conducting the research interviews

Once I had completed my first bracketing interview, I felt more prepared to begin the process of recruiting and interviewing my participants for this research and I describe the procedures I used and the ethical challenges I faced in detail below. All of my participants knew that I was a teacher, a counsellor and a part time PhD student at Keele; some had heard me speak professionally about the personal impact of my miscarriage at Keele conferences where I had given papers. I feel that the knowledge that I had experienced miscarriage helped my participants feel comfortable and safe to talk about their own intimate experiences in-depth.

The data was collected through interviews lasting between 60 to 90 minutes each. Two of the interviews were conducted in a room in the School of Psychology at Keele University, one interview at the participant’s place of work and two of the interviews in the participants’ own homes. These venues were chosen for the convenience of my participants. I did not have a sense that the different venues affected the interviews in any

significant way, although I am mindful that the impact of location is discussed in the literature (e.g. Braun & Clarke, 2014). It is possible that because my participants were familiar with the counselling process they were aware of the practical issues in setting up an interview. In all the venues, the need for comfort, privacy and safety was achieved successfully. The interviews were recorded using a digital audio recorder and then the media files were uploaded on to my computer's hard drive which is password protected.

In-depth, unstructured interviews

In this section, I aim to describe the interview procedures that I adopted and to justify why I chose to use in-depth unstructured interviews. It is important in qualitative research that the role of the interviewer is transparent and the interview process is clearly described and reflected upon (Lowse & Prowse, 2000; Brocki & Weardon, 2006).

The use of semi-structured interviews is usually the standard method of data collection in IPA (Brocki & Weardon, 2006; Langridge, 2007; Smith et al., 2009). However, for a number of reasons, I chose to use in-depth unstructured interviews, rather than semi-structured interviews with an interview schedule. I wanted a method that would allow my participants to express their own feelings about their experience of pregnancy loss, in their own words, without my agenda getting in the way. Langridge (2007) suggests that one of the main advantages of unstructured interviews is that they are “conversational in style” (p. 68) and this is more likely to engender rapport with participants and thus achieve a more authentic response. However, he cautions that this method is more difficult to use successfully as it requires considerable practice. As a trained counsellor, I was confident that I had sufficient expertise to adopt a conversational style and through attentive, empathic listening skills I could facilitate my participants to talk fluidly and extemporaneously about the sensitive topic of miscarriage. I felt that this approach would

allow me to obtain more spontaneous and dynamic material (Kvale & Brinkman, 2009) and create the strong relationship which I feel is the most important aspect of a successful and fruitful interview (Knox & Burkhard, 2009). A successful model for this method was used by Hall (2006) in her study of women's experience of post natal depression.

I began each interview with "a single core interview question" (Smith et al., 2009, p. 69), although, on reflection, it felt more like an invitation to talk rather than a question requiring an answer. Each interview started with a statement such as, "Just tell me something about your miscarriage" or "I would like to know something about your miscarriage". The phrasing was slightly different in each case as I put my participant at ease and created the appropriate atmosphere for intimate talk. Thus, my interviews were very much participant led and focused on the participants' own perceptions of miscarriage, in line with IPA's idiographic commitment.

I stressed from the very beginning, that it was fine to stop the interview at any time. It can be seen in the transcripts that at some points my participants do cry but all wished to continue and the crying felt like a natural part of recollecting emotional events. At these moments, I used an empathic response to show that I understood their distress for example, "You're finding this upsetting." During the interviews, I used open questions when I needed further clarification and reflections and brief summaries to show I had understood what had been said. Within the last 5 to 10 minutes of the interviews, I indicated that the interview was moving towards the end, although the lengths of the interviews were fluid and I tried as far as possible to work towards a natural ending. Once the recording equipment was switched off, we did a short debrief to allow the participant time to reflect on the process and to recover emotionally.

In IPA, the interviewer plays an interpretative role through her choice of interventions, and I address this later in this chapter (Lowse & Prowse, 2000; Willig, 2012). Thus, I saw no need to be unduly concerned about objectivity or interview bias during the actual interviews. Indeed, I felt it necessary to make interpretations during each interview otherwise I might not have reached sufficient understanding of my participants' meaning making for a good IPA analysis (Frith & Gleeson, 2012). I felt that after my initial bracketing interview, I had a clear understanding of my own agenda. I had reflected on my experience of miscarriage and I was aware of my concerns around disenfranchised grief and the need for validation. I knew that I would have an opportunity to reflect further and consider how these assumptions might influence the research, at a later date in my second bracketing interview. Therefore, at this point, I wanted my research interviews to be unrehearsed, genuine human encounters (Finlay, 2011).

Limitations of unstructured interviews

However, this approach is not without its limitations. Brocki and Weardon (2006) suggest that it might be difficult for the reader to judge the quality of an interview without a copy of the interview schedule or to evaluate how the interview has impacted on the data.

Another disadvantage of not using an interview protocol lies in the fact that it may be more difficult to generate themes if each participant has not been asked the same questions (Knox & Burkhard, 2008). Yet conversely, using an interview schedule may limit the depth of exploration to what the researcher already knows about the research topic, thus effectively structuring the analysis before the data collection begins (Brocki & Weardon, 2013).

Smith et al. (2009) argue that a semi-structured interview schedule is useful when researching into sensitive topics as it allows the researcher to plan for difficulties they

might encounter and to practise phrasing difficult questions. They suggest that an interview schedule given to participants in advance may help prepare them for the unexpected and avoid a traumatic emotional response. Similarly, having an interview schedule may reduce anxiety on the part of the interviewer, allowing the interview to proceed smoothly without the fear that it may grind to an uncomfortable halt. However, as an experienced counsellor I was confident that I could sustain an interview without becoming over anxious. I was also fortunate in that my participants were articulate and already conversant with therapeutic technique and interview style. They were all either counsellors or had been in therapy previously. They were familiar with talking about sensitive issues and prepared for the emotional impact. Yet, this might not always be the case. Ultimately, my interviews did result in very rich and fruitful data as my participants related moving and poignant accounts of their experiences of abortion and stillbirth, in addition to talking about miscarriage. This may not have happened if I had used an interview schedule.

Ethical issues in undertaking sensitive research

“Research concerning socially sensitive issues may create areas of vulnerability for people who are fully functioning in all other ways” (Bond, 2004, p. 8).

I have no doubt that undertaking this type of sensitive research can present the researcher with ethical issues. Lee (1993, p. 4) defines sensitive research as “research which potentially poses a substantial threat to those who are or have been involved in it”. He goes on to argue that those who are involved in sensitive research inevitably pay a price for their participation. Whilst this seems a rather dramatic declaration, there is growing recognition in the literature of the challenges faced by those engaged in qualitative research on sensitive topics (e.g. Dickson- Swift, James, Kippen, & Liamputtong, 2007; Liamputtong, 2007). My participants in this research are not vulnerable in the sense that they live

marginalised lives or have diminished autonomy (Liamputtong, 2007). However, I consider miscarriage to be a sensitive subject because it involves the private sphere of the individual (Robertson, 2000) and is concerned with issues that are stressful and sacred for some women (Lee, 1993).

Impact on the participants

For participants, being interviewed on a sensitive topic such as miscarriage may feel intrusive. It is important to recognise this and to ensure that participants are aware of the intense feelings they might have during and after the interview process (Frith & Gleeson, 2012). There is also a risk that participants may disclose private material without thought to the consequences later. A skilled interviewer, through facilitating trust and building rapport, may unwittingly encourage a participant to divulge material that they have never revealed before. At this point it is too late to withdraw and the participant may regret this revelation and feel intruded upon and distressed (Duncombe & Jessop, 2002, p. 119).

I believe it is the researcher's responsibility to be aware of this risk whilst recognising that participants have autonomy. However, in this situation, it is questionable whether the participant can give fully informed consent as it is not known if and when an indiscrete disclosure might happen (Duncombe & Jessop, 2002). This was my experience in my interview with Susan when she disclosed to me personal details about her abortion and became distressed. It is hard to find a balance between a participant's need to talk and respect for their emotional well-being and it can feel like walking a fine line between the requirements of the research and the best interests of participants.

Therefore, I made sure that I gave my participants time and space to deal with their emotions and I provided information on where they could go to address these feelings if

required. It was mainly for these reasons that I chose to undertake only one interview with each of my participants. In a number of IPA studies the participants are re-interviewed later in the research (Eatough & Smith, 2008; Smith et al., 2009). Yet, I felt that subjecting my participants to another interview, even months later, could be too painful and might feel abusive.

However, it is important to remember that this intimate encounter can also have positive effects for the participant (Etherington, 2004; Finlay, 2011). Lowes and Gill, (2006) describe participants finding contributing to research as “therapeutic” and “beneficial” (p. 593) and some express a desire to altruistically help others. McLeod (2013) also suggest that it is useful to ask participants about their experience of being interviewed because their response can be further evidence of the validity of undertaking the research. This is illustrated below when I asked Susan why she had agreed to take part in her interview:

Interviewer: I’m just looking at my watch and we’ve got about 5 minutes left. I’m wondering what made you talk about it today or agree to, because it’s obviously painful.

Susan: Because it’s helping you

Interviewer: Well thank you

Susan: In helping you look into this- I would help anyone to learn more.

(Susan: 23/716-721)

Being truly listened to can have a profound effect (Finlay, 2011) and this is particularly important for those who have experienced pregnancy loss and who might feel they have not been heard or given a voice. All my participants expressed their gratitude for being

given the opportunity to talk and to indirectly help other people through their participation. They also felt that their experience of miscarriage had been validated in some way.

Researcher's responsibility to self

“Researchers have responsibilities to themselves to ensure personal safety and an entitlement to be treated ethically” (Bond, 2004, p. 11).

It is also important to consider not only the safety of my participants but my own well-being whilst undertaking sensitive research. Beale, Cole, Hillege, McMaster, and Nagy (2004) recommend that the researcher prepares carefully beforehand by considering how she may be affected and by setting up suitable protective strategies for debriefing; my first bracketing interview was helpful in this respect. Similarly, Finlay, (2011, p. 214) points out that “researchers use themselves as tools” in the interview process and this can be challenging. In all probability, the researcher can expect to have an emotional response to an emotive topic, particularly when they have a close interest in the phenomenon being researched or have directly experienced it.

Although I found it beneficial to have good counselling skills when interviewing my participants, it also presented me with some additional ethical issues. I was aware that I could not react during my research interviews as I would in a therapy session. In some ways this felt liberating because I felt able to ask questions and show my emotions in a less restrained way. Nevertheless, I was aware of how easy it might be to blur the distinction between a therapeutic and a research interview (Finlay, 2011). There is also a possibility that therapeutic responses may bias the data collected from the interview (Knox & Burkhard, 2009). I know that at times during my interviews I found these concerns challenging. Although I made my role absolutely explicit, there were moments when I

unintentionally responded to my participants in a therapeutic manner. I was not always fully aware of this during the interviews but it became clearer to me as I analysed the transcripts. However, I take heart from Finlay's reflections on qualitative interviewing as a relational process and her advice to researchers to "let yourself go, be open and unknowing" (p. 214). I believe that it is the authenticity of the research encounter that really matters.

Sensitive research can also be emotionally distressing when an element of self-disclosure is expected from the researcher, either during the interview process or during the writing of the thesis (Liamputtong, 2007). All my participants knew that I had experience of miscarriage and occasionally during the interviews we cried together. By sharing my own experience, I felt I was building the relationship and encouraging intimacy. It was also a way of reducing the power imbalance in the encounter (Dickson, et al., 2007; Liamputtong, 2007; Lee, 1993).

I have tried to view my interviews as creative opportunities for uncovering the unexpected. However, because these encounters can be intense, it is important that researchers space out their interviews and afterwards give themselves time for reflection and debriefing (Beale et al., 2004; Lowse & Gill, 2006). My research interviews took place over a period of 18 months and during this time I wrote consistently in my reflexive journal, made sure that I practised self-care and had frequent access to a personal therapist and academic supervision. Thus, although the interview process was exhausting and emotional at times, I had plenty of time to recover between interviews and I made full use of the support available to me. The fact that I have worked on my thesis part-time ensured that I had breaks in the interview process and during the analysis. This meant that I experienced the emotional intensity of the work in more measured doses.

Transcription

Once each interview was complete I began the process of transcription following the principles set out by O'Connell and Kowal (1986). Sometimes transcribing felt upsetting because I was listening over and over again to painful accounts of pregnancy loss and similar reactions to this have been documented in the literature (Warr, 2004; Liamputtong, 2007). Throughout this time, I kept a reflexive journal where I noted my response to the interviews. During my second and third bracketing interview, I also reflected on the personal impact of these interviews and I have given a fuller account of this in my Reflexivity Chapter.

Each interview was transcribed verbatim and words were spelt conventionally unless they were used by the interviewer or participants unconventionally. Non-verbal utterances such as laughter or crying were recorded in brackets and pauses by ellipsis or dashes. IPA does not require the interviewer to time pauses or to record all non-conversational expressions. A clear, accurate script is sufficient for analysis (Smith et al., 2009). During the process of transcription, I removed all reference to names and places to ensure that the anonymity of my participants was preserved. I found punctuating the transcripts difficult as speech does not follow the usual syntactical conventions but I have endeavoured to use punctuation to give the best approximation of meaning (Gillham, 2005). A sample of transcription from Janet's interview can be found as appendix B.

SECTION 3: DATA ANALYSIS

In this section, I describe in detail the process of data analysis that I followed after I had completed my first interview and I consider how I have critically evaluated my own research. I explore issues around the process of interpretation and reflect on what we actually do as researchers when we analyse and interpret our participants' data.

Throughout my data analysis, I adopted the same procedures described below for all my research interviews. Unless otherwise stated the main source for this method comes from Chapter 5 of the book on IPA written by Smith et al. (2009). However, Smith et al. make it clear that this text should be used merely as a guide and not as a recipe book because good IPA is flexible and innovative and the onus is on the researcher to adapt it to fit their own research project. I hope I have undertaken my data analysis in this spirit.

I believe that since IPA is relational and thus a joint creation between the participant and the researcher, every piece of IPA will be a unique exploration into the participants' lived experience. This will involve interpreting how the participants make meaning of their experience through the analysis of verbatim transcripts. The researcher oscillates between analysing the whole text and examining small parts of the text in detail; it is dynamic and creative. The researcher is free to analyse the text in an imaginative and innovative way whilst working within certain parameters. How I undertook this challenging task is described below. Throughout this process I have kept a reflexive research diary and I have detailed its function and purpose in my Reflexivity Chapter.

Reading and re-reading the text

All the examples used for illustration in this section are taken from Janet's transcript because she was my first participant. I hope this detailed account of my analysis of her transcript will give a clearer picture of what can seem a rather mysterious procedure.

As soon as I had transcribed Janet's interview, I began the task of re-reading the transcript whilst simultaneously listening to the recording so I could hear the finer nuances of speech. Usually, in IPA, because of its idiographic nature, each case is analysed in detail and themed separately before the researcher moves on to cross transcript analysis. As I read, I allowed myself to become immersed in Janet's account and occasionally I made notes in my reflexive diary about the personal impact this was having on me. I began to see patterns in the interview and how our conversation ebbed and flowed. I noticed contradictions in Janet's story and I could sense some of the main themes beginning to emerge.

Initial noting

Before I began the initial process of analysis, I opened a word document on my computer and divided it into three columns. Then, I copied and pasted Janet's transcript into the middle column, numbered the lines and printed the document. After two further readings of the transcript, I began to handwrite notes in the right hand column, undertaking a process described by Smith et al. (2009, p. 83) as "free textual analysis." (It is usual when working with IPA to make initial notes in the left hand margin. I have reversed this process as to me it felt more natural to work in this way.) I also underlined on the transcript parts of the text I considered important. I commented on anything that I considered relevant and at this stage my notes were mainly descriptive, focusing on the literal meaning behind Janet's words. Next, I moved on to a more interpretative analysis. I looked closely at Janet's use of language, trying to gain a sense of her "lived world" (p. 83) and interrogating the

transcript in more detail. I made my notes by hand, the descriptive comments in black ink and the more conceptual comments in brown (Smith et al., 2009, p. 84).

Close analysis of Janet's transcript

The following account of how I analysed and interpreted a small section of Janet's data is based on page 13 of her transcript. (A copy of this page is provided as appendix B). On this page, Janet is talking about her miscarriages and comparing them to her experience of stillbirth. I underlined key phrases and made descriptive and interpretive comments such as "she fears sounding hard" and "protects herself from emotional attachment" and thus I slowly began to build up a picture of Janet's life-world (Smith et al., p. 88). I also looked at Janet's use of language. She uses the word "pain" seven times on page 13 and I am intrigued by the phrase "entered me". This could have so many different layers of meaning in the context of childbirth and pregnancy loss. In this section I can see Janet hesitating; there are many pauses as she tries out the words "enter" and "entered". I observe her struggle to make sense of what pregnancy loss means for her; and I sense she does not usually allow herself to have these thoughts. I think one of the most poignant comments here is when Janet says that if she looked at her miscarriages as children she had "3 dead children" and that is too painful to think about. It raises all sorts of questions about what a miscarriage actually is in Janet's mind and is quite challenging to my own perceptions of miscarriage. I recorded my reaction to this statement in my research diary and reproduce it here:

'Janet makes it clear that seeing her miscarriage as losing a child is too unbearable. I wonder how this squares with "not a bereavement?" She uses the word "acknowledges" – this is worth a closer look and some further interpretation.

I find this sentence quite heart breaking – it is the colloquialism perhaps of “those two” that is upsetting me’ (RD, 3/1/12).

Finally, I made more conceptual annotations where I tried to come to a deeper understanding of the meaning of pregnancy loss for Janet and at the same time bring in my own personal reflections and experience. This can be seen when I wonder if Janet is protecting me. She knows that I have had a miscarriage but I sense that she is trying to tell me that a stillbirth is more painful from her perspective but she is being very hesitant. After this, I question whether someone can choose to feel pain or not, what prioritising pain might mean. Is there the idea here that the pain of the stillbirth was so great that she could not add to it by allowing herself to feel even more pain after the miscarriages? I am wondering about the idea of detachment and what this means in the context of pregnancy loss. Thus, I moved away from a purely descriptive account to a more “abstract” and “critical” engagement with the text (Eatough & Smith, 2008; Smith et al., 2009, p. 90). This required me to take a more exploratory and reflexive approach. This brief account illustrates how I analysed the whole of Janet’s transcript.

Developing emergent themes

At this point in the analysis the data set now consisted of Janet’s transcript and all my annotations. I worked with my initial notes to see what themes were emerging and concentrated on looking at small pieces of the transcript to check that the emerging themes were closely aligned to the text. Thus, I was engaged with the hermeneutic circle (Smith et al., 2009) described earlier in this chapter. I was moving from an analysis of the whole text to scrutiny of small portions of the text and then eventually back to the whole text, looking for patterns, connections and emerging themes. At this point, through a process of selection and interpretation, I was moving away from the literal words spoken by Janet and trying to

capture and distil what pregnancy loss meant for her in a more compact and abridged fashion.

I then wrote the emerging themes in the left hand margin of the transcript, aiming to produce a concise statement which captured Janet's initial words but also my interpretations (Smith et al., 2009). The first emerging theme *Things just need to be dealt with* summarised the idea that Janet could not allow herself to feel any emotion about her miscarriages. This led into the theme *Pain can be prioritised*. I believed that Janet was saying that she could choose the amount of pain she allows herself to experience. She accepts the pain of stillbirth but has no emotional resources left to recognise the pain of miscarriage. This links with the final theme that emerged from Janet's transcript, *Miscarriages are not about losing children*. Janet recognises that she was pregnant six times but does not wish to acknowledge that she lost three babies through stillbirth and miscarriage. At this point, I noted in my research diary the impact this analysis was having on me and I give an account of this in my Findings and Discussion Chapter.

Searching for connections between emergent themes

I then typed up chronologically the list of emergent themes into a word file on my computer. Then, I looked at how I could cluster the themes by moving them around using the cut and paste function. As the clusters developed, I gave them names and these eventually became the eleven master themes for Janet. Sometimes the name came from one of the emerging themes such as *Just get on with it*. Others were more abstract and interpretative like, *The shadow of stillbirth*. I also used the technique of "polarisation" (Smith et al. 2009, p. 97) where I focused upon "difference instead of similarity." For example, throughout the transcript, Janet emphasised the negative aspects of pregnancy

loss. However, at some points she focused on her experience as transformative and I called this theme *Pregnancy loss as a life changing experience*.

I was also attentive to particular “key life events” and “temporal” moments which made up Janet’s narrative (Smith et al., 2009, p. 98). This resulted in the main themes of *Family history*, *The struggle to have a family* and *The impact of pregnancy loss on subsequent births*. The frequency which some themes emerged was also a consideration for developing a cluster. Smith et al. (2009) note that this method might be particularly relevant if the interview has been unstructured as it highlights particular concerns for the participant. This resulted in three further themes: *Don’t pity me*, *Self-preservation*, *Keeping secrets*, and finally *Health professionals*. Some themes did not fit into these clusters and I put these under the heading *Complex feelings*. Finally, I drew up a table of master themes and sub-themes for Janet, using a Microsoft Excel spread sheet with page and line numbers and illustrative quotes. In this way I felt that I had captured Janet’s perceptions of miscarriage many years after the event in a clear and accessible way.

Next, I moved on and repeated this process with Dee’s transcript. I continued these steps until I had analysed all five of my participants’ transcripts. As Smith et al., (2009) point out, at this stage it was difficult not to be influenced by the themes that emerged in previous cases but I strived to set these aside and to do justice to each case in an idiographic manner. I was fortunate because I had long gaps between analysing cases and there was time for the themes to fade from my memory between each analysis. However, I do acknowledge that at some level I must have been influenced by what I found earlier. I feel it is also significant that I generated a large number of main themes during the analysis of Janet’s transcript, far more than for my other participants. This might be because the interview was more wide ranging or because I was still refining the process of analysis.

Looking for patterns across cases

At this stage, I had a table of master themes and subthemes for each of my five participants. The number of master themes for each participant ranged from 11 to 4 which I feel was partly the result of my becoming more efficient at theming as the process of analysis progressed. I then laid out all these tables and looked for connections between cases. I felt overwhelmed by the volume of data, so I made a table illustrating just the major themes for each participant.

Developing super-ordinate themes

From this table, I was able to see similarities between major themes for each participant and importantly differences. For example, I could see that in four cases there was the major theme of *'Pregnancy loss is a life changing experience'*. I also noticed that the theme *'adoption'* was unique to just one participant. It was immediately clear that *'Contact with health professionals'* might be a major theme across the cases and I use this as an example to illustrate how one of my initial super-ordinate themes developed.

This realisation, gave me a place to start in all the muddle and I began to work in more detail on how the participants perceived their relationship with health professionals. I went back to the tables of master themes and themes for each participant, looking closely at the themes that had a link to health professionals. I also returned to the transcripts to re-read the extracts that referred to contact with health professionals. At this point, I noticed that there were also themes across transcripts to do with the reactions of friends and family to pregnancy loss and some divergence in women's attitudes to medical staff both within the transcripts and between transcripts. Once again I used the cut and paste function on my computer to build up clusters of cross transcript themes in a word document. Thus, very slowly, the initial super-ordinate theme *Women's perceptions of the attitudes of other*

people towards pregnancy loss emerged. Within this theme “nested” (Smith et al., 2009, p. 101) three other themes *Perceived insensitivity of medical staff*, *Support from medical staff* and *Attitudes of other people towards miscarriage*. I then drew up a very detailed chart for this super-ordinate theme. I recorded on the chart every quotation I could find from each participant that was relevant to this theme and noted the line and page numbers from the transcript. I hoped that this would help me at a future date to access quotations quickly when I wrote up my analysis.

Very slowly, I repeated the process time and time again with all the major themes and subthemes, using the chart of cross transcript themes for each participant as a point of reference. Eventually, by the end of August 2012, after a long and laborious process, I had four super-ordinate themes and seventeen nested themes. I then drew up a master table of themes for the whole group illustrating how sub-ordinate themes were nested within super-ordinate themes, which participants contributed to the theme and including cross references and indicative quotes.

Looking at the themes again.

However, a year later I revised these super-ordinate themes, including the one I use for illustration above. In December 2012, I reviewed my data analysis and I began to suspect that I had not done full justice to the super-ordinate themes. Intuitively something did not feel right. I also thought that the sub-themes “*The shadow of stillbirth*,” “*Living with the effects of termination*” and “*Adoption*”, that had been generated by only two of my participants, could be subsumed into other themes. I realised that these important individual issues could be effectively addressed in the analysis of my findings and did not need to be represented as themes in their own right.

In order to explore this further, I arranged for a colleague, with experience of qualitative research, to independently theme two of my transcripts. We spent some time discussing her theming, which were remarkably similar to mine, and I deliberated with her about my initial super-ordinate themes from August 2012. I began to write up the analysis of these results but during the writing process it started to become clear to me that I only needed three super-ordinate themes. The first would focus on the initial impact of miscarriage on my participants, the second on the longer-term consequences of miscarriage and the third on how my participants felt about miscarriage in the present. This particular order felt more compact and chronological. The themes appeared to follow a natural progression, through the actual pregnancy loss up to the present time. However, I acknowledge that recollections of life events such as miscarriage are not linear; memories of pregnancy loss are messy; they jumble and merge, appear vivid and then blur. A reading of my transcripts makes this very apparent. Nevertheless, theming and ultimately producing a table of my findings required some judgements to be made around sequencing and this appeared to be a logical and more satisfying choice. I then produced a chart which illustrated how my themes had changed from August 2012 to this final point in June 2013.

In January 2014, after I had written up my findings and discussion for the first Super-ordinate theme "*Memories of the Initial Impact of Miscarriage*" I decided to merge the two sub-themes *Support from medical staff* and *Perceived insensitivity of medical staff* into one sub-theme entitled ***Perceived attitudes of medical staff***. This development again illustrates the fluid nature of allowing themes to emerge from the data and the sense that engaging with these themes is an ongoing process. A master table for the group which presents my final super-ordinate themes and nesting sub-ordinate themes illustrated with quotations from each of my participants is reproduced as appendix A. An abridged table of these

findings is presented below (Figure 1). The next chapter in this thesis is a detailed discussion and analysis of these findings.

Figure 1: Abridged master table of themes for the group

WOMEN'S PERCEPTION OF THE EXPERIENCE OF MISCARRIAGE MANY DECADES AFTER THE EVENT
<p style="text-align: center;">SUPER-ORDINATE THEME 1.</p> <p style="text-align: center;">MEMORIES OF THE INITIAL IMPACT OF MISCARRIAGE</p> <p><i>Sub-ordinate themes:</i></p> <p><i>The physical process of miscarriage</i></p> <p><i>The early psychological effects of miscarriage</i></p> <p><i>Attitudes of other people towards miscarriage</i></p> <p><i>Perceived attitudes of health professionals</i></p>
<p style="text-align: center;">SUPER-ORDINATE THEME 2.</p> <p style="text-align: center;">THE LONGER TERM CONSEQUENCES OF MISCARRIAGE</p> <p><i>Sub-ordinate themes:</i></p> <p><i>Reproductive struggle and the longing for another child</i></p> <p><i>The effect of reproductive loss on subsequent pregnancies</i></p> <p><i>The impact of miscarriage on family life</i></p>
<p style="text-align: center;">SUPER-ORDINATE THEME 3.</p> <p style="text-align: center;">MAKING SENSE OF MISCARRIAGE IN THE PRESENT</p> <p><i>Sub-ordinate themes:</i></p> <p><i>Contradictions and complications in coming to terms with loss</i></p> <p><i>Miscarriage as a life-changing experience</i></p> <p><i>Commemorating miscarriage and bearing witness</i></p>

Ethics of interpretation

I am completely aware that in undertaking this research I can only discover a small part of what might be women's experience of miscarriage. As I made clear at the beginning of this chapter, the researcher undertaking IPA must always acknowledge the impossibility of ever making complete sense of another person's experience. They can only rely on their own interpretation of another's personal world. However, Willig (2012) warns of the "power of the interpreter" (p. 45) and suggests that researchers may abuse this by offering interpretations that are not consistent with the reality of what participants are describing. She also warns of the temptation to manipulate interpretations to benefit the researcher's own agenda. I believe that throughout this research I have endeavoured to remain open to alternative interpretations and I have not attempted to force my findings into existing theoretical frameworks. In this respect, it was beneficial to undertake my literature review after I completed my data analysis. This meant that my interpretations were based solely on my own intuition and curiosity and I avoided the temptation to make the theory fit with the literature. I allowed the themes to emerge and then interpreted the data. It was only at this point that I looked for commonalities and differences within the extant literature.

Conversely, Willig (2012) also argues that avoiding interpretation can be unethical. She states that it is important for researchers to recognise that our participants' accounts might not always make sense and that people are equivocal. Undertaking qualitative research can mean becoming enmeshed in the messiness and trauma of other people's lives and this is certainly true of research into women's experience of miscarriage and it is important to recognise this aspect in my own research.

Yet, throughout the process of analysis, I have become more aware that my participants might not always find my interpretations palatable. This has become more apparent to me

as my thesis draws nearer to its conclusion. I know that I am reluctant for my participants to read my discussion because of the impact it might have on them. This raises further issues for me about how fully a participant can give informed consent to a researcher's interpretation of their data. I have not offered my participants an opportunity to see or object to my interpretations as I feel that the logistics of this type of contracting would be extremely complicated and I cannot envisage how it would work. This dilemma is rarely discussed in the literature, although Etherington (2004) considers it in the context of developing ethical relationships with participants whilst at the same time interpreting what they reveal through a reflexive lens. An awareness of this power imbalance is perhaps even more pertinent when researching an issue such as miscarriage where participants may already feel voiceless and disenfranchised. However, I have as yet no answers to this concern.

What do we do when we interpret?

It seems appropriate at this point, to consider what actually happens during the mysterious process of interpreting data. Brocki and Weardon (2006) suggest that the interpretative role of researchers is often not sufficiently considered by those claiming to undertake IPA and therefore I wish to address this. They state that the procedures for accessing deeper levels of interpretation, in this type of research, need to be explained more clearly despite their assertions that IPA has straightforward guidelines.

Finlay (2011) suggests that IPA operates at three different levels of interpretation. The first level is when the researcher identifies the emergent themes and uses them to create a summary of the original experience. Then the researcher uses her interpretative skills more creatively by perhaps constructing the participant's story and by introducing the participant's use of imagery and metaphor. Finally, she proposes that deeper levels of

interpretation are brought to the analysis through attempting to understand the text by bringing in other theoretical ideas and perspectives. Similarly, Smith et al. (2009) in their account of “Layers of reflection” (p. 189) which I have discussed earlier and Smith’s article (2011) “We could be diving for pearls” do go some way to offering an account of the process of interpretation and I return to this article later.

In my experience, interpretative analysis is a mysterious, intuitive process and engaging with the double hermeneutic is far from simplistic and indeed very hard to explicate. Therefore, it is not surprising that there appears to be a lack of guidance on how to undertake deep level interpretation and analysis. I am aware that this Methodology Chapter can only give a snapshot of the procedures I undertook and does not do full justice to the long, iterative, intuitive almost magical process. I have explained the procedure that I followed but I do not have total clarity about how my findings eventually materialised other than to say I kept on reading the transcripts, thinking, reflecting and finally writing in a process almost akin to alchemy.

Interpretation as a mysterious process

Jonathan Smith, in his conversation with Carla Willig talks about the mysterious process of interpretation and the difficulties of explaining the process (Willig, 2012, p. 211). Willig responds by commenting that Counselling and Psychotherapy literature offers some insight into this phenomenon. This resonates with me as a humanistic therapist. Crucially, there is a connection between the work Carl Rogers did on “focusing” with Gendlin (1981) and the practice of interpretation described by Finlay (2011). Gendlin styles focusing as, “A process in which you make contact with a special kind of internal bodily awareness” and calls this a ‘*felt sense*’ (Gendlin, 1981, p. 10). This might give us a model for how we interpret as researchers.

In this type of experiential therapy, the client is encouraged to pay attention to this 'felt sense' or gut feeling and to express these feelings through metaphor or symbols. These new meanings are then placed into context with previous meanings and through dialogue further meanings are developed and the cycle continues (Finlay, 2011; McMillan, 2004). Thus, drawing on ideas from Heidegger and others, Gendlin concluded that humans are firstly pre-reflective and then they interpret (Finlay, 2011). Finlay proposes that these ideas can also be applied to research. She suggests that firstly the participant describes their experience and tries through a 'felt sense' to capture it in the most appropriate words. The researcher focuses on being open and present to the participant and pays attention to how her own 'felt-sense' is being impacted upon. Then further understanding is arrived at through discussion. Finally, during the analysis of transcripts, the researcher tries to be open to this same process paying particular attention to bodily awareness. She focuses again on allowing the deeper meaning of the words to resonate within her 'felt sense' and is open to the emergence of further meanings and interpretations. However, I would add a further step to this cycle. By writing down my responses to what my participants have said and by focusing closely on my written words, further meanings occur to me. This is similar to the process of working with the hermeneutic circle (Smith, 2009) described earlier in this chapter. Yet, I am attempting to explain the process of intuition or interpretation here, rather than just saying that it occurs. Inevitably, this is only a very brief account but as a counsellor, I do feel that there are analogies between the way we work with client material and the process of undertaking qualitative research and this could be developed further.

However, I see this perceived lack of direction on how to interpret as an asset of IPA, in that it has given me autonomy over the research process. Throughout my research, I feel that I have been able to adopt an approach that is both empathic and questioning (Finlay,

2011; Smith et al., 2009) but most importantly unique to me. I am confident that my experience of using IPA has enabled me to move beyond description towards a deeper interpretation of what the experience of miscarriage means for my participants and this has led me to explore “new and unanticipated territory” (Smith et al., 2009, p. 113).

Evaluating qualitative research

There is much debate in the literature over what makes good qualitative research and how it should be evaluated (Sparkes & Smith, 2010; Tracy, 2010; Yardley, 2000, 2008). Indeed, there is a recent movement within qualitative research, defined by Sparkes and Smith (2010) as “The letting go perspective” (p. 194) that resonates with me. From this standpoint, Sparkes and Smith offer an innovative way of evaluating qualitative research. They suggest that rather than borrowing the terms reliability, objectivity, generalizability, and validity from quantitative research, qualitative researchers should adopt a more relativist approach as these universal standards are not necessarily applicable to determining what makes good qualitative research. They view well-established criteria, such as the principles provided by Yardley (2000, 2008), as being valuable tools in the process of evaluation. However, they argue that qualitative researchers should adopt an approach whereby they adapt these criteria, making them uniquely relevant to their own work and this approach should be articulated clearly as a justification and basis for the study.

I find this approach to evaluating research engaging and open to creative possibilities. I am mindful that my own personal list of criteria has grown and developed almost unconsciously as this research has progressed. Nevertheless, I am also aware that I would not have been able to articulate a definite list of criteria at the beginning of my research and therefore it was useful to have well-established criteria as a focus for what was

required at the start (e.g. Yardley, 2008; Tracy, 2010; Smith, 2010). Yet, as my research nears its end, I feel more confident to set out the distinctive criteria against which I hope this research will be judged and to offer my own evaluation.

Is this research good IPA?

Primarily, I would hope that my research can stand up to scrutiny against the standards for what makes good IPA set out by Smith (2010). In this article, Smith refers to seven principles for judging what makes a good IPA paper and I have alluded to these throughout the writing of this thesis. Although, some of these could apply to most qualitative research, these criteria are very specific to IPA and therefore, it is appropriate to evaluate my research in the light of these principles first.

Smith's (2010) first two criteria are that the research should have a clear focus and have strong data. My research concentrates on my own and five women's perception of miscarriage many decades after the event and this is central to all my analysis and discussion. The data is strong because of the in-depth material acquired through the use of unstructured interviews which allowed my participants to set their own agenda. A thematic analysis of my first bracketing interview provides additional rich data. This is supplemented by extracts from my subsequent bracketing interviews and my research diary.

Smith states that good IPA should be rigorous and sufficient space given for the elaboration of each theme. He suggests that rigour is established by the use of well- chosen quotations to illustrate each theme and maintains that in a study with a sample size of 4-8 participants, each theme should be represented with extracts from a least half the participants. However, this attempt to quantify IPA and place emphasis on sample proportion has proved controversial (Chamberlain, 2011; Todorova, 2011). Certainly, I feel

that one resonant quotation may illustrate a theme more succinctly than two or three. However, it is clear from my findings that I have ample representation of extracts from well over half my participants for all of the themes. I also have the luxury of space in a PhD thesis, to explain and interpret each theme in detail.

Importantly, Smith (2010) argues that IPA should be interpretative not just descriptive and that the writing should be nuanced to capture convergence and divergence whilst at the same time focusing on the individual experience of participants. In this research, I have chosen to combine my findings and discussion section so that my interpretative commentary sits alongside the phenomenological analysis. This combination, gives the reader a clearer idea of how each theme has developed and how it relates to the extant literature. In this way, I am engaging in the double hermeneutic (Smith, 2010, p. 24) and deepening the interpretation in a transparent way for my readers.

Finally, Smith (2010) claims that IPA must be carefully written with an engaging narrative. Throughout this research, I have attempted to chronicle the individual stories of miscarriage whilst considering the commonalities and differences between the accounts. I have thought carefully about the arrangement of every chapter and deliberated over the best way to present my findings in an appealing and thought provoking way. I have attempted to fully involve my readers in my participants' perception of miscarriage. However, it is ultimately for the reader to decide how successful this enterprise has been.

Pointedly, in his set of criteria, Smith has concentrated mainly on the mechanics or skills set required for IPA. It is notable that he does not comment on the need for a strong philosophical underpinning in good IPA or for a focus on the phenomenological project as suggested by Finlay (2011). There is no mention of the requirement for creative flair or the need for ethical rigour, although these are detailed earlier in Smith et al. (2009).

Diving for pearls

In a later article Smith (2011), returns to the theme of evaluating good IPA. He introduces the metaphor of the researcher “diving for pearls” or looking for the “gem” (p. 6) in a participant’s transcript. He suggests that these gems capture the essence of a participant’s experience and that these utterances influence our analysis and “shine a light on the phenomenon, on the transcript and on the corpus as a whole” (p. 7). Smith describes three types of gems. The “shining gem” is very apparent to the researcher and the participant is fully aware of its impact. A “suggestive gem” requires more attention to discover its meaning and the participant may only have some awareness of its intended meaning. Finally, a “secret gem” may have its meaning partly obscured from both the participant and the researcher. Indeed the participant may not be fully aware of what exactly they have said or its deeper implications.

I have experimented with this approach a little in my research. In my Findings and Discussion Chapter, I have commented where I feel a particular quotation fits within this spectrum and provided an in-depth analysis and interpretation of these “gems”. I have reproduced some of these in the chart (figure 2) below.

Figure 2: A Chart depicting examples of the spectrum of gems within my research

Diving for Pearls – women’s experience of miscarriage		
Shining Gem:	‘You'd have shown me more understanding if I had lost my handbag’	Lucy, 9/272
Suggestive gem:	‘That’s the space I was trapped in for a long time, that metaphorical toilet’	Lucy, 17/426
Secret Gem:	‘I was pregnant but I wasn't going to have a baby’	Janet, 3/76-77

I found it reasonably easy to pick out the shining gems. Certainly, I have sometimes felt that there is a shining gem in every line of my transcripts. However, I have found it more difficult to discriminate between a suggestive gem and a secret gem and I wonder whether attempting this distinction lends anything extra to my findings. However, I do believe that the spectrum may inform the reader of the level of analysis required to reach an interpretation. Poignantly, the metaphor of a qualitative researcher being a diver of pearls does speak to my experience of undertaking research. When I first had my miscarriage I wrote that it felt like I had lost a precious pearl:

*“But my grief has worn away my heart.
They are talking to a shell,
An empty oyster
That has lost its pearl”*

Now, the knowledge that the findings of my pearl diving expedition are contained within this thesis helps to mitigate my sorrow and fill the emptiness a little. In the conclusion to my Findings and Discussion Chapter, I return once more to the idea of “gems” in qualitative research.

Wider evaluation criteria

In the spirit of Sparkes and Smith (2013), I also want to suggest some wider evaluation criteria which are pertinent to my own study. Firstly, I am basing these on Yardley’s (2000, 2008) four quality principles for evaluating qualitative research:

1. Sensitivity to context
2. Commitment and rigour
3. Transparency and coherence
4. Impact and importance

These criteria can be applied to both experiential and more constructionist methods in a flexible and open way and they have become the recommended guidelines for most qualitative researchers (Braun & Clarke, 2013; McLeod, 2011; Smith et al., 2009; Willig, 2013). To this list, I also want to add “worthy topic,” “sincerity” and “resonance” from a set of criteria proposed by Tracy (2010, p. 840). Arguably, there might be some overlap in these two sets of criteria but I think that in tandem they offer a comprehensive check list.

Further Evaluation of my research

Throughout my research, I have been sensitive to context by writing a detailed social and historical review of the literature on miscarriage and by observing that there is very little

written on women's experience of miscarriage from a long term perspective. Similarly, I have considered the ethical issues that may arise when researching an emotive topic such as miscarriage. I trust I have presented miscarriage in all its complexities and have remained open to the many different meanings in my data. Throughout, I have been committed to being rigorous in my methodology and depth of analysis. Within, this chapter, I have aimed to give a cogent account of my methodological process and principally in my Findings and Discussion and Reflexivity Chapters, I have been transparent and 'sincere' about my own role in this research.

Only time will tell how much impact this research may have. Hopefully, this study will raise awareness of the long term impact of miscarriage on women and their families and might draw attention to the lack of research in this area from a counselling and psychotherapy perspective. In this context, there is no doubt in my mind that this is a 'worthy topic' that has 'resonance' for the reader. I understand resonance as being like the ripples in a pond reaching out to the audience once the researcher has thrown in a stone to disturb the water. In the conclusion to my Findings and Discussion Chapter, I have endeavoured through my poetic representation to evocatively characterise the women's voices in this research, in the hope that this might impact my audience and raise awareness of the experience of miscarriage.

I also wish to include some further additional criteria. It is clear to me that this type of qualitative research requires creativity, courage and a willingness to be vulnerable. I hope I have fulfilled these criteria in my continuous commitment to reflexivity. Finlay (2011) describes five lenses of reflexivity through which the researcher can be evaluative. Three of these lenses, strategic, contextual and ethical reflexivity, appear to be analogous to Willig's (2013) description of epistemological reflexivity and hopefully I have considered

these in this chapter. Finlay's description of embodied reflexivity and relational reflexivity relate more closely to Willig's description of personal reflexivity and echo how I have used bracketing interviews and a reflexive journal in this thesis. During the interview process, through embodied reflexivity, I used my felt sense to engage in a relationship with my participants and again afterwards in the intuitive process of analysis and interpretation of the data. Similarly, by engaging with relational reflexivity, I have explored the depths of my own personal relationship with the research as a whole most notably in my Reflexivity Chapter.

Finally, I agree with Finlay (2011), when she argues that qualitative research should also be judged on its ability to capture the messiness of being human. Therefore, if I have encapsulated the many complexities of miscarriage for my readers then I am content.

Summary

In this chapter, I have situated my philosophical position and offered a clear rationale for the use of IPA as a suitable methodology for my research. I have presented an in-depth account of the procedures I have used in undertaking three bracketing interviews, the gathering of my data and in the data analysis. Leading on from this, I have produced a master table and an abridged table of my findings. Throughout this chapter, I have strived to make my research process as transparent as possible. Furthermore, I have considered the ethical dilemmas that I have faced whilst undertaking qualitative research into the complexities of miscarriage. I have explored what makes a good interpretative phenomenological analysis and established the criteria against which I want to evaluate this research, including the usefulness of Smith's (2011) concept of "the gem" in qualitative research.

Carrying out research into such a sensitive and intimate topic as miscarriage has been emotionally draining and challenging. Yet, in the midst of all the methodological procedures and ethical dilemmas, I remain aware of the benefits of undertaking this form of research for me personally and for my participants. At this point, before I present the discussion of my findings in the next chapter, I think this quote from my second bracketing interview sums up how I am feeling about my research:

“I feel as if I am sitting in this big mass of information, experience and feeling. I have a responsibility to try and treasure it all. Let it just take its shape” (B2: March 2011).

CHAPTER 5: FINDINGS AND DISCUSSION

In this chapter, I have chosen to combine together my research findings with a discussion and analysis of these findings in dialogue with the literature. The rationale for this decision is explained more fully in the introduction to this thesis. As a result of the inevitable volume of material this generated, I have had to find a plan for this chapter that would avoid confusing or overwhelming the reader. Therefore, the chapter is divided into three sections according to my three super-ordinate themes: **Memories of the Initial Impact of Miscarriage**, **The Longer Term Consequences of Miscarriage** and **Making Sense of Miscarriage in the Present**. In order to give clarity for the reader, at the beginning of each section, I have produced a table that illustrates the nesting sub-ordinate themes that belong to each super-ordinate theme.

I have briefly introduced each super-ordinate theme and then gone on to divide the section under each sub-ordinate theme. For clarity, I have written the title of each sub-ordinate theme in bold and underlined it and then I formatted subsequent sub-headings in italics. In line with good IPA, I have illustrated each sub-ordinate theme with a variety of quotations from my participants' transcripts. In brackets, after each quotation I have indicated the name of the participant and the line and page number of the transcript. I have also included extracts from my three bracketing interviews. After each extract I have put in brackets the number of the interview and for the first bracketing interview the relevant line numbers. Where appropriate, I have incorporated excerpts from my research diary which I have also dated. These extracts are printed in italics so they can be easily differentiated from the main body of the text. I have included a reflection at the end of each section which summarises the main points for my readers.

SECTION 1: MEMORIES OF THE INITIAL IMPACT OF MISCARRIAGE

SUPER-ORDINATE THEME 1: MEMORIES OF THE INITIAL IMPACT OF MISCARRIAGE

Sub-ordinate themes:

The physical process of miscarriage

The early psychological effects of miscarriage

Attitudes of other people towards miscarriage

Perceived attitudes of health professionals

“As a physical occurrence a death before a birth is itself an ultimate paradox. We are at one moment nurturing life and the next minute embracing death, and at times the distinction cannot be clearly made” (Hey,1995, p. 129).

When I began each of the in-depth interviews for this research I asked my participants to tell me about their experience of miscarriage. Four of my participants have had multiple reproductive losses and each time they have a miscarriage the distress appears to be made worse by remembering the previous one. For some of these women talking about miscarriage takes them back to remembering their experiences of abortion and stillbirth and at some points during my analysis of their transcripts it is not always possible to distinguish which experience they are remembering. Significantly, all the memories are very vivid, even after twenty years, and it can feel as if their miscarriages happened far more recently. For my participants their experience of “lived time” appears to have become

subjective and the boundaries between past, present and future blurred as together we struggled with the existential issue of temporality (Finlay, 2012, p. 20).

Initially, my participants focused on the embodied, lived experience of miscarriage. For many women miscarriage is a visceral process associated with pain and blood loss. The bleeding can be heavy and frightening and the severity of the pain unexpected, particularly if the woman experiences a natural evacuation of the products of conception without medical intervention (Moulder, 2001; Ogden & Maker, 2004; Sejourne et al., 2010). Subsequently, they go on to recount the early psychological effects of miscarriage and they tell me about their shock and distress. However, these emotions are also situated in a cultural dimension. In particular, they have clear memories of both the negative and positive impact that friends, family and healthcare professional made upon them.

Sub-ordinate theme: The physical process of miscarriage

Miscarriage's visceral and private nature

All five of my participants remember the actual physical process of their miscarriages clearly even though they happened many years ago. For Janet and Dee in particular, it is the intensity of the pain that they recall and during a miscarriage this can be shocking and reminiscent of the early stages of child birth:

‘I just had these incredible stomach cramps’ (Janet, 1/13).

‘I had the most horrendous pains like the worst period pain (Dee, 5/123).

Some of my participants also remember their miscarriages taking place in the toilet, a place usually associated with getting rid of waste and flushing away things that are distasteful:

‘I went to the loo and lost the baby basically’ (Janet, 1/16).

‘I just went to the loo and lost it (Lucy, 1/9).

‘Ultimately, I can’t quite remember how I lost the baby – in the toilet...and not completely either. It was horrible’ (Tess, 12/340-2).

Similarly, because of the blood loss, miscarriage may also be linked with the stigma attached to menstruation, which sometimes occurs even in modern Western society and is documented in the literature (Chrisler, 2011; Stubbs & Costos, 2004). Thus, because of a need for privacy, a woman may be alone when she miscarries and this might lead to feelings of loneliness and disenfranchisement.

Beyond words

Janet, Lucy and Tess, all use the euphemism ‘lost,’ to describe the end of their early pregnancies. Perhaps, this word is more acceptable because it avoids talking about the unpleasant physical aspects of miscarriage, the pain, bleeding and expulsion of fetal remains. I look more closely at the language of loss associated with miscarriage (Jonas-Simpson & McMahon, 2005) in my Literature Review.

Tess eloquently portrays the tensions and incongruities between what she actually experiences during her third miscarriage and the baby she might imagine in her womb. She talks about losing ‘the baby’ (Tess, 11/324) at home but then continues, ‘I took this, whatever out of the toilet’ (Tess, 12/342). It is as if she has no words to define what she held in her hand and it does not match with the notion of losing a baby. It can be difficult to make sense of this contrast between the physical reality of miscarriage, flushing the remains down the toilet, and the loss of an imaginary baby. My own experience feels similar and I recount it in this extract from my bracketing interview.

Lois: *I lay in the bath and it was a bit like scene from Lady Macbeth you know... It was like sitting in a bath of Ribena. So the next day I wasn't sure – I still wasn't sure. You know when you haven't had a miscarriage before you don't know. Anyway I got up and had breakfast normal things and I thought ok I need to go to the loo. It was like a really urgent feeling and that's when I had the miscarriage and actually the placenta and everything came away and I sort of didn't know what to do. It was horrible because it was like an instinctive feeling to catch it.*

Heather: *Yes like something precious rather than...*

Lois: *Yes so I did.*

Heather: *Right.*

Lois: *I'm sorry it's a bit gruesome.*

Heather: *No that's ok*

Lois: *So I did and then I didn't know what to do – so I flushed it down the toilet.*

Heather: *Right.*

Lois: *And as soon as I had done that I wished I hadn't but it was too late. It was sort of literally - what it looked like when I was holding it in my hands was this large piece of liver (B1: 89-120).*

I am very moved by the parallels between Tess's experience of the physical process of miscarriage and my own and I can witness to the long term psychological distress of this experience as I describe later in my bracketing interview:

“I feel that’s – that’s what’s so hard about having a miscarriage. For months – for years – I felt as if I had flushed my baby down the toilet” (B1:251-53).

Dee describes the physical process of expelling the foetus as a ‘slipping away’ and that the nurses came and ‘basically caught it’ (Dee, 5/130). For Susan it felt ‘like a lump coming out’ (Susan, 24/742). Lucy remembers the product of miscarriage looking like ‘a jelly bean’ and goes on to describe the experience as ‘Strange...really bizarre’ (Lucy, 1/12). Thus, the fear, isolation and horror of discarding an imagined baby, as if it were a waste product, may add to the misery of miscarriage.

There is also a part of me as researcher that is slightly shaken by the willingness of my participants to share these intimate recollections so openly. At this point in my writing, I am struggling with the tensions between feeling the shame and stigma around discussing the physical process of miscarriage, its impact on me and my desire to give voice to the experience. I include an extract from my research diary to illustrate this dilemma.

Research Diary: 7th February 2014

Today, during supervision, Maggie asked me where my voice was in my writing and whether I was afraid to include my own voice for some reason. This has given me much food for thought and I have to admit I had never considered giving voice to my own experience of miscarriage in this research so openly. I think I am scared. I am afraid of the shameful feelings when I write or talk about my own experiences especially around the physical process of bleeding and expelling the products of conception (what unpleasant language!) even though I remember it so clearly. This has taken me back to an extract from a poem I wrote many years ago not long after my own miscarriage:

“You left me alone

Alone in the black of night

I felt you run between my legs

And you were gone.”

Even now, twenty years later, my own language here slightly repulses me and yet it captures the essence of what I am struggling with and I think my participants too. My baby feels real enough to talk to and be angry with for the perceived desertion and yet the leaving and separation is felt through the blood leaving my body and running down my legs which is abhorrent and in no way connected to the image I have of my baby in my mind. However, I feel that in denying my own voice, I am disenfranchising myself and I need to acknowledge the validity of my own experience and its value in illuminating my research. From now on I am going to try to dare greatly and be heard.

This suggests to me that because of the potential stigma attached to miscarriage women may even collude in their own disenfranchisement because of their unwillingness or inability to discuss something they perceive to be so personal and private. It is also difficult for the researcher not to become part of this conspiracy of silence. I am torn between wanting to give an honest account of what it feels like physically to have a miscarriage and the desire to protect my readers and possibly myself from this reality. I am also aware of a real concern around what other people might think and whether I have gone too far in sharing something so intimate and private.

Perhaps I should not be surprised at my feelings here. As someone researching women's experience of miscarriage I am confronted regularly with other people's reactions to my research topic. I have come to the rather sad conclusion that, even in so called enlightened times, when no topic appears to be off limits, that talking and perhaps even writing about miscarriage is still perceived by some as challenging and difficult. However, I think over

the last year or so, I have developed more sympathy for these attitudes. I have come to acknowledge more and more my own struggle to find my voice in this research and to give a truly authentic and uncensored account. It is therefore not so surprising that other people hearing about my research topic for the first time may feel some distaste and uncertainty around how to respond. Most importantly at this point, my overriding feeling is how privileged I am that my participants felt comfortable and trusting enough to attempt to find the words to describe this physical process for my research. Possibly, I just have to accept that sometimes trying to express what it feels like to have a miscarriage is almost impossible as I say in my first bracketing interview:

“It’s beyond words and it’s almost beyond tears” (BI: 157).

Is miscarriage a traumatic experience?

Research shows that for many women miscarriage can be traumatic (Abboud & Liamputtong, 2005; Gerber-Epstein et al., 2009; Lee & Slade, 1996; Letherby, 1993; Malacrida, 1998). Cain et al. (1964) observed that during a miscarriage, “The woman is often frightened, shaken by the appearance of clumps of blood and foetal tissue” (p. 61). This certainly accords with the recollections of my participants and my own memories recalled above. Therefore, it comes as no surprise when Letherby (1993, p. 165) suggests that for some women miscarriage, “may be one of the most traumatic events in their lives.”

The unforeseen nature of miscarriage

Certainly, my participants’ experience of the physical and psychological process of miscarriage appears to fulfil, to a certain degree, many of the attributes of trauma as described in my Literature Review (Tedeschi & Calhoun, 1995; Malachrida, 1998). There is no doubt that for my participants, associated with the distress of the physical process of

miscarriage, is the shock that comes with the sudden and unforeseen nature of the experience. My own experience of seeing that first very small blood stain and realising deep within what it meant and the inevitability of what was to follow stays with me. This is in accord with Dee's and Tess's accounts below.

Tess sums up these feelings of shock and surprise:

‘The process with that first one was very, very quick. Almost before you knew what had hit you one minute you were pregnant and the next minute you weren’t’
(Tess, 2/35-37).

Her last sentence is a powerful metaphor that symbolises the abrupt nature of miscarriage and reminds the reader there is no in between stage of pregnancy. Dee (3/86) remembers that when she had the first symptoms of miscarriage she thought ‘Oh my goodness, this can’t be true’ and then recalls that one of the worst parts was, ‘Going through it and not knowing what was going to happen or how it was going to pan out’ (Dee, 6/206-8). Thus the progression of miscarriage is very much out of the woman’s control. Indeed, Parsons (2010) suggests that being out of control is one of the most frightening aspects of miscarriage.

Possibly, it is the sudden loss of identity as an expectant mother that can be the hardest to fathom. Stirtzinger and Robinson (1989) intimate that mourning for miscarriage is made more complicated by the fact that the loss is so abrupt and the woman is given no time for anticipatory grieving. During the nine months of pregnancy a woman usually has time to process and prepare for the transition to motherhood. This process of transition is abruptly snatched away by miscarriage and may cause distress and anxiety even to a woman who already has an identity as a mother. Although, there are transition models that can be used

to describe the process of miscarriage (e.g. Maker & Ogden, 2003; Murphy & Merrell, 2009), which I discuss in my Literature Review, I do not feel that these sufficiently capture the rapid and unforeseen nature of this experience. Gerber – Epstein et al. (2009) sum this up so succinctly in their emotive research title, “The greater the joy the more painful the crash.” Here they illustrate the delight that some women describe in discovering that they are pregnant and the pleasure that they take in creating dreams and fantasies in anticipation of the birth. However, these plans all come crashing down when the pregnancy is lost. In my view, the ensuing struggle to make sense of such a distressing and unanticipated event can have a powerful psychological effect and leads me to believe that my participants may perceive the physical process of miscarriage as traumatic.

A further attribute of trauma described by Tedeschi and Calhoun, (1995) is that the sufferer is unable to find someone else to blame for the event. To a certain extent this is the case for my participants because, with the exception of Dee, none of my participants were given an explanation for their miscarriages. Nevertheless, I do feel there is an element of looking to blame the medical profession for some of their distress and I refer to this again under the theme “*Perceived insensitivity of medical staff*”. In this model, the final attribute pertaining to trauma is of an event occurring at a critical moment in life. This is also recognisable for the women in my study. Pregnancy is an important life stage for women and thus to suddenly lose a pregnancy may be threatening to a woman’s identity and sense of self (Layne, 2003; Letherby. 1993; Malacrida 1998).

Vivid memories

Particularly striking in this first super-ordinate theme is the vividness and the detail of my participants’ recollections so many years later, when they recall the very visceral nature of miscarriage. This leads me to question whether the women in my study remember their

miscarriages and other reproductive losses so vividly because of the traumatic and harrowing nature of the experience.

Yet at this point, I am aware that I am entering into one of the most controversial areas in Psychology when I begin to consider how victims remember what might be perceived as traumatic events and whether this experience makes memories more vivid (McNally, 2003). There appears to be little consensus around whether the intensity of an emotional experience enhances memory. Brewin (2007) in his review of the research into autobiographical memory for trauma concludes that the answer is not straightforward. He writes:

“Naturalistic studies have had inconsistent results, some supporting the idea that traumatic memory is qualitatively distinct, of unusual clarity, and more consistent over time; some that it is prone to amnesic gaps, and indistinguishable from or even inferior to normal memory” (p. 230).

This area of traumatic memory is complicated further when research into post-traumatic stress (PTSD) is considered. According to the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV; APA, 1994), PTSD is characterised by high frequency, distressing and involuntary memories that individuals are unable to forget and make great efforts to prevent coming to mind (Brewin, 2007). As I discuss in my Literature Review, research shows that some women do experience psychological reactions similar to PTSD after miscarriage (Engelhard et al., 2001). I am not suggesting that my participants show definite symptoms of PTSD. They do not report having involuntary memories that they are desperate to forget, although Susan is adamant that she wants no reminders of her miscarriage or stillbirth and is shocked and upset at the thought that other women might want to remember (Susan, 21/664-71). However, it is possible that Susan’s memories of

her stillbirth, where she describes feeling ‘a little limb come out’ as ‘bloody terrible’ (11-12/321-345) has all the hallmarks of re-experiencing linked to PTSD and these memories may have been triggered again by her subsequent miscarriage. For my other participants, there appears to be an element of relief in recalling memories and having permission to talk about them as Tess says, ‘I needed to talk about it’ (Tess, 31/919).

Current research shows that the memories of people with PTSD are distinguished from those without because they contain, “prominent perceptual features, being highly emotional, and involving an intense reliving of the event in the present” (Brewin, 2007, p. 232). There is no doubt, from the analysis of my transcripts, that my participants generally recall their experiences of reproductive loss vividly, emotionally and sometimes as if it was happening in the present, although the events occurred many years earlier, and this may be evidence that they perceive their miscarriages as traumatic.

My findings are similar to those of Frost et al. (2007) where they note that participants could remember their miscarriages in “astonishing detail” and “the shocking nature of the loss seemed to encourage near total recall” (p. 1008). In their study, women were interviewed initially eight weeks after their miscarriage and then later after twelve months, which is relatively soon after their miscarriages compared to my participants who are recalling events from eighteen to twenty years ago. This ability to intensely recall is certainly evident in my findings and made even more extraordinary by the fact that my participants are recollecting events from so long ago. It is only Janet who glosses over her first two miscarriages without any attempt to describe them in much detail, possibly because these events were overshadowed by the distress of her stillbirth which had occurred a few years before her miscarriages. However, like Susan above, early on in her

interview Janet has good recall of the trauma of her stillbirth and nearly thirty years later she can recount clearly what happened. She tells me:

‘They were going to do an emergency section but they didn’t because the baby had died. The baby died two days before she was due to be born and they didn’t do a section because of getting over the operation. They induced her’ (Janet, 4/108-110).

This suggests to me that life- changing and disturbing events endure long in the memory.

Cecil (1996), writing about the recollections of pregnancy loss of twelve elderly women in Northern Ireland, speculates that the women who felt their loss as significant had the most vivid memories of the experience even many years after the event. These findings are supported by my own research where there appears to be a link between the traumatic nature and emotional intensity of the experience and the ability of my participants to recall it vividly many years later. This is also borne out by Ashcroft (1994, p. 243) who writes:

“The time lag since an event, whilst important, has a less powerful effect on recall than the salience or importance of the event, and the degree of emotional involvement.”

This has undeniably been my own experience and in my first bracketing interview I refer to this as “Time travelling” and say that “I never know quite which part of the continuum I am on” (B1: 511). I have difficulty separating my experiences of eighteen years ago from how I feel now and sometimes I can remember my miscarriage as if it happened yesterday. I think that in interviewing my participants there is definitely a sensation of moving forwards and backwards in time and I have discussed this concept earlier in my Reflexivity Chapter.

These findings, based on my research and my own personal experience, strengthen my belief that miscarriage can be a traumatic event for some women and this is evinced in the literature (Abboud & Liamputtong, 2005; Gerber-Epstein et al., 2009; Lee & Slade, 1996; Letherby, 2003; Malacrida, 1998). My research would seem to suggest that even many years later the memories of miscarriage lie close to the surface and are easily triggered when women are asked to give a partly retrospective account. However, as well as the somatic aspects of miscarriage which may lead to trauma, there are also other possible psychological consequences and these are discussed in the following sub-ordinate themes.

Sub-ordinate theme: The early psychological effects of miscarriage

For all of my participants, apart from Dee, their pregnancies were planned and looked forward to with the pleasurable expectation that a healthy baby would be successfully delivered. Having a miscarriage may turn a woman's assumptive world upside down rapidly. It therefore seems inevitable that, as well as trauma caused by the physical aspects of miscarriage, some of my participants experience other psychological consequences, such as anxiety, after their miscarriages.

Developing symptoms of anxiety

However, as I discuss in my Literature Review, there is some debate around whether the feelings women describe after miscarriage are depression, anxiety or grief and whether these can be separated and delineated (Stirtzinger & Robinson, 1989; Lee & Slade 1996). I have a sense that in my research the prevailing reaction of my participants is anxiety. Thaper and Thaper (1992) found that three months after a miscarriage 32% of women had clinical levels of anxiety, although as Englehard, van den and Arnoud (2001) point out there is little research into the actual symptoms and nature of anxiety after miscarriage.

Throughout this first super-ordinate theme all my participants recall, to a certain extent, feelings of panic and anxiety after their miscarriages and as I discuss earlier this may be caused by the traumatic nature of miscarriage. Tess tells me, 'I can't remember the sequence of events. I was so anxious and emotional by that point' (Tess: 12/331) and she goes on to say, 'I think it's left me hyper-sensitive to anxiety. I do a lot to avoid being anxious' (Tess: 23/687-8). This was also my and Lucy's experience and leads me to believe that anxiety that develops after a miscarriage may continue to persist for many years.

Lucy experienced three miscarriages after the birth of her son but it was the second miscarriage that she describes as having the most profound psychological impact. This is borne out by the literature that shows the intensity of grief may increase with each subsequent loss after miscarriage (Klier et al., 2002). Lucy begins to suffer with severe anxiety and depression after her second miscarriage. However, because of inconsistencies in her transcript, it is sometimes difficult to discern which miscarriage she is talking about and to gauge her level of psychological distress after each one. She tells me that her first miscarriage was, 'sad but I didn't think too severely about it' (Lucy, 4/91-2). She then contradicts herself by going on to tell me that she was 'overwhelmed with maternal instincts' and her desire for a baby. She remembers:

'I was worried after the first miscarriage. It was a good job people didn't leave their kids outside Sainsbury's like they used to do a few years ago because I was worried that I might pinch someone else's' (Lucy, 20/575-6).

Although the above comment is expressed in a rather light hearted way, there is an underlying truth here about the desperation of yearning for a baby. This emotional need makes Lucy's second miscarriage feel an even greater loss:

‘I think it was the fact I’d identified with it a lot more. I’d had a scan, got the date...and because of losing one from before you sort of think like this is even more precious because you’ve lost the last one’ (Lucy, 5/120-5).

I feel that the most important word here is ‘precious’ as this completely sums up the value of this pregnancy for Lucy. As in Lucy’s case, Frost et al. (2007) argue that the use of ultrasound technology in ante natal care means that women may identify with their baby much earlier in their pregnancies. However, there is research that supports the view that having previously viewed the baby on ultrasound has little effect on feelings of bereavement after miscarriage (Beutal et al., 1995; Klier et al., 2002) but it is evident that more research is needed in this area. I have discussed the challenges presented by the use of ultra-sound to diagnose miscarriage more fully in my Literature Review.

Struggles with agoraphobia

After the loss of this second pregnancy, Lucy tells me that her anxiety developed into agoraphobia which she still struggles with years later:

‘I think I just shut off...didn’t like the world, didn’t like what was happening to me, couldn’t deal with emotions I felt’ (Lucy, 11/308).

Lucy withdraws in an attempt to escape from her pain and grief and it is only after a long battle with agoraphobia that she feels brave enough to re- enter the world and pick up her life again. This sense of sadness and regret is summed up in her touching yet bitter comment:

‘And that’s the space I think I was trapped in for a long time, that metaphorical toilet’ (Lucy, 17/426).

This idea of being confined in a “metaphorical toilet” encapsulates for me what it means to have a miscarriage and this is also discussed in the previous theme *The physical process of miscarriage*. This is an example of what Smith (2011, p. 11) calls a “suggestive gem” because the researcher has to work a little harder to fully grasp Lucy’s meaning. The toilet feels like a trap and yet it is perhaps a safer place than the uncaring world on the other side of the toilet door. It is therefore not surprising that this experience leads to the development of agoraphobia. Lucy’s experience resonates with me particularly because one of the long term effects on me of miscarriage is a propensity to experience agoraphobia. I reflect on this below:

Research Diary: 21st December 2011

As I read and read Lucy’s transcript and proceed with my analysis it brings home to me how I too have suffered from a form of agoraphobia since my miscarriage eighteen years ago. My difficulties in travelling on my own in trains and buses and my need to sit on the end of rows in theatres and cinemas I am sure stems from this time. Although I have discussed this in therapy occasionally, I have never really tried to link it explicitly to the trauma and anxiety of miscarriage where I felt there was no safe place to be and if I could lose my baby so suddenly and unexpectedly then anything could happen. I know also that there are other events in my life that might have indirectly contributed to this too but miscarriage has definitely made me feel that the world is not a very safe place. Sometimes I wonder, if like Lucy, I would have preferred to stay behind the toilet door with my baby rather than come out and face the enormity of what has happened to me. I wrote after my miscarriage,

“I expelled you and every breath

Tortured me with your leaving”

Perhaps this research is allowing me to open the door just a chink and to contemplate leaving not only the bathroom but this pain behind.

Notably, as I state in my Literature Review, Geller et al. (2002) found that miscarriage did not increase the risk for panic disorder or specific phobia such as agoraphobia. Yet, this does not seem to be the case for Lucy or for me. It is of course possible that Lucy and I may have an underlying propensity for anxiety and I can never be certain that it was these experiences of miscarriage that were the main cause of our agoraphobia but that is my perception. This analysis of my findings also leads me to wonder whether it is the memories of anxiety that are more easily recalled after a long period of time, especially if they have long term consequences such as persisting agoraphobia or a generalised anxiety state.

Dee's story as an exception

I am aware that the fact my participants agreed to take part in this research is an indicator that they felt their miscarriages had been an important event in their lives. I had assumed that women who did not feel miscarriage to be significant would probably not volunteer to be interviewed. In this respect, Dee is intriguing. Miscarriage does not appear to have had such a dramatic psychological effect on her as on the other four women in my research and this is clear throughout my analysis. This leads me to question why miscarriage was not so anxiety provoking for Dee.

Dee found herself pregnant with her fourth child in her early forties when her other three children were in their teens. This caused her to feel ambivalent about her pregnancy and her miscarriage and I think this ambivalence is also present many years later during her interview. This is illustrated when she says that, 'Although, I'd not planned it, I didn't

want to lose it either' (Dee, 4/114) but goes on to say a little further on in her interview that to a certain extent her miscarriage 'was a relief' (Dee, 6/200). It is possible that the equivocalness of her feelings about the pregnancy protects her from the anxiety and trauma expressed by Susan, Lucy and Tess.

Significantly, out of my five participants, Dee is the only one who has been given some explanation for her miscarriage and this might have mitigated the psychological effects somewhat, as she says:

'What did help enormously was they did some tests on the placenta and the fetus...and I was told about five weeks later that the baby had an extra chromosome...it would probably have been Downes...it made me feel better about it' (Dee, 7/224-29).

Possibly, having some clarification about why the miscarriage happens, in my view, takes away some of its mystery and power and can make it more bearable. Dee was able to accept the miscarriage as, 'nature's way of dealing with a baby that wasn't going to survive with any quality of life' (Dee, 7/224-29) and this is concomitant with the literature, showing that women who have an acceptable medical explanation for their miscarriage have reduced anxiety levels and are less likely to blame themselves for their miscarriage (Tunaley, 1993; Conway, 1995; Frost et al., 2007). Perhaps the knowledge that the foetus has chromosomal abnormalities feels less like a failure of the woman's own reproductive system and might therefore diminish the guilt some women experience when there is no medical explanation for the loss.

Dee is the only woman in my research who mentions her religious beliefs and she appears to take strength from her Christian faith and to see her miscarriage as part of God's plan

rather than a random and inexplicable occurrence. She says, 'We have a predisposition to want to look for God's hand in what happens' (Dee, 15/494) and this brings her consolation. Frost et al. (2007) found that religious belief could help women view miscarriage as a positive experience in that it fostered personal development and the ability to empathise with the suffering of others. This resonates with me because my faith has been both severely challenged and to a certain extent deepened by my miscarriage. Therefore, it feels appropriate at this point to include an account from my research diary which illustrates my own struggles with faith after my miscarriage.

Research Diary: March 2013

This part of my reflective process, as I continue to analyse Dee's transcript, feels very personal and painful but also necessary if I am to fully explore and explain my own position in regard to religious beliefs and attitudes to miscarriage. Dee is able to find strength in her religious beliefs and I can now but twenty years earlier, just after my miscarriage, it was a different story. I am a practising Roman Catholic and for this reason the experience of miscarriage presented me with a variety of ethical dilemmas and challenges to my faith.

I think one of the most acute dilemmas I faced was caused by my feeling that during my miscarriage I flushed my baby's remains down the toilet. This was a wanted pregnancy and one that I had already imbued with personhood so this experience, although born out of acute exigency, caused me to face theological questions about just what I had lost and issues around the sanctity of the body. There are no words to describe how it feels to give birth to death and I felt that I had not only been betrayed by God but somehow that I had failed as a woman and therefore as an instrument in God's creation. I was also deeply concerned about my baby's soul because my baby had died without baptism. The Catholic

priests I consulted were very well meaning in their efforts to answer my questions but their expectation that I could just rely on the love of God to keep my baby safe in heaven was not consoling or reassuring and for many weeks I completely refused to attend mass or find any comfort in prayer.

I found a similar lack of consolation in the Catholic literature. I include here an extract from 'Mulieris Dignitatem' (An apostolic letter on the dignity of women) by John Paul II where he presents vividly and in my view poetically the Catholic view on motherhood:

“Motherhood involves a special communion with the mystery of life as it develops in the woman’s womb. The mother is filled with wonder at this mystery of life and ‘understands’ with unique intuition what is happening inside her. In the light of the ‘beginning’ the mother accepts as a person the child she is carrying in her womb” (no. 18).

However, there are no healing or comforting words to be found here when a child actually dies in the womb. Although the Catholic Church recognises the personhood of the child in the uterus it does not recognise baptism for the unborn. The Catechism of the Catholic Church states: “With regard to children who have died without baptism, the liturgy of the Church invites us to trust in God’s mercy and to pray for their salvation” (1283, p. 289). So after my miscarriage I suddenly found myself in a very grey theological area. My unborn child only seemed to have a worthy soul once it was born and I found this very difficult to equate with the Church’s strong belief that personhood exists from the moment of conception.

What I wanted at the time was certainty that my baby was safe in heaven. I did not want to rely on my own weak faith or trust in the mercy of God to ensure eternal life for my child.

In my anger I felt very far removed from God's forgiveness and compassion. I did have a blessing used especially by the Church for parents who experience miscarriage but this did not address my pressing theological concerns and I felt that the Catholic Church had no answers for my distress around miscarriage.

These angry memories were triggered again recently when I read Reagan's (2003) views that the language of the pro-life movement and the Catholic Church has been hijacked by the pregnancy loss movement particularly in America. She goes on to state that this has prevented forthright discussion about the range of emotions and feelings experienced by women after miscarriage. These views may explain why, in my view, some feminist writers and those who are pro-choice only offer lukewarm support to women who experience miscarriage.

I feel there is a lack of understanding here around how miscarriage is viewed by the Catholic Church and the difficulties this may present to women like me who are often struggling to find a Christian feminist theological position that can sustain them in their sorrow after miscarriage. Having a miscarriage has certainly made me more understanding of the pro-choice position. I believe that it is for the pregnant woman to decide how much her pregnancy means to her (Parsons, 2010) and I can see merit in the argument that personhood of the fetus is assigned through the mother's relationship with and desire for her imagined baby. Indeed, in holding the products of conception expelled from my uterus during my miscarriage, I had visible proof that what I had lost looked nothing like a baby. Significantly, I also think that it is this dilemma that affected me the most psychologically and exacerbated by anxiety and depression after miscarriage. Thus, I would like some official support from the Catholic Church around how to resolve this dilemma theologically.

Jones (2001) in her article on theological reflections on reproductive loss encourages women who have had miscarriages to find a theological image that helps them to make meaning from the loss. I am aware that over the years I have created many images. Initially after my miscarriage I conjured images from the story of the crucifixion in my poem 'Good Friday' which is produced below:

Good Friday

A splinter from your cross

Struck my heart.

One thorn from your crown

Pierced my womb.

The die was cast

The blood lost

Rolled under the stone.

Battered, broken, scourged

You lay in your mother's arms.

My arms are weak

My hands bloodied

And the stone won't roll away.

Over the years I am aware that these images have changed and mellowed and now symbolise the fact that I have made my peace with God. The image that is often in my mind as I write this research comes from the chorus of a devotional song composed by Michael Joncas. Its words are loosely based on Psalm 91 and Isaiah 40: 31.

"And he will raise you up on eagle's wings

Bear you on the breath of dawn

*Make you to shine like the sun
And hold you in the palm of his hand.”*

Now, most days, thankfully, I can feel privileged to have held the remains of my unborn baby in the palm of my hand after my miscarriage. I can also leave my baby to rest peacefully in the palm of God’s hand knowing that it is safe and held in his tender care.

It strikes me, that there is a dichotomy between Dee taking comfort in both a scientific explanation for her miscarriage and in her less rational belief of the hand of God. Perhaps they are reconciled through Dee’s belief that miscarriage is nature’s way of preventing children being born with severe disabilities and what happens in nature is part of God’s plan. In Dee’s mind this design can be verified through scientific confirmation that her baby might have been born with Down’s Syndrome. It is possible that because of Dee’s more ambivalent attitude towards her pregnancy she moved through the three phases of “separation, transition and incorporation” (Murphy & Merrell, 2009, p. 1590) more quickly than the other women in my research.

It is also possible that Dee’s uncertain feelings about the pregnancy from the beginning prevented a close bond developing between her and her unborn baby resulting in less emotional distress after she miscarried. As she says: ‘It wasn’t a huge loss because it never impinged on us really to that extent’ (Dee, 9/305). There are parallels here in Janet’s reaction to her miscarriages as the extent of her heartache over her stillbirth perhaps prevents her from forming a close attachment to her subsequent pregnancies and this may reduce the psychological effects of her miscarriages. There is a continuing theme in the literature that stresses the importance of recognising that the psychological impact of miscarriage, for some women, is often determined by the initial closeness of the relationship with the unborn child (Hey et al., 1989; Letherby, 1993; Layne, 2003; Parsons,

2010). Thus, feasibly for my participants, the psychological response after miscarriage may be partially determined by the depth of the relationship that they had developed with their unborn child and possibly their desire for the pregnancy.

Sub-ordinate theme: Attitudes of other people towards miscarriage

I agree with Moulder (2001, p. 64) that it is the “individual meaning of the miscarriage” for each women that is important. However, this focus on the individual response may absolve Western culture from any obligation to recognise miscarriage as a social loss (Malacrida, 1998). In this respect, I also believe that if the importance of this loss is denied by society in general, and mirrored by friends and family close to women who miscarry, then psychological distress and feelings of loneliness and isolation may be compounded. Although the distress of losing a baby comes from deep within the emotional centre of a woman, it can be magnified by society’s apparent inability to understand this pain and I explore this idea in more detail in this sub-ordinate-theme.

Minimising the loss

Another memory of the initial impact of miscarriage, that my participants recall, is attitudes of other family members and friends to their loss. Three of my participants, Janet, Lucy and Tess talk about receiving insensitive comments from friends, family and other acquaintances, particularly in the immediate aftermath of their miscarriages, and this experience is reflected in the literature (Hazan, 2003; Leppart & Pahlka 1984; Letherby, 1993). Kavanaugh et al. (2004), in their examination of how 22 mothers and 9 fathers described the ways family and friends supported them after they had experienced a reproductive loss, found that very few parents reported receiving words of comfort or encouragement from friends and family. They felt their loss was minimised and the

recommendations given around having a subsequent pregnancies were ill advised and intrusive.

Tess recounts her feelings when she is told by well-meaning friends that her miscarriage was only the loss of a 'collection of cells' and she goes on to recount:

'One of my overriding experiences is nobody understands until you've experienced miscarriage – it's unnoticed. Family and friends would go but it's early or it was meant to happen ...and it would just make me so angry and hurt...It wasn't a baby. It was only a collection of cells and that was from the majority of people' (Tess, 16/449-60).

Her use of the word 'unnoticed' is meaningful. It is easy to keep a miscarriage secret. An early pregnancy can be safely hidden and unless a woman chooses to tell, nobody need ever know it has happened. As I discussed earlier, miscarriages often take place in private, possibly hidden away out of necessity for seclusion and concealment because of its links with bleeding and menstruation. Paradoxically, this may lead to the belief that women are used to dealing with the loss of blood regularly and therefore miscarriage ought not to have too great an impact on them. There is also a connection with the idea that miscarriage is natural, the body's way of coping with foetal abnormality and that miscarrying women are not losing a baby, just blood and tissue similar to that lost during a monthly period.

Similarly, throughout her interview Lucy expresses anger at other people who comment on the fact that already having a child somehow mitigates her loss:

'And people use to say, "Oh well you've got one." Alright you've got two kids; which one shall I bump off because you've got another one?' (Lucy, 8/219-20).

Lucy wants it understood that she perceives losing an unborn baby to be as painful as the death of a living child. Her use of the colloquial expression ‘bumped off’ suggests that for Lucy, losing a child through miscarriage is equivalent to having your child murdered. Tess describes a similar attitude from friends and family as, ‘a lack of compassion’ and recounts angrily how she felt when well-meaning people reminded her that she already had two children and she should, ‘Be happy with that’ (Tess, 26-27/771-88).

There does seem to be a tendency for some people to expect women to count their blessings after a miscarriage, to be grateful that they already have children or that they are still young enough for future pregnancies. Letherby (1993) describes this as the “never-mind better luck next time” response (p. 166). Tess has much to say around this theme and does it very eloquently. She tells me:

‘Er well you’ve got two children be happy with that... That’s the message we got. We honestly got the message – it was only eight weeks. Well you’ve got two children. Or, well there are people who have seven or eight miscarriages’ (Tess, 26-27/771-88).

Tess’s experience here is one of puzzlement tinged with anger over other people’s inability to appreciate her distress. The existence of her two sons does not mitigate her sorrow over the miscarriage. Neither does the fact that it was an early miscarriage at eight weeks gestation or that other people have suffered more miscarriages.

However, Dee’s experience challenges the idea of feeling misunderstood and disenfranchised after miscarriage. She tells me, ‘I almost feel guilty that I wasn’t more distressed because people expect it’ (Dee, 13/418-20). It is noteworthy that Dee felt there was an expectation that she would find having a miscarriage upsetting, unlike my other

participants who feel that the emotional impact on them was not sufficiently recognised or understood.

It is important to acknowledge at this point, that not all women will experience miscarriage as a traumatic and misunderstood event (Corbett- Owen & Kruger, 2001). As Wong et al. (2003) suggest, this false assumption that all women view miscarriage as a life changing event may add to the guilt some women experience after miscarriage and this might be the feeling that Dee is expressing here.

Social isolation

Feelings of social isolation after reproductive loss are well documented in the literature (e.g. Cecil, 1994; De Montigny et al., 1999; Malacrida, 1998; Kavanaugh et al., 2004). De Montigny et al. (1999), in their research on how perinatal loss impacts on family social networks, describe an uneasiness between family and friends after a perinatal loss. There is a reluctance to talk about the loss and a struggle to find the right words which ultimately leads to avoiding the topic and this may result in the bereaved parents feeling misunderstood and isolated. As I discussed previously and in my Literature Review, it can be difficult to find words to describe the physical process of miscarriage or to talk about reproductive loss. Equally, it can be problematic to find the words to tell people about a loss. Janet reflects on this:

‘When you’re with people, when you’re giving people unhappy news about you... then you always feel you’re taking care of them in the situation and that’s difficult’ (Janet, 7/183-185).

Here, Janet describes a need to shield others from her grief and pain and perhaps a desire to protect herself from their response. She perceives that other people do not always know how to respond or what to say for the best and she goes on to tell me:

‘Then you have all these things from people don’t you...platitudes from people. Oh I know people that happened to and they went on to have three babies or whatever. That’s quite a difficult thing to deal with because you want to say but they are they and I’m me and my feelings are mine and my pain is mine and this is how I feel today’ (Janet, 16/459-53).

Janet wants an acknowledgement of how she is feeling. She does not want her grief minimised or any attempt by others to mitigate her pain and distress by telling her she will go on to have other successful pregnancies. Her acquaintances feel the need to share their own stories of bereavement at this time, which is understandable but not always helpful. The word ‘platitudes’ is important. In general, Janet’s experience is that other people do not know how to react to her as a woman who was pregnant and looking forward to a joyful event which suddenly turns into a sorrowful one. It may be inevitable that some appear to turn to prosaicisms and clichés in their struggle to commiserate. Jonas- Simpson & McMahon (2005) argue that ironically this use of cliché in conversation with grieving parents only adds to the feelings of disenfranchisement and the perception that their loss is being diminished in some way. However, it could be argued that these clumsy attempts to communicate are examples of others attempting to reach out and share experiences and might highlight the willingness of people to talk about miscarriage if they are given the right opportunity.

Other people’s discomfort around talking about the experience of miscarriage may act as a spur to the woman to try to move on and forget even when she craves some

acknowledgement and understanding over what has happened (Leppert & Pahlka, 1984). After a miscarriage women must integrate into a society that does not always readily accept their loss, or allow them to talk about it meaningfully, possibly causing them to deny their need to have the experience of miscarriage openly validated and acknowledged. This may result in psychological distress. Is it therefore, any wonder that Tess near the end of her interview says:

‘I’m wondering talking to you, does it lie with miscarriage because certainly when I think back I was almost not allowed to grieve’ (Tess, 27/786-8).

Other than its perceived taboo nature (Letherby, 1993), there has been limited attention paid as to why miscarriage seems to produce such negative attitudes and inept responses even from loved ones. One of the reasons for this sense of disenfranchisement may be that parents tend to isolate themselves from friends and family at this time in order to avoid the insensitive comments and the feeling that their loss is not fully understood (De Montigny et al., 1999; Rajan & Oakley, 1993; Rowland & Lee, 2010). Malacrida (1998) describes these attitudes as a discrepancy between the valuation placed on the lost baby by the parents and the value attributed to the loss by others in society. She states that miscarriage is not seen as a “social death” (p. 64) and this might explain why the expected support and understanding was not present for my participants. In my view, it is this interstice in understanding that may cause women like Janet, Tess and Lucy to feel anger and alienation at a time when they most needed sympathy and support. It is as if they come up against a wall of incomprehension and this may be perceived as a deliberate refusal by some people to accept miscarriage as a significant loss.

Women may also find their own beliefs about perinatal loss challenged and struggle to validate their own experience. I comment on this in my bracketing interview:

“Yea I get torn between – it makes me feel when I admit publicly– it makes me feel very vulnerable – what an impact this had. There’s part of me and this is very interesting and it’s the academic – how have I been conditioned – what has happened in my life to condition me to feel that somehow a miscarriage is not up there with other bereavements” (B1: 688-91).

There are resonances here with the views of Neimeyer and Jordan (2002) when they suggest that:

“At the most individualistic level, a bereaved person can experience empathic failure with reference to self by denying, disowning or disapproving of some aspect of his or her grief experience” (p. 98).

I know I intuitively felt that I had suffered a huge loss after my miscarriage and yet my experience was not always being validated or accepted by those around me. This caused me internal conflict and feelings of shame that perhaps my response was not appropriate. I even worried that I was being too self-indulgent. I express this again in my first bracketing interview:

“This taps into my biggest fear which is that ... somehow I don’t have a right that I don’t have a – I’m making mountains out of mole hills – that people will say to me so you’ve had a miscarriage ok get on with your life – get over it – it wasn’t even a real baby – you were only pregnant for a few months – you’ve already got children” (B1: 631-36).

Hey et al. (1989) sum up these feelings very poignantly:

“It is particularly hard for women to assert their need to grieve without being accused of being weak, sentimental, over-emotional, selfish... It makes our loss

and even greater tragedy when we have to fight the right to mourn, as sadly so many women do. We need our experience to be recognised as valid, even if it is not necessarily understood and so we should not have to hold back from expressing our grief” (p. 119).

I feel that for some of my participants and for me personally, there is fear around fully expressing the extent of our loss after miscarriage. Correspondingly, in my role as a researcher into miscarriage this fear is also present and I have explored this more fully in my Reflexivity Chapter.

Attitudes in the work place

Lucy’s account of how she was treated at work after her miscarriage is painful to read. Her work colleagues appear to have behaved appallingly and it is salutary to remember that she was working for the NHS at the time. Lucy needed a period of time off work to recover and her colleagues were only concerned about the increased work load this caused for them.

‘They were horrible; they were vile. I went back to work and they didn’t even say they were sorry. I put in a letter to them, which did end up in the bin, ‘you’d have shown me more understanding if I had lost my handbag’ (Lucy, 9/272-84).

The lost handbag image is very powerful and really sums up Lucy’s perception of the disenfranchisement and alienation that she was feeling. I have the impression that this is another example of a ‘shining gem’ (Smith, 2011, p.11) as Lucy is fully aware of its impact. Hazen (2003), in her research on workplace responses to perinatal loss, states that there is very little literature that considers how such a loss impacts on women at work. She suggests that miscarriage is a taboo subject in the workplace, as it is in the rest of society,

because of its emotional, physical and sexual nature and concludes that both grief in the workplace and perinatal loss are disenfranchised. Therefore, it is not surprising that Lucy found very little help and support when she returned to work. I have a sense here that Lucy's growing experience of isolation in the workplace may have fuelled the agoraphobia that begun just after she returned to work because the world outside her home did not feel safe.

Rowlands and Lee (2010) discuss the importance of social support for women who have experienced perinatal loss. They state that research suggests that women who perceive they have good support from friends and family suffer fewer health problems after miscarriage. Overall, the women in my study talk very little about having much emotional support from partners, friends or family after miscarriage. Possibly for my participants themselves, and for those close to them, it was just too difficult to understand and make meaning of something so inexplicable and therefore it was easier to keep silent. Perhaps the fact that the women in my research experienced their miscarriages as long as twenty years ago has some relevance here and it might be that in more recent times, society has been more open about reproductive loss. Nevertheless, I have been surprised by the fact that the women in my research talk very little about receiving support from friendship. I know that my own experience of miscarriage was made far more bearable because of the help and support I received from female friends.

Sub-ordinate theme: Perceived attitudes of health professionals

Insensitivity of medical staff

As well as coping with feelings of social alienation from friends and family, some of my participants recollect having to deal with perceived insensitivity on the part of the health professionals they came into contact with during their miscarriages. There appears to be a lack of training in how to communicate with women who are feeling vulnerable after miscarriage (Corbet-Owen & Cruger, 2001). This lack of sensitivity, compassion and inability to communicate by medical professionals is prevalent in much of the literature (e.g. Brier, 2008; Letherby, 1993; McLean & Flynn, 2012; Nikcevic et al., 2007; Simmons et al., 2006; Rowlands & Lee, 2010).

Thoughtless words

Out of my five participants, only Janet seems to have had both her miscarriage at home without medical intervention. Miscarriages may start in the toilet then women consult their GPs and are referred to hospital for examinations and scans. Sometimes, because of the extent of the haemorrhaging, miscarriages can turn into medical emergencies requiring admission to hospital (Evans, 2012). When the women in my study came into contact with medical staff in hospital they were often in a very emotional and vulnerable state and they recall their treatment with a high level of anger and emotion.

Lucy's anger comes from remembering thoughtless words spoken by a radiographer who performed a scan after her second miscarriage:

‘This really stupid radiographer, who should have known better, I’m sure they have training in these things, said never mind have fun trying again...I thought how

callous is that – have fun trying again and I’ve just lost my baby...even now I’m still really angry about this’ (Lucy, 7/189-93).

Here there is incomprehension that a ‘professional’ could be so unaware of the impact of her words or how inappropriate an attempt at humour is at such a time. The word ‘callous’ suggests Lucy felt it was a cold and hardened response to her suffering and grief. Her perception was that she had suffered bereavement and the fact that this was not acknowledged still rankles over twenty years later.

Tess describes how upsetting she found the medical language used to describe her miscarriage:

‘He said it was definitely a spontaneous abortion and I burst into tears and he went I don’t know why you’re crying. You already know this. I didn’t know what to do with myself. It’s just a horrible name... It surprises me that even after all these years it can still evoke the level of emotion and it’s the treatment and lack of compassion’(Tess, 13/363-74).

The use of the words “spontaneous abortion” may seem shocking but reflects the fact that Tess had her miscarriage in the 1990s when this type of language was still relatively common amongst health professionals (Moscrop, 2014). As I discuss in my Literature Review, from the 1980s there had been a movement by health professionals to use the term “miscarriage” rather than “spontaneous abortion” when talking to patients but this was still in transition. Furthermore, Moscrop suggests that this change had come about more for “legal, technological, professional and social benefits” (p.98) rather than from a desire to be sensitive to women’s feelings. He concludes by writing:

“This may represent a significant development, but the shift of medical language from “abortion” to “miscarriage” reminds us that it will take more than words to truly improve patients’ experience” (p. 103).

Unfortunately, Tess’s account above appears to bear this out.

Janet also experienced the use of insensitive language whilst visiting a consultant about her infertility after her stillbirth and miscarriages:

‘He said, “Have you any live children?” and it was just absolutely horrific. It was like someone cutting you with a knife. I can’t believe even now that someone who is in that profession could be so insensitive to someone’s feelings after losing three children’ (Janet, 2/43-48).

The anger here is palpable and the metaphor of his words cutting into her like a knife is significant when she is recalling medical intervention particularly around her stillbirth. Such insensitivity may lead women like Janet and Tess to feel angry because their feelings have been disregarded. This was also my perception and I describe this in my first bracketing interview where my anger here is still very evident:

“Looking back I don’t think doctors understand - I’m not sure nurses do. They tap you on the knee – radiologists whatever they call the people who do scans – they tap you on the knee and say you can have another baby. The number of times I was told how old are you 32 or whatever – oh you are young enough to have another baby, as if it was a puppy” (B1: 318-323).

In a pilot study by Conway (1995) carried out with 24 women to examine women’s experience of miscarriage retrospectively, 62.5 per cent of respondents reported feeling anger after miscarriage and this appears to be particularly obvious in my research when

health professionals use insensitive language. However, as I comment earlier, when discussing the traumatic nature of miscarriage, it is possible that my participants direct their anger towards the health professionals because they are seeking someone to blame for what has happened.

It is clear that my participants experienced both men and women saying insensitive things, but their perception is that men do it more frequently and unhelpful comments are generally made by doctors who during the 1990s tended to be men. Tess sums this up when she says, ‘The kindness I’ve had- those kindnesses have been offered by women’ (Tess, 14/407). Again, this is established in the literature (e.g. Conway, 1995; DeFrain et al., 1996; Rowlands & Lee, 2010). Jonas Simpson and McMahon (2005) in their reflection on the language used by medical professionals when talking to women about miscarriage show how words can have the power to console and comfort or enhance suffering. They also suggest that the words used linger far longer in the memory of patients than the actual treatment. This was certainly Lucy’s, Janet’s and Tess’s experience where it is evident that the memory of insensitive words still hurts over twenty years later.

Miscarriage is treated as routine

In my view, miscarriage is a unique form of bereavement in that it emanates from the woman’s own body. It requires particular sensitivity so that a woman is not made to feel that she is responsible or a failure in some way. When a woman has had previous reproductive loss, like both Susan and Tess, she may be made more anxious by remembering prior bad experiences in hospital (Simmons et al., 2006). However, a perceived lack of empathy by medical staff and inability to offer comfort and consolation to women suffering miscarriage is a recurring theme here and in the literature (Frost et al., 2007; Rowlands & Lee, 2007). This is echoed by Susan when she recalls:

‘It was like you were going to have a tooth out or something...I was carrying all this stuff and it was not the slightest bit routine for me’ (Susan, 15/436-443).

And later she tells me:

‘I found it quite shocking when I had the miscarriage... it’s though you’ve come to have your tooth out or you’ve got a broken toe. They’re buzzing around you just waiting for the baby to come out of you. I just thought it was dreadful because I was petrified’ (Susan, 23/725-33).

In the above quotation, I am also struck by the phrase ‘carrying all this stuff’. All Susan’s memories of her previous abortion and stillbirth are with her at this time and the health professionals appear oblivious to this. There seems to have been no record of her history of reproductive loss or any recognition of the impact this might have on her during a miscarriage. In research by McLean and Flynn (2012), women, in a very similar way to Susan above, describe feeling that for them miscarriage is a medical emergency which can feel overwhelming and frightening whereas medical staff are perceived as treating miscarriage in the same way they would a basic dental procedure or a smear test. This apparent lack of understanding and support from health professional is sadly often supported by the literature (e.g. Adolfsson et al., 2004; Murphy & Merrell, 2009; Wong et al., 2003).

Tess describes a similar experience to Susan when she is rushed into hospital during her third miscarriage. She recollects:

‘A senior house officer talking to the nurse about Star wars as if I was just a lump of meat...he just said there’s no heartbeat and there was no compassion in it...for him it was just a routine procedure’ (Tess, 7/181-7).

These accounts from my participants are quite deplorable and beg the question why is it that some medical staff struggle with empathy around reproductive loss? This question is repeatedly raised in the literature (e.g. Mclean & Flynn, 2012; Wong et al., 2003).

However, in attempting to answer this question it is important to remember that the women in my research had their miscarriages during the 1990s. As I discuss in my Literature Review, this was the time when Bourne and Lewis (1991), consultant psychotherapist writing in the BMJ, were warning health professional of the dangers of equating the psychological effects of early miscarriage with those occurring after later perinatal loss. They suggested that women should be encouraged to view early miscarriage as frequent and almost inconsequential and this has no doubt influenced the culture of health professionals treating women who miscarry.

In this context, it becomes easier to understand why miscarriage is not viewed as a significant loss if it is observed every day on an ultra-sound monitor or in an A&E department. Similarly, the high incidence of miscarriage may cause it to be perceived by health professionals as a routine medical problem and evidence that the women's body is appropriately rejecting damaged embryos (Hey et al, 1995). Therefore, health care teams might see it as their role to normalise miscarriage and to portray it as an "unremarkable life event" (Wong et al., 2003, p. 700). Yet for the majority of my participants, miscarriage was not experienced as a mundane event but a life changing one and this attitude by health professionals was perceived as a lack of empathy with little recognition of the trauma and sadness they were experiencing.

In my view, the fact that miscarriage is common and yet can have long lasting emotional effects on women needs to be acknowledged. Significantly, in a study by De Frain et al. (1996) 11.4% of the women interviewed said they had considered suicide after

miscarriage. Therefore, although medically miscarriage may only require brief medical intervention, it must not be forgotten that it can have far reaching psychological consequences, as this research and my Literature Review demonstrates (e.g. Adolfsson et al., 2006; Lee & Slade, 1996; Leppart & Pahlka, 1984; Prettyman & Cordle 1992; Stirtzinger & Robinson, 1989; Swansen- Kauffman, 1986; Swansen, 1999; Wojnar et al., 2011).

However, as I point out in my Literature Review, it must be remembered that healthcare professional may also find miscarriage difficult and distressing (Jonas-Simpson & McMahon, 2005; Reader 1995). Possibly, the lack of any medical intervention to prevent miscarriage is felt as a medical failure, arousing feelings of inadequacy and guilt in health professionals caring for women after a miscarriage which may lead to unintentional insensitivity.

I would also like to think that there has been some change in approach and outlook in the past decades but sadly more recent research would suggest that it has not been entirely the case (e.g. Evans, 2014; Jonas- Simpson & McMahon 2005; McLean & Flynn, 2012).

Kindness from medical staff

Yet, amidst the unacceptable experiences described in this theme there were some examples of my participants receiving support and care from healthcare professionals. In particular Dee talks about the kindness of the nurses who looked after her:

‘I do remember the staff nurse coming to me and saying you know I am really sorry. We quite understand if you’re very distressed about this’ (Dee, 5/150-54).

Later she tells me:

‘I mean in the hospital the nursing staff have been trained to be aware of all the emotions and so on and they were very loving and caring and supportive’ (Dee, 13/423).

Dee’s whole experience of being hospitalised seems to be very positive and she makes no adverse comments at all about her treatment by hospital staff. Thankfully, there are examples in the literature of women experiencing a personal touch and understanding from health care professionals (DeFrain et al., 1996; McLean & Flynn, 2012; Wong et al., 2003) but it appears to be inconsistent as my own research indicates.

Janet has both undesirable and helpful experiences. In the previous theme she talks about being terribly hurt by insensitive comments from her consultant but below she describes another consultant who supported her through her next pregnancy after her stillbirth and miscarriages:

‘He was really nice and really, really thoughtful and it came across he was empathic...he used to hold my hand’ (Janet, 3/62-85).

It is the small gestures of human compassion that are remembered, particularly those that involve touch such as in Janet’s account and in Tess’s below:

‘I remember this theatre nurse- she didn’t do a huge amount but it was just somebody stroking my face and in the fuddle coming round from the anaesthetic saying, “I’ve lost my baby,” and she’s saying, “I know love; I know” (Tess, 25/724).

This is such a warm and kind-hearted response. The gentle acknowledgement of Tess’s loss is very moving and in such stark contrast to the behaviour of the Senior House Officer she recounts in the previous theme. When healthcare professionals do reach out and offer

compassion and acknowledgement of the miscarriage it is remembered as significant and this is confirmed in previous research (e.g. DeFrain et al., 1996; McLean & Flynn, 2012; Rowlands & Lee, 2010; Wong et al., 2003).

My findings appear to show that the ability of staff to empathise is very important when dealing with women having miscarriages. These caring moments are remembered as a small oasis of compassion in an otherwise bleak landscape. Apart from Dee, all my other participants experienced both negative and positive attitudes from health professionals. Possibly, Dee is correct in her assumption that it is nurses who have more training in compassionate caring and it is also likely that most nurses tend to be women. However, there is no doubt that the women in my research felt less anxious and afraid when they were listened to and their feelings acknowledged by those caring for them.

Reflections

Throughout my analysis of this super-ordinate theme *Memories of the Initial Impact of Miscarriage*, I have been struck by the remarkable consistency between my participants' perceptions of the initial impact of miscarriage and the findings of much of the research in the field. This is despite my small sample of five women. The initial effect of miscarriage on the women in my research appears to have had both a physical and psychological impact. At the outset of their miscarriages, my participants had to deal with the trauma of excessive bleeding and the horror of expelling a fetus which in their mind was a baby. They experienced pain, fear and anxiety and felt angry and shocked about the random nature of what has happened. Often they experienced feelings of alienation from friends and family and perceived that their experience of miscarriage was minimised. If they consulted a doctor they faced the indignities of intimate examinations and the lack of privacy and sometimes caring in hospital. In this situation they needed treating with the

utmost sensitivity and not as a matter of routine. Unfortunately, in my participants' experience, this did not always happen. However, when they were shown kindness even the smallest gesture was remembered as making the whole process more bearable.

Here, there is a link to what Finlay (2012) describes as the existential issue of 'lived relations' (p. 20). She writes, "Lived relations is our experience of others such as when we feel shamed by another's critical gaze or how we can blossom under a loving one" (p. 20). This is particularly apparent in the account of Tess above where she expresses feelings of shame and humiliation in encounters with medical staff when she has to deal with intimate bleeding and the necessity for internal examinations but warmth towards her nurse who was so compassionate. Perhaps, there is also embarrassment, as in Lucy's account, in talking about a loss with others when there is a perception that the extent of the loss and emotional reaction is not fully understood or appreciated.

I feel that an explanation for these feelings might lie in the varied and conflicting opinions and attitudes towards miscarriage. On the one hand is the reality of what is expelled from the womb and the common belief that miscarriage is nature's way of dealing with fetal abnormalities. Following from this is the belief that a failed pregnancy can easily and swiftly be remedied by a successful one. The view that the loss is quite minor and easy to recover from is in opposition to my participants' feeling that after a miscarriage an actual baby has been lost along with all its future potential. The unborn baby can feel as precious as a living child and therefore its loss is a genuine bereavement. The women in my research are caught up in this conflict, this clash between the physical process, its psychological impact and society's expectations that the pain is short lived. This links to Finlay's (2012) fourth phenomenological facet, 'The Assumption that Body, Self and World are intertwined' (p. 21). Here the phenomenologist recognises the strong

relationship between the body and the world in which it is situated. Our physical and mental wellbeing is interdependent on our relationship with the world and society in which we live. This complex relationship or inter-dependency appears to be brought very much into awareness through the process of miscarriage. This heightened awareness of the fragility of our human body and of our assumptive world can be challenging. Therefore it is not surprising that the experience of miscarriage may not only have an initial impact on women but cause even longer term psychological effects and consequences as demonstrated in the next super-ordinate theme which I explore in the following section.

SECTION 2: THE LONGER TERM CONSEQUENCES OF MISCARRIAGE

SUPER-ORDINATE THEME 2: THE LONGER TERM CONSEQUENCES OF MISCARRIAGE

Sub-ordinate themes:

Reproductive struggle and the longing for another child

The effect of reproductive loss on subsequent pregnancies

The impact of miscarriage on family life

“One of the most liberating things that the midwife who cared for me during my miscarriage said to me was, ‘You will never forget this experience’. Looking now at these words they seem harsh, even punitive, and certainly I didn’t fully grasp their significance at the time. But I now know that she was right, in the sense of recognising the importance and power which the event would hold for me” (Hey, 1995, p. 147).

For all of my participants, except Dee, the major longer term consequences of miscarriage seem to focus on the yearning for another child and the fear and anxiety that an ensuing pregnancy brings. The struggle to become pregnant again and the risk of further miscarriages can cause tensions in relationships with partners and friends and these may impact significantly on family life. There is not a large body of research that focuses on the long-term psychological effects of miscarriage. However, Prettyman and Cordle (1994) found that 68% of women who completed a follow up questionnaire after their miscarriage

were still feeling upset by their miscarriage two years later. More recent research suggests that miscarriage, particularly during a subsequent pregnancy may cause psychological problems for some women (e.g. Armstrong, 2004; Geller et al., 2004; Firtl et al., 2009) and these research findings appear to accord with my own and my participants' experiences.

Four women in my research go on to have subsequent successful pregnancies. Janet eventually has three sons, Susan a son and daughter, Tess a son and Lucy adopts a baby boy. Only Dee chooses not to become pregnant again, but as I have already discussed in the previous section, she had very ambivalent feelings about her pregnancy in the first place. My own experience is different to Dee's in that after my miscarriage, although I desperately wanted a baby, I eventually decided I could not face the prospect of another miscarriage and possibly all the subsequent trauma. After much soul searching, I decided not to try to become pregnant again because of the risks. This choice was the right one for me but I think made my loss after my miscarriage particularly hard to bear. For this reason, I have been intrigued by the compulsion to have another baby that drives Janet, Lucy, Susan and Tess to ignore the fear and embark on the arduous journey of facing a subsequent pregnancy after miscarriage. I felt unequal to the challenge and according to the statistics described in my Literature Review I am in company with only 16% of women (Cordle & Prettyman, 1994). This has led me to ask what impels some women to want a baby so much that they are prepared to ignore the risk as statistics show that after a first miscarriage there is an increased possibility of suffering another (Firtl et al., 2009).

Feasibly, some of these motivations appear self-evident like the desire for genetic immortality or the outward expression of love between two people but I suspect the impetus to reproduce is more complex, particularly after a reproductive loss, and I explore this more closely in my discussion of the themes below.

Sub-ordinate theme: Reproductive struggles and the longing for another child

It is thought-provoking to observe that in the previous super-ordinate theme *Memories of the Initial Impact of Miscarriage*, which focuses on the immediate effects of miscarriage, my participants were angry when it was suggested to them by the medical profession, friends and family that they would feel better if they tried again for a baby. Yet later on, apart from Dee, they all go on to experience the longing for another baby.

Baby fever

Rotkirch (2007, p. 89) states that in Finland a yearning for a baby is called “Baby Fever,” an expression which feels congruent with the inexplicable desires described by my participants. He argues that this strong longing for children is more evident in low-fertility societies in which there is an element of choice over reproduction. He proposes that this hunger may be triggered by physical age, falling in love, previous pregnancies and exposure to the babies of relatives and friends and I have explored this in more detail in my Literature Review. I would also tentatively suggest that for some women, this craving may be exacerbated by losing a baby through miscarriage. Thus, it is a potentially plausible explanation for the motivations of the women in my research who were determined to try again for another baby, despite numerous obstacles and all the distress occasioned by their miscarriages.

There appears to be a strong connection here to Lucy’s experience just after she was first married. She remembers:

‘ I didn’t feel it and then all of a sudden once it was in my head everybody in the whole world seemed to be pregnant – a couple of girls at work were pregnant and I

was like, the jammy devils, and I didn't realise I wanted one so much' (Lucy, 2/ 32-36).

Lucy recalls that she 'never got broody over children' (Lucy, 1/25) but then when other women at work announced their pregnancies she was suddenly overwhelmed by longing. These experiences fit with the finding of Rotkirch (2007) above, that being around other people who are pregnant stimulates the yearning for a baby, possibly driven by hormone changes and cultural expectations.

Conversely, after I experienced a miscarriage I could not bear to be around other women who were pregnant or who had recently had babies as I saw this as a stark reminder of all I had lost. By a strange coincidence both my sisters' in law were pregnant in the same year that I lost my baby and it took me six months before I could bring myself to visit either of my new nieces which was very difficult for my immediate family to either accept or understand. It is possible that I instinctually knew that seeing another new baby so soon would stimulate my desire for a baby so intensely that it would be beyond my endurance. Significantly, I can find no research that examines why women choose not to have another baby after a miscarriage. I include an extract below from my research diary where I explore these feelings.

Research Diary April 2012

Beginning to explore and analyse the theme of longing for another baby has really brought back to me the twelve months after I had my miscarriage and the struggle that was going on for me during this time. My heart, and indeed physically my whole body, was yearning for another baby to fill up the emptiness I was experiencing and at the same time there was a common sense voice telling me not to try again for another child as I could not

psychologically cope with another miscarriage. These feelings were compounded by the fact that I had two nieces born during this time. One four months after my miscarriage and one in March which was the same month my baby was due. Significantly it was the niece born four months later that really caused me problems. I could not bear to go and visit her and I did not see her until she was six months old. Although my family showed understanding at this time, I suspect they were still hurt by this behaviour. I could not explain that the only baby I wanted to hold was my own whilst at the same time I feared that seeing my niece would break my resolution not to have another child. Even though my second niece was born very near my own baby's due date, I did not find meeting her so traumatic. It was at this time I wrote the following poem which I think explains clearly my complicated feelings:

For My Niece

*Today I went to buy you a welcome present
But ran out of the shop confused.
It's not that I don't love you,
My new born niece.
Just that you remind me of all my
Stunted hopes,
Born within a week of your lost cousin's
Expected delivery.
I can't think of you without overwhelming grief.
I hope you can forgive me
For you are a woman too.
Within your womb already lie
All your potential children.
Perhaps I will hold them one day*

*When all my heartache is in the past.
You're my flesh and blood only
A little way removed.
We are united in that.
But your every milestone as you grow,
Even your children,
Will remind me of all that
I have lost.*

Nearly twenty years later, I still find this eloquent testimony to the long term effects on me of miscarriage and the intense longing for another baby it can induce. Memories of my miscarriage are triggered very infrequently now. However, when my nieces recently graduated from university, I did allow myself to momentarily imagine what my baby might be doing now had she lived.

A greater understanding of what has been lost

It is also possible that the longing for another baby is exacerbated for some women after a miscarriage because they are not childless and therefore have a greater understanding of what they have lost. I feel this is what Lucy is suggesting in the following extract when she compares her feelings about losing this second baby to how she would feel if she lost her son:

‘Like for me it was as if I’d lost the potential for an O and the thought of ever losing O...’ (Lucy, 8/224).

Her emotions become too strong at this point and she is unable to complete her sentence. The word ‘potential’ is significant here. The presence of her living son intensifies her feelings of loss as he symbolises all that her lost baby might have been in her imagination.

Significantly, this strength of feeling is at odds with the findings in some of the literature (e.g. Peppers & Knapp, 1980; Leppert & Pahlka, 1984). In fact, Neugebauer et al. (1992) argue that existing children may mitigate the distress of miscarriage because their presence may actually provide the woman with psychological support and afford reassurance that they have enjoyed reproductive success in the past. Research also indicates that there is a greater risk of depressive symptoms after miscarriage for childless women (Klier et al., 2002; Adolfsson et al., 2004; Brier, 2008). Indeed, Brier (2008, p. 460) reports that, “studies related to the absence of living children at the time of miscarriage seem consistent in indicating relatively higher levels of grief in women who do not have living children.” This might be because as Firtl et al. (2009) imply, miscarriage may sensitise women to the fear it may happen again and also increase the dread of being unable to have children in the future. Nonetheless, for Lucy having a son prior to her miscarriage only appears to emphasise the extent of her loss.

Fertility problems

Janet, Lucy, Tess and Susan all report having gynaecological problems that make pregnancy difficult and which required them to seek medical help for fertility problems. This leads me to speculate whether the knowledge that subsequent pregnancies might be difficult because of fertility problems, stimulates my participants’ hunger and craving for a baby after a miscarriage. Janet is aware of her fertility problems from an early age:

‘I have always had a lot of hormone problems – lots of period problems...so I had been seeing people for a long time. I honestly thought or I did think that I wasn’t going to have children and I accepted it’ (Janet, 10/285-295).

Initially, she believes that she probably will not be able to have children. However, she does not undertake any fertility treatment and eventually conceives her first child naturally. It therefore seems particularly cruel that after an apparent trouble free pregnancy she suffers a stillbirth followed later by two miscarriages. Yet subsequently, Janet is prepared to risk having another pregnancy even though she cannot fully articulate her motivation.

Janet: Why did I do it again? Why did I risk it? When I look back I risked it twice more after that for some...I don't know. I don't know what's in you to do that, where it comes from.

Researcher: The desire to have a baby?

Janet: Yes because I wasn't...as I said to you I was quite happy...I was never very motherly...and talking about the biological clock. Maybe there was a bit of that – if I don't do it now what will happen' (Janet, 15/436-447).

Here, it is interesting that Janet says she is not 'motherly' and I am curious about what this means. I think that Janet is suggesting that she is not overwhelmed by maternal instinct and perhaps, contrary to Rotkirch's (2007) theories described above, she is not made desirous of another baby by seeing other pregnant women around her or by the presence of babies. Nevertheless, despite knowing that pregnancies do not always have happy outcomes, she is prepared to try again. She repeats the word 'risk' in relation to becoming pregnant and this suggests that she perceives pregnancy after her previous reproductive losses as a gamble or speculation. For Janet then, pregnancy is associated with something that could possibly be harmful or dangerous. However, she faces this precarious undertaking for reasons she cannot fully explain, other than experiencing some kind of biological imperative spurring her on and possibly a feeling that for her time was running out.

After her third miscarriage, Tess had an under active thyroid diagnosed and eventually she was referred to a research project on recurrent miscarriage through the Miscarriage Association. This intervention finally resulted in the birth of her third son almost five years later. Tess expresses similar feelings to Janet above when she tries to explain her compulsion to struggle through what she describes as the ‘darkest years’ (Tess, 6/156) meaning the five years she took to become pregnant with her third son:

‘I don’t know why I put myself through- I honestly don’t know why I put myself through it but I’m glad I did because we’ve got this lovely young man but I don’t know why and common sense would say don’t do it. I don’t know why’ (Tess, 25/741-744).

In a similar way to Janet, Tess can offer no explanation for her longing to have another baby. In retrospect, she has a son who brings great joy to her life but the five years she spent trying to conceive him were extremely difficult. However, she never gave up trying because of an instinctive desire that drove her on. There is also a suggestion in Tess’s interview that once she was on the research project for recurrent miscarriage, she finally felt that her reproductive difficulties were being heard and understood:

‘They were going to listen and I saw this professor, a big name man, a lovely chap and he said yes we will refer you on to my researcher, who was just a wonderful, wonderful woman. Yea, and that makes me emotional (crying)...It’s like being heard at last isn’t it...I eventually got pregnant again’ (Tess, 21/560-562).

I have a sense that Tess’s struggle became less acute once somebody was listening to her concerns and she was finally given some answers as to why she was experiencing recurrent miscarriages. I believe that it is the memory of eventually being heard and the relief she

felt on being given a credible explanation and medical support, that makes Tess cry during the research interview. It is also possible, that undergoing fertility treatment gave Tess a sense that she was back in charge of her own reproductive process. I would also suggest that, in a similar way to Dee, eventually having a medical explanation for why she had multiple miscarriages may have reduced her stress and anxiety levels and made it more likely that she would conceive and go on to have a successful pregnancy.

In Tess's situation, it is not surprising that there is a natural tendency to turn to the medical profession to provide the answers and a huge sense of relief when fertility treatment is successful, although it must be recognised that this will not be the case for all women. It is thought provoking to observe how warm Tess's feelings are towards her doctors in the above extract, compared to how she felt the medical profession treated her during her miscarriages, which is so evident in the theme, *Perceived attitudes of health professionals*. It feels as if she is in a much more equal partnership with her doctor as they work together to solve her infertility problems.

Perhaps, it is the case that doctors are able to respond to infertility in a more positive and solution focused way in contrast to the impotence they may feel in the face of a miscarriage where there very few reliable medical interventions (Corbet-Owen & Cruger, 2001). For this reason, it might be easier for health professionals to have a rapport with patients who are coming for help with infertility rather than with those who are being treated for miscarriage. I think there is even a sense of relief from Tess that she can hand over control of her fertility to someone else that she trusts. It is no longer her responsibility, which relieves the pressure she has put on herself to have another baby.

Despite a stillbirth, a difficult pregnancy and a miscarriage, Susan still goes on to become pregnant a fourth time and faces all her challenges with fortitude. After Susan's stillbirth, it

was discovered that her abortion at sixteen weeks gestation had damaged her uterus resulting in an incompetent womb. This meant that it was difficult for her to sustain a pregnancy to full term without medical intervention. She needed to be hospitalised for each subsequent pregnancy and her cervix stitched, making pregnancy and delivery unsafe. Ignoring the risk, she goes ahead and has three more pregnancies, the second of which was a miscarriage. She tells me:

‘I may well have wanted another child after T. After having all that trauma and R who was an adorable little thing in lots of ways but she was horrendously difficult. Then I had the miscarriage and then T. T was a delightful gorgeous little thing. I would have just liked another. But having T when I went into labour my womb just split open and in fact I nearly died. They just had to stitch and patch it up and do the best they could but they said there is no way you can carry another baby. You must not get pregnant again’ (Susan, 10/272-280).

Eventually she is forced to accept that she must not attempt another pregnancy even though she would have liked to try again. It is possible that Susan’s guilt about her abortion influences her desire to become pregnant. She seems to view it as a reparative act when she says:

‘It’s all linked even though – it is all linked. I wouldn’t have lost those babies if it wasn’t for that’ (Susan, 8/234).

Although Susan was only eighteen when she had the abortion and experiencing very difficult circumstances, I have a sense that she still feels that throughout her pregnancies she was on trial to determine whether she was worthy to have a baby:

‘I did feel that I am being tested all the time. And this kind of thing always feels like there are more tests. Yea and I think even now I could lose her. I’ve gone through all these other things to get to here and it could still happen’ (Susan, 17/487-489).

The confusion of tenses in this extract and the fact that my participant is perhaps unaware of the full extent and complexity of what she is saying, suggests that this is an example of a “secret gem” (Smith, 2011, p. 11). As a researcher, I had to look very intently at the underlying meaning in this quotation before it was revealed. I think what is heart breaking here is Susan’s anxiety and fear that she could still lose her grown up daughter. I believe this fear is connected to Susan’s persistent belief, even over twenty years later, that her first daughter’s stillbirth was a punishment for her abortion.

In their book on exploring reproductive trauma, Jaffe and Diamond (2010) describe working as psychotherapists with clients who experience problems around infertility and pregnancy loss. They argue that becoming a parent plays a major role in the self-concept of both men and women. Thus when a woman experiences a threat to this self-concept such as miscarriage it can be devastating:

“Reproductive trauma triggers an identity crisis that can leave patients confused and disorientated. Their sense of self must shift from healthy/normal to patient, from someone who is ‘trying’ to someone who has ‘failed’ to conceive, from a parent to be to someone grieving a child who never was” (p.42).

It is possible that the women in my study are determined to overcome almost insurmountable obstacles to become pregnant again because they long to regain their self-concept and identity as fertile, adult women.

Thus, for Susan, Janet and Tess their experience of miscarriage appears to act as an incentive or a driving force, urging them to try for a pregnancy, despite having to overcome infertility problems. For Lucy, there is the sense that her overpowering love for her first son increases her desire to reproduce that relationship with another baby. I will never be able to explain why I wanted three children and why having only two feels like a loss. Therefore, I can fully appreciate my participants' desire to go on and have subsequent pregnancies, despite all the difficulties. I admire and envy the courage they display both here and in the next sub-ordinate theme.

Sub-ordinate theme: The effects of reproductive loss on subsequent pregnancies

Janet, Lucy, Susan and Tess all become pregnant again after their miscarriages and I have the impression that their previous experience of reproductive loss influences their attitudes to the pregnancy. I have already described in my discussion of the first super-ordinate theme **Memories of the Initial Impact of Miscarriage** the high levels of anxiety that having a miscarriage produced in my participants. Following on from this, Janet, Lucy Susan and Tess report an increase in anxiety during subsequent pregnancies after miscarriage and they tell me about their feelings of fear and foreboding. As Janet says, 'There was nowhere where it felt safe' (Janet, 14/411). She is filled with apprehension that something will go wrong again.

Detachment from the pregnancy

Janet recalls that she did not want to tell anyone about her pregnancy for at least the first three months in case something went wrong again:

‘I thought to myself I need to get past these three months before I told anybody and the (pause) it was just - there was fear, there was fear and I think – I think I’d have to be inhuman not to have fear...you want to be optimistic, you want to look but it’s like I can’t look forward in case something goes wrong’ (Janet, 15/421-429).

The emphasis here is on fear; the dread of telling anyone about the pregnancy in case it fails again and the inability to trust that all will be well and make plans for the future. Janet copes with these feelings by detaching herself from the pregnancy and by not allowing herself to believe she is going to have a baby:

‘I had got the idea that it wasn’t going to happen so I was pregnant but I wasn’t going to have a baby’ (Janet, 3/76-77).

This is an example of a “secret gem” where the full meaning is initially obscured from both the participant and the researcher (Smith, 2011). Janet is able to believe in the possibility of a pregnancy but not in the prospect of successfully delivering a baby.

Cote- Arsenault & Morrison-Breedy (2001) report similar findings in their qualitative study on the long term effects on women after perinatal loss. The women in their study recount feeling that they were naive in believing that they would have a successful pregnancy and therefore like Janet, they avoided investing emotionally and forming an attachment to the unborn baby in a subsequent pregnancy. In their earlier research, Cote-Arsenault and Morrison-Breedy (2000), describe women in a focus group portraying this feeling as going through pregnancy “one foot in; one foot out” (p. 473) which I believe is a pertinent metaphor for Janet’s experience.

It is possible that these feelings of foreboding are exacerbated by the fact that Janet previously had a stillbirth and two miscarriages. It is therefore understandable that she

might separate the concept of being pregnant from the idea of delivering a healthy baby. However, contrary to Janet's experience, Firtyl et al. (2009) found an increase in attachment to the pregnancy by women who had suffered previous miscarriage and I believe this was the case for Lucy, Tess and Susan. It is hard to explain why Susan's and Janet's reaction should be so different when they both had similar experiences of stillbirth and miscarriage. Perhaps, this just serves to show that despite commonalities, my participants respond to miscarriage and their subsequent pregnancies in their own idiosyncratic way.

Increased attachment to the pregnancy

I sense that for Lucy, Susan and Tess it is their close attachment to their subsequent pregnancies that causes them to be so fearful of having another miscarriage. Lucy's fear was particularly intense every time she went to the toilet:

‘You go to the loo, you're thinking I hope there is nothing there. I hope there's no blood’ (Lucy, 5/132).

For Lucy, bleeding is a warning sign that something is going wrong with the pregnancy and again there is the association with miscarriage and toilets. This fear keeps her in a constant state of anxiety which she evocatively describes as:

‘Like sitting on a cliff waiting to see if you were going to fall off’ (Lucy, 6/150).

Here, her trepidation is palpable. She cannot trust that she will have a successful pregnancy and exists in a world of uncertainty. Sadly for Lucy, her fears were confirmed and she had three miscarriages before she eventually adopted her second son.

Comparable fears are expressed by Susan:

‘You just thought this is all going to go wrong again. I was really worried that it was going to go wrong’ (Susan, 16/461-2).

Although Susan did eventually have a daughter, she faced months of living with acute anxiety and fear that she would lose her baby again. She found it very difficult to relax and enjoy her pregnancy because of this overriding fear and anxiety. This is particularly sad because of the challenges Susan faced becoming pregnant again after experiencing a previous abortion, stillbirth and miscarriage.

After a lengthy struggle to become pregnant for a third time and medical interventions to treat her infertility, Tess does eventually conceive but describes this period as ‘the most anxious nine months of my life’ (Tess, 22/643). Nevertheless, regardless of her fear and anxiety, Tess was still very determined to have a successful pregnancy against all the odds. She was resolved to continue with the pregnancy, despite being warned of the possibility that her baby could have a chromosomal abnormality:

‘I had a blood test and the scan was fine but the blood test indicated there was a high chance there might be a problem. And I was offered amniocentesis but I just knew from the word go I wasn’t going to have it...I said a baby with Downe’s that’s fine. I’ll cope with that. I can’t lose another baby especially at 20 weeks’ (Tess, 23/670-75).

After three miscarriages, it is not surprising that Tess refused to have tests that could result in a further miscarriage and that she feels strongly attached to the pregnancy. Her fear of losing another baby out- weighs any other consideration including the possibility of coping with a child who may have special needs. However, as I describe previously in the theme,

The early psychological effects of miscarriage, living in a constant state of anxiety ultimately takes its toll and is still impacting on her fifteen years later.

Lucy's experience of adoption

I have chosen to include at this point in my thesis, a more detailed account of Lucy's experience of adoption, to illustrate the struggles and the joys that Lucy and her husband had to go through to eventually have a second son. I could have included this section under the theme *Reproductive struggles and the longing for another child*, as Lucy's deep desire for another baby are clearly portrayed here. However, I think what Lucy tells me also fits under this theme, because, after the heartbreak of her miscarriages, Lucy does subsequently go on to have another child and she experiences all the stress and anxieties, illustrated in this theme, whilst waiting for the child to arrive. Throughout the analysis for this chapter, I have found that in undertaking this type of qualitative research, it can be difficult to separate experience into discreet themes and inevitably there will be some overlap. If I omitted this part of Lucy's experience, I feel that I would be somehow diminishing my findings by not including the full impact of the experience of reproductive struggle for all my participants, and that includes adoption. I have documented this dilemma in my research diary and produce the relevant extract below.

Research diary August 6th 2013

I need to include Lucy's account of her adoption in my research at some point because I find the idea of her adoption being a reward, after such a long struggle with pregnancy loss and all the trauma she went through with anxiety, depression and agoraphobia, very poignant and moving. I am touched by the significance of the date when she first brings J home and I am struck by her determination to travel to Wales to collect him despite her

agoraphobia. I was moved to tears by her description of the car journey and her sitting clutching a picture of J in one hand and a packet of valium in the other to help her endure the journey because of her agoraphobia. Perhaps the most significant part of the interview is when Lucy says that without her miscarriages she would not have had J and that her baby should have been J although it is difficult to know how to interpret this and which theme to include this experience under. All that is clear to me at the moment is that without the miscarriage, she would not have thought about adopting and so it is pleasing to have a happy ending. I am unsure whether I am any closer to understanding why some women have a desire to go on and have subsequent children despite all the heartache and why others do not. Yet, I am certain that this will always be an exceedingly difficult and complex question to answer.

Lucy's experience was different from that of Janet, Susan and Tess. A few years after giving birth to her first son, she discovered that she had polycystic ovaries which significantly reduced her chance of becoming pregnant. However, after three miscarriages, she still desperately wanted another child. She sums up this longing when she tells me she just wanted, 'an object to give your affection to.' (Lucy, 21/583) She goes on to say:

'I'd got O already but it was so intense I thought God I'm going to suffocate him'
(Lucy, 21/584).

All Lucy's maternal affections were being focused on her first child and the word 'suffocate,' sums up how overwhelming and powerful this was for Lucy and how it was affecting her son. In response to these emotions, Lucy channels these desires into a long and arduous process of adoption and eventually, she successfully adopts a nineteen month old little boy.

Initially, when she first begins the process of adoption, Lucy fears that they will be refused as suitable adoptive parents because of her mental health problems. She tells me how she first goes to her GP to express her concerns and about her delight at his response that he would support her going ahead, despite her difficulties:

‘It’s that good enough thing. Am I good enough to adopt because I’ve got a mental health issue. So I said I’m going to go to the doctors first and have a chat with him ...and he was lovely. He said Lucy, you’ve been through some things but in all the time, however ill you’ve been, O has always come first. You’ve never neglected him. You’ve always looked after him’ (Lucy, 19/482-493).

A little later in her interview she describes the thoughts running through her mind on the day she is waiting for a phone call to tell her whether or not the adoption could go ahead:

‘Please give us the stamp of approval- please let us know I’m good enough to adopt a baby. And they said yes you’ve got through and I was the main adopter. It felt like a reward for all the hard work and all the trauma. I had the delivery date for the miscarriage which was the 6th January. That was the significant one and we met J on the 7th January... and it just seemed as if it was meant to be’ (Lucy, 22/620-630).

As I read this extract, it feels as if Lucy is reliving this moment again in the present and for me this is one of the most moving parts of Lucy’s interview. Everything appears to come full circle and to fall into place and her family is complete. Ultimately, the intensity of Lucy’s longing for another baby is captured in her moving description of her bringing home her adopted son for the first time:

‘People might find it bizarre but the Mummy stuff just kicked in. My boobs ached for weeks. If he had been young enough I would have tried to breast feed him but with him being nineteen months he was too old’ (Lucy, 23/651-654).

The need for a child is experienced by Lucy as a physical ache. Her body responds to this in an instinctual way that she experiences as strange and incomprehensible. There appears to be a strong connection between a physical response and an emotional longing for a child. It is very thought provoking to realise that the close connection Lucy felt towards her new son could activate the hormones in her body that produce breast milk, although this is documented in the literature (Gribble, 2006). It is interesting to note that at this point in Lucy’s research interview, I comment that her adoption process ‘sounds harder than an actual delivery of a baby – worse than a labour.’ Lucy replies, ‘I was just relieved but that happened when I had O. My husband cried and I was just relieved’ (Lucy, 22/642). This dialogue suggests to me that Lucy equates the arrival of her adopted child with the actual birth of her eldest son and in that touching moment of our interview, that was also my perception.

This theme illustrates that the experience of reproductive loss influences how my participants feel about their subsequent pregnancies and in Lucy’s case adoption. It appears to make them more determined to have another child even when they already have children as in Lucy’s and Tess’s accounts. Conceivably there is something about wanting to prove to your-self and to others that you can ultimately have a successful pregnancy and perhaps in some ways, like Susan, assuage previous feelings of guilt and failure. However, this may result in feelings of fear and anxiety during the subsequent pregnancy, and in Janet’s case an inability to relate to the pregnancy, all of which may have long term effects on emotional wellbeing and mental health.

Sub-ordinate theme: The impact of miscarriage on family life

Another longer term consequence of miscarriage for my participants is the impact it has on family life and relationships and this is well documented in the literature (e.g. Conway, 1995; Cote- Arsenault, 2003; Rowlands & Lee, 2010). Although the experience of miscarriage is primarily the woman's, inevitably it takes place within the social context of the family (Cecil, 1994). In particular, the strain placed on parental relationships after a miscarriage is documented in the literature and is discussed in my Literature Review (e.g. Gold et al., 2010; Turton et al., 2009).

Certainly, for Tess, her struggle to become pregnant again after three miscarriages placed a huge strain on her relationship with her husband. She tells me:

‘It took a long time to get pregnant. The third time caused a serious rift in our relationship. I was by that time obsessed’ (Tess, 9/255-56).

Her husband had difficulties accepting Tess's longing to become pregnant again and the extent to which she was prepared to go to satisfy her longing. He could not understand why she was not satisfied with the two children they already had and although he continued to be supportive it nearly cost them their marriage.

‘It did take our relationship to the breaking point. We survived it and I do think it is stronger as a result’ (Tess, 15/438-9).

Fortunately, the marriage endured and Tess went on to eventually produce a third son. However, there is a sense here that after such stress and anxiety they were lucky to have reached this point.

Effects of miscarriage on family dynamics

Rosenblatt (1996, p. 48) suggests that after a miscarriage, the birth of a subsequent child might result in “muted grief.” The mother may not allow herself to feel sorrow for her miscarriage because she is expected to be glad she has had a successful birth and find joy and comfort in her new baby. There appears to be limited research literature in this area. However, Rosenblatt and Burns (1986) argue that when a miscarriage is followed quite quickly by a successful pregnancy and the miscarriage is perceived as necessary in order for the next child to be born, this may lead parents to feel that by mourning the miscarriage they are in some way denying the value of the living child (p. 244). To the outside world there appears to be a happy ending, but the woman still has to find a way to resolve all the complexities of feelings and emotions about the pregnancy she has lost.

Tess reflects on this when she tells me how having her third child after a phase of multiple miscarriages has changed her family dynamic:

‘It’s still there but then it gets balanced out by this child being there. We wouldn’t have him. He wouldn’t be who he is. Our family wouldn’t be how it is.’ (Tess, 19, 142-3)

For me, this quotation really sums up the dilemma faced by families who go on to have a subsequent child after reproductive loss. The ‘it’ here refers to Tess’s feelings of loss and grief after her miscarriages. Her sorrow is then mitigated in some way by the birth of her next child, perhaps made even more precious because of her long five year struggle to have a successful birth. However, she then reflects on the fact that if she had not had her previous miscarriages this longed for child would not have been born and the family dynamic would have been different. There is tension for Tess between remembering the

place in the family of her lost children and acknowledging that because of these losses she eventually gave birth to the son she describes as ‘this lovely young man’ (Tess, 23/684).

Lucy, when talking about her adopted son J, says something remarkably similar to Tess above:

‘He’s not a replacement but he’s filled the gap. The void isn’t there... it just feels meant to be. He’s so much larger than life. He’s very hard work at times. He pushes you to the edge of all your emotions, the laughter and the sadness and the anger because he is quite naughty. But he is big enough and large enough to fill it’ (Lucy, 23/658-663).

Lucy is stating here, perhaps more clearly than any of my other participants that she does not see her adoptive son as a replacement for the children that she lost but as someone who fills the vacuum that has been created in her family by her miscarriages. The impact he makes on the family is vividly described and bringing him up is not easy. However, she no longer feels empty but fulfilled. Tellingly, at the very end of our interview, Lucy says something that again reminds me of the dilemma around finding a balance between sorrow for the children lost by miscarriage and joy in subsequent children:

‘But that baby should be J. I would never not have wanted to have J and if I hadn’t been through this I couldn’t have had J’ (Lucy, 29/845-6).

This appears to be a very pithy but complex statement and once again brings the impact of miscarriage on family dynamics into sharp focus. It is as if she is suggesting that in her fantasy, if she had not had a miscarriage, then the baby she would have desired to give birth to is J. The two have been conflated in her mind. Yet at the same time there is an understanding that the miscarriage led to the adoption and therefore something good and

positive resulted from it. Both Lucy and Tess have found ways of accommodating all their complicated feelings around sudden and unexpected loss through miscarriage and they have married these with their feelings around the joy and satisfaction of successfully completing their families later on.

Reid (2007) sums up this dilemma well when writing about her own research on women in psychotherapy after experiencing the loss of a baby and a subsequent new birth:

“A finding of the research...was the complexity of feelings associated with the both the conception and birth of the next baby. It was difficult to imagine a sense of the mother wishing to replace on a conscious or unconscious level. They simply wanted the infant they had lost. What became increasingly clear as the work progressed was that mothers felt they could never replace the lost baby and that they knew they had to accept this on one level if they were to recover emotionally” (p. 182).

She goes on to describe children born after a reproductive loss as “born in the shadow of the lost infant rather than as a replacement” (p. 182). I think this is what Tess and Lucy are describing. They make it clear that their subsequent children are not surrogates for the babies they lost. However, there is a need to acknowledge at some level that these children’s place in the family has been determined by the fact that miscarriages happened.

In my view, it is this paradox that plays a part in making miscarriage such a unique and complex bereavement. Biologically, a woman can become pregnant again after a miscarriage quite quickly, and as the statistics show, this happens often within one year of the miscarriage (Klier et al., 2002). Although, psychologically there is not necessarily a conscious desire to replace the lost baby, which has its own unique place in the mother’s

heart, at the same time, there may be a yearning to have another baby which can feel inexplicable and out of control. Perhaps it is this perceived ability to replace the lost child relatively easily that makes a woman's feeling of loss and grief after miscarriage so misunderstood by friends and family and possibly Western society in general.

The impact of agoraphobia on Lucy's family life

There is no doubt that Lucy's family life has been severely affected by her experience of miscarriage leading to agoraphobia and this is a continuing theme through my analysis.

Lucy's on-going experience of agoraphobia, many years after her miscarriages, has a substantial impact on her experience of adopting her second son and continues to affect and curtail her family life in the present. Lucy cannot go away on holiday or take her children out. She tells me, 'Everyone lives their lives around it' (Lucy, 17/438-9).

Although her family have accommodated Lucy's agoraphobia over the years, she stills feels even now that her husband does not fully recognise the extent of her difficulties:

'They were really tolerant, very tolerant. I'm not sure that C understands. He's accepted (crying)' (Lucy, 17/438-9).

Throughout this part of her interview, Lucy was very distressed and crying. She wants to be understood but there is a gulf between her husband's ability to accept their situation and to comprehend it. Possibly, the sense of loneliness and isolation here adds to the agoraphobic feelings of being trapped that she describes earlier. Later in the interview she tells me that in the early days of her agoraphobia she felt such despair that she did contemplate suicide:

‘I do remember earlier times in the past thinking my family deserve better than this – I’m not good enough for them. I felt they would be better off without me’ (Lucy, 26/759-61).

This level of distress is a clear indication of the long term psychological consequences of miscarriage for Lucy and her family.

Dee’s different perspective

Dee views the impact of her miscarriage on her family from a different perspective. Even though she found the prospect of having a fourth child in her forties daunting, nevertheless, her family were just coming to terms with all the changes a new baby would bring when the miscarriage happened:

‘We had got our heads around it. We were making plans. We were looking at what we would need and thinking we will have to swap bedrooms around and so on’ (Dee, 3/81-3).

It is only Dee that talks about the need to make ordinary every day adjustments to family life when expecting a new baby, such as where everyone will sleep and whether the car is big enough. Even though they were obviously planning for the baby’s arrival and the inevitable upheaval this would cause, Dee tells me that the miscarriage subsequently made very little impression on her children:

‘I had three grown up children...so it wasn’t that we were desperate for a family. We were a family and this would have been just an extra little one...I wouldn’t have wanted it to happen that way but I don’t think any of us were desperately distressed when it did’ (Dee, 10-12, 329-399).

Dee feels that her family is already established and there is the sense that the new baby would be almost superfluous to her family unit. For this reason she did not find the miscarriage particularly upsetting because it was not a longed for or much anticipated pregnancy. I find the words Dee uses here, 'just an extra little one' really touching and they remind me of a quote in Cecil's (1994) research when one of her participants says, 'I wouldn't have minded a wee one running about' (p. 151). Throughout my research, it is clear that Dee does not view her miscarriage as a great loss. Nevertheless, the words she uses here to describe her baby are affecting and I feel imply that this baby would have been welcomed into the family.

Although at the time, Dee did not know about the possibility that her baby might have chromosomal abnormality, looking back, she feels that it would have been more disturbing for her family to have a child with special needs than it was to have a miscarriage:

'So it would have been unsettling in a sense for the whole family and even more unsettling if the baby had been disabled' (Dee, 15, 471-2).

She makes it clear that a new baby at this point in their lives would have been perturbing for every member of the family but perhaps even more so for her children.

Although Dee appears to be adamant that her miscarriage did not impact hugely on her family, the children were involved in making plans for the new arrival. Very near the beginning of her transcript she tells me about her ten year old daughter's reaction to her mother's pregnancy:

'My daughter was all excited. It was lovely. She would like a baby to play with' (Dee, 2/43-44).

Later on in the interview I ask her whether the miscarriage had an effect on the children.

She replies:

‘I was going in (to hospital) and I mean the boys weren’t little... Yes the boys obviously understood. Well, C did really. She knew about miscarriages’ (Dee, 8/266-269).

I have a felt sense that this miscarriage might have impacted on her children and particularly her daughter more than Dee acknowledges. The above quotation makes me ask how much a ten year old girl can really understand about the process of miscarriage and how she felt about her mother being admitted to hospital and suddenly not having the prospect of a baby to play with.

There has been very little written in the literature about the effect of miscarriage on other children in the family since Cain et al. (1964) wrote their seminal article on “Children’s disturbed reactions to their mother’s miscarriage.” They write:

“Even in the face of gross evidence to the contrary, parents may state that their children knew nothing of a pregnancy and miscarriage, or showed no noteworthy reaction to the miscarriage” (p. 59).

In the above research, the participants comment on the reactions of their children to miscarriage and the general feeling was that older children did understand the loss to a certain extent but their responses varied from asking questions about where the baby had gone, to making cards, feeling upset and crying to saying nothing and appearing to act as if nothing had happened. I would suggest that children’s reactions may be very dependent on the attitude the parents take to the miscarriage, how much they were involved in

discussions about the pregnancy initially, how much they were told and in what manner about the miscarriage.

Although attitudes to involving children in major events in family life and in particular death and bereavement have changed over the last fifty years (Wilson, 2001), I believe that there is still a general attitude in Western society that miscarriage is something to be hushed up and kept secret. Therefore, it is not surprising that parents find it hard to discuss miscarriage with their children. Moulder (2001, p. 176) in her chapter with the poignant title “Mummy where did that baby go?” considers the possibility that having a miscarriage when there are already children in the family may cause even more complications for the parents because children cannot be fully shielded from the experience and need to have their feelings considered at a time when often the parents are struggling to come to terms with their own loss. The Miscarriage Association (2011) provides a leaflet written by Christine Moulder on how to talk to children about miscarriage and here she points out that older children, in a similar way to their parents, may struggle to make sense of what has happened and need to ask questions. This is illustrated affectingly in the leaflet by the example of a child asking “Is it called a miscarriage because we miss the baby?” I know from my own experience that I found it very difficult to talk to my own children about how they felt about my miscarriage and I neglected to consider how it affected them at the time. I reflect on this in my research diary below.

Extract from my Research Diary January 2012

When I first began to analyse Dee’s comments about her daughter being so excited about the prospect of a baby to play with and then her matter of fact statement that her children understood about miscarriages and that they didn’t talk about it, I found myself at first feeling quite judgemental. I found it hard to understand how Dee could be so insensitive to

her children's needs. Then I wondered if this was just a part of Dee's own denial around her feelings about the miscarriage. Or more importantly, was this what I wanted to see here.

Now as I embark on a more detailed analysis and feel more immersed in Dee's story I am inevitably taken back to my own experience and I have come to the realisation that there are similarities between us. I find myself remembering my shock at going to a parents' evening and talking to the teacher of my six year old son. She told me that he had been refusing to speak to the adults at the school for the past six months and was in effect electively mute. She was wondering if there was anything wrong at home. At this point, I was torn between my anger at the fact that I had not been told of my son's distress sooner and the fact that I had failed to inform the school of my miscarriage or to notice any of my son's suffering. It became clear to me that I had been too caught up in my own loss to help my son cope with his feelings. Even though, when I had the miscarriage, I had left him with my parents and effectively abandoned our summer holiday, I failed to realise he would be affected by this. We had only just told the boys about the pregnancy when I had the miscarriage, and although I did tell them there was no longer going to be a baby, I cannot remember what words I chose or whether they asked questions. Even now, it is not something I ever talk about to my sons. This makes me feel sad and a bit guilty and makes me want to question why this is so difficult but at the same time it gives me a better insight and understanding of Dee's experience. I also want to acknowledge that I am sure we both did what we felt was best for our children at the time.

A little further on in the research interview, I ask Dee whether they ever talked about her miscarriage as a family. Her reply is significant:

‘I don’t think we ever did really. No, it wasn’t that we didn’t talk about it- we didn’t choose not to’ (Dee, 8/271-2).

There is a sense here, that something is unspoken but there has never been a conscious decision made not to talk about it. It feels like it has become a family secret, although not intentionally. A little later on, Dee reflects on these feelings now that her children are much older and with families of their own. She wonders if they would even remember her having the miscarriage:

‘It would be interesting to say to them now, “Do you remember me losing the baby?” I’m not sure it would be something that would actually feature’ (Dee, 9/282-32).

As a researcher, I would love to have an answer to this question and pondering over my analysis left me wondering whether as a mother, I would like to ask my own family this question too. Therefore, as is my habit, I went to my research diary to clarify these thoughts and the result is recorded below.

Research Diary April 2014

Today I have been reflecting deeply about asking my sons whether they remember me having my miscarriage. This has come about because I wrote in my thesis today that I would like to know the answer that Dee’s family would give to the question, “Do you remember me losing the baby?”

I have very rarely ever talked about my miscarriage to my sons but I took my courage in my hands and asked my youngest son what he remembered. He told me that he definitely remembers me having the miscarriage whilst we were on holiday when he was six years old, now twenty one years ago, but he did not understand what it really meant. To my

surprise he also remembers being in the kitchen when I told him that I was pregnant a few weeks before this. I chose not to intrude into his feelings around the miscarriage, that might be for another time and not to be included here, but I was shocked that he would still remember and there is also a part of me that is pleased we have that shared experience. This conversation has brought home to me how much children can be aware of painful events in family life even when parents try to shield them from the effects. This was something I did not expect to be considering when I first began this research.

At the time of the interview, it felt as if Dee was considering the impact of her miscarriage on her family for the first time. I now wonder, whether compared to earlier in her interview, she is a little less certain that there was no impact on her family.

Janet's situation is different from both Dee's and mine, in that her three children were all born after her stillbirth and miscarriages and she tells me that her sons have always been made aware of these reproductive losses from the beginning:

'Researcher: Do your children know you had miscarriages?

Janet: Yes, they know all about everything. They were brought up with it. We are quite open as a family' (Janet, 12,331/3).

It is possible that it is easier to talk to children about previous reproductive losses if they occurred in the family before they were born and they were not emotionally involved in the loss. I can also understand why Janet would feel it was important to bring up her sons knowing that they had a sister who died before they were born. Ironically, helping her sons to understand this loss might make it easier to talk about her miscarriages.

Significantly, despite being open with her sons, Janet tells me earlier in her interview about the secrecy she maintained around her miscarriages with her mother. She chose not to tell her mother about the miscarriages until her mother was ill and dying:

‘In fact I didn’t tell my mother about them. When my mother died...she was very poorly at the end and I did tell her...I’m wondering if there are any superstitious feelings in that. I don’t know that if I talked about it – it might happen again’
(Janet, 6/163-78).

I can only speculate on why Janet wanted her miscarriages to be kept secret from her mother. There is the irrational but completely understandable fear that if she talks about miscarriage she is tempting fate and it might happen again. Schaffir, (2007) discusses the wide range of folkloric beliefs that surround miscarriage. Even in the 21st century we find miscarriage mystifying and inexplicable. Thus, when doctors often cannot provide reasons for why it happens, it is understandable that we might return to more primitive and inherent superstitious practises to stave off evil consequences that we naturally fear and cannot control.

I also sense in Janet’s story, a feeling that she wanted to forget about her miscarriages and just put them from her mind. She does not dismiss their impact, since they are sufficiently important to be revealed to her mother on her death bed. Yet, Janet does not allow herself to dwell on their importance as this would be too painful. She just wanted to get on with her life and perhaps keeping her miscarriages from her mother was part of an attempt to get back to normal after the devastation of her stillbirth without having to dwell on further episodes of reproductive loss. She may even have wanted to protect her mother from further distress at the time.

In contrast, Susan talks very little about her family during the interview in the context of her miscarriage. They are mentioned far more at the beginning when she is describing the trauma of the events around her abortion. She does tell me about her son and daughter and the fact that giving birth to her daughter felt healing after the ordeal of an abortion followed by a stillbirth:

‘Researcher: So when you got pregnant with your daughter that was more healing.

Susan: Yes, because I felt it wouldn’t always be like that. I wouldn’t be childless because of what I had done’ (Susan, 14,397-400).

For Susan having a family appears to be reparative. It takes away the fear that she might remain childless as a punishment for her abortion. Perhaps for this reason, she does not discuss her reproductive history with her children. Later in the interview she mentions her ex-husband for the first and only time. She is talking about the secrecy surrounding reproductive loss even among her family and friends:

‘It’s a bit tucked away thing isn’t it because nobody is ever – it isn’t something that anybody knew about if you know what I mean. It was just me and my husband at the time’ (Susan, 22/699-703).

In the first phrase of this quotation, I sense Susan was about to say that nobody can understand the enormity of what has happened to her so she does not attempt to talk about it. From Susan’s perspective it is beyond the comprehension of family and friends and the experience is only to a certain extent shared with her ex-husband. It stays in Susan’s own words ‘tucked away.’

Thus, for all my participants, I perceive that even many years later, miscarriage is still something that has a powerful impact on families, and that sometimes this influence might be hidden and not spoken about.

Personal reflection

Inevitably, analysing these themes above has caused me to consider my own feelings around the longer term consequences of miscarriage. I have found myself reflecting on why I chose not to try again for another baby after my miscarriage. I have come to realise that this was more complicated than I had first thought and that the story I have told myself in answer to this question has changed and shifted over time. I think my thoughts and feelings have altered in the last two years since I wrote the extract from my Research Diary dated April 2012 which I included earlier. This occurred to me quite recently, when for the purpose of this research, I listened again to my second bracketing interview and heard myself talking about my attitude to becoming pregnant again after my miscarriage. To illustrate this, I include the extract from my second bracketing interview below.

March 2011: Second bracketing interview

Lois: *I can identify with the fear of another pregnancy. I tell myself this. I don't know whether it's my truth or not that I think I decided after a while that I wasn't going to have another baby because I didn't want to go through another miscarriage. However, sometimes, I am not sure that's entirely true. I think at first I did try for another baby but never had one.*

Heather: *You've woven that story?*

Lois: *Yes. Three of my participants went on to have children after their miscarriages but I line up with my second participant Dee in that respect. Although I think my third*

pregnancy was a wanted pregnancy it was going to turn my life upside down a bit.

Through all that grief and bereavement, I sometimes let myself think that not having that baby gave me the freedom to do other things, probably even this.

Heather: *Is there guilt attached to thinking that?*

Lois: *No, I don't think I touched guilt there – just realism. I recognise that my life would be very different if I had a 17 to 18 year old now who would be at home. There is that recognition and I am able to identify with the feeling that what will be will be. Life isn't always neat and tidy.*

Heather: *When you've done these interviews has your experience of miscarriage shifted in any way?*

Lois: *That's a really tough question. It's a story you tell yourself isn't it. So maybe in a way my story has changed a bit. I don't know whether it is because I have done these bracketing interviews or just thought more about it. In some ways it's harder for me to connect with that really sad feeling. I don't have that gut wrenching rawness anymore.*

Recently, I have come to realise that I am able to identify with Dee's experience, discussed in this super-ordinate theme, far more than I ever thought possible after I first interviewed her. Initially, I found it very difficult to accept Dee's account of not feeling upset by her miscarriage and I found myself trying to find evidence in her interview that she was more impacted than she thought. Perhaps, this change has happened because I have recognised that, like me, she is the only one of my participants who chose not to have another baby after miscarriage. Similarly, I can also understand that when you already have a strongly established family, an unplanned pregnancy might cause feelings of shock and upheaval to the whole family. As I say in my bracketing interview, although my pregnancy was

planned, I can still remember those feelings that my life was going to change. My youngest child was six years old and I was working almost full time. I think my decision not to have another child was made over a much longer period of time that I had initially thought. In the aftermath of the miscarriage, all I wanted was a baby but it was the baby I had lost not necessarily another baby. Then we did try for another baby for another year or so and when nothing happened came to a gradual realisation that perhaps the risk of another miscarriage was too great and that we were happy with our family as it was. It is clear that our stories change over time as we discover new meanings for our experiences and, as I have discovered in my own life, we gradually form different interpretations and perceptions around what has happened to us. I feel it is important to recognise this as I conclude the presentation of this theme.

Reflections

Ultimately for Janet, Lucy, Susan and Tess, the longer term consequences of miscarriage influence their desire for another baby and raise their levels of anxiety during succeeding pregnancies. In Dee's case, having a miscarriage confirms her view that having another baby was not the right choice for her family.

Throughout the analysis of this theme, I am struck by the determination of my participants, apart from Dee, to become pregnant again after miscarriage. They are prepared to undertake an arduous struggle to overcome infertility and become pregnant. Then, they put themselves through the anxiety of waiting to see if the pregnancy, or in Lucy's case the adoption, will be successful. The desire for a baby seems to override any considerations around the difficulties and problems they may face.

Inevitably, this leads me to wonder about the driving force that makes the women in my research so eager to become pregnant again. I can only speculate but I do have a sense that

my participants are experiencing a need to prove to themselves and others that they can have successful pregnancies. Possibly, the desire for another baby comes from biological influences driven by hormonal changes after miscarriage (Rotkirch, 2007) but there is also the social context to consider. Having children is part of our transitional journey into adulthood (Levinson, 1986). It is a cultural and societal norm and perhaps the women in my research are prepared to overcome obstacles to fit in with this expectation. Thus, in modern Western society where there is a low level of fertility and where women feel they have some choice over their fertility, reproductive loss can be very challenging. This may create a desire to fight against these challenges, almost as if a woman is on trial and needs to prove that she is able to have another baby despite the odds (Jaffe & Diamond, 2010). There may also be a desire to take back control of fertility after a miscarriage by becoming pregnant again, even though sadly there is a higher possibility of miscarriage in subsequent pregnancies. Perhaps, there is also a need to ultimately assuage feelings of guilt and failure and this creates a resolve to carry on against all the odds to have a child. There can be difficulties, as Tess's account shows, when a male partner may not view the need for another child quite as obsessively as their female partner and this puts a strain on relationships. There may be issues about having to tell other children in the family about miscarriage and acknowledging their distress. My participants describe a tension between a desire for openness and also a need for secrecy within their families. In this respect, they all found some parts of their experience difficult to talk about to other family members, whether it was their partners, mothers or children. Inevitably, these stressors and difficulties have an impact on family life.

When my participants do become pregnant after a miscarriage, it can be a very anxious time. They express well founded fears that something will go wrong again and the

pregnancy can feel more of an ordeal than full of promise and anticipated joy. Once the baby is born, they describe having difficulties around separating sorrow for the loss of the miscarriage with joy at the delivery of a healthy baby. This may result in concerns about the changes a new baby brings to the dynamics within the family.

Once again, I have also noticed the feelings of loneliness that pervade these accounts. The women in my research mainly endure their fears and anxieties alone. They do not tell people they are pregnant for fear of something going wrong again and then when something does go wrong there are very few people with whom they can share their distress. Fortunately, apart from Dee, the women in my research do go on to have subsequently healthy children. However, the long term effects of miscarriage do continue into the present, as I discuss in the following section.

SECTION 3: MAKING SENSE OF MISCARRIAGE IN THE PRESENT

SUPER-ORDINATE THEME 3: MAKING SENSE OF MISCARRIAGE IN THE PRESENT

Sub-ordinate themes:

Complications and contradictions in coming to terms with loss

Miscarriage as a life-changing experience

Commemorating miscarriage and bearing witness

“Death always raises thorny issues of meaning, but determining the meaning of the death of someone who never lived is particularly problematical” (Layne, 2003, p. 299).

The ‘present’ here is 2010, the time in which I undertook these interviews. It also refers to the parts of the research interviews where I felt that my participants were engaging in meaning making more in the moment. I have mainly used illustrations for this theme from parts of my interviews where I perceive that my participants are talking about their feelings in the present. I have also focused on where they tell me how their attitude towards miscarriage has changed with time. The women in my research had their miscarriages at least 15 years ago and as they reflect on their experiences, I sense movement from the loss and trauma after miscarriage, described in my first super-ordinate theme, towards a greater acceptance in the present of what has happened. There is also an acknowledgement and

understanding, with possibly the exception of Dee, that they have been changed by their experiences.

Inevitably, there is a close link between the themes discussed in this super-ordinate theme and the previous themes. However, I think there is a particularly close connection with the previous sub-ordinate themes, *The effects of reproductive loss on subsequent pregnancies* and *The impact of miscarriage on family life*. My participants' concerns within this super-ordinate theme are not so close to the immediate years after miscarriage. However, because this is a partly retrospective study, there will always be some issues from the past that still resonate for the women in this research and this is also reflected in this theme.

Sub-ordinate theme: Complications and contradictions in coming to terms with loss

Throughout my research, and particularly within this theme, my participants' reveal the idiosyncratic complications and contradictions they have experienced in coming to terms with the loss after miscarriage. Therefore, I want to explore how far the process they describe is reflected in contemporary bereavement literature (e.g. Ingram et al., 2000; Klass et al., 1996; Machin, 2008). However, I also include in my analysis of this theme some discussion of the more traditional grief models (e.g. Parkes, 1972/1996; Stroebe & Shut, 1999; Worden, 1983) and examine their relevance to miscarriage. I have given a more detailed account of bereavement theory in my Literature Review.

How relevant are traditional bereavement models in miscarriage?

There does appear to be some similarities between my participants' recollections of coming to terms with reproductive loss and the stages in traditional grief models. Some of the phases, described by Parkes (1972/1996), are clearly pertinent to my own and my

participants' perceived experience. For example, I recognise the "yearning and pining" (p. 43) phase and associate this with the immediate aftermath of miscarriage, when the longing for a baby can be all consuming. I have described this more fully under the theme *The physical process of miscarriage*. I know that after my miscarriage, I kept taking pregnancy tests because, in retrospect, I think I was searching for the lost pregnancy as I so desperately wanted there still to be a baby. This causes me to wonder whether after a miscarriage there is a longing for the pregnancy as well as for the baby and this may be an additional complication in the process of coming to terms with loss. There is also a connection to the theme *Reproductive struggles and the longing for another child*, where my participants express longings to become pregnant again and to have another baby quite soon after their experience of miscarriage.

For most of my participants, having a subsequent successful pregnancy enabled them to move on and adjust to life after the experience of miscarriage. However, in this context, Worden's task "relocation of the deceased" (1983, p. 35) is challenging because I have the impression that, after a miscarriage, the baby can only be remembered as present in the womb or in the imagination. This may make it more difficult for a woman to emotionally separate from the attachment. I know that I still locate my lost baby in a place deep inside my body and that feeling gives me comfort; I do not associate this feeling with unresolved grief. For this reason, I am drawn to the theory of 'continuing bonds' (Rando, 1985; Klass et al., 1996; Machin, 2008) as discussed in my Literature Review and my Reflexivity Chapter. As a bereavement counsellor, I see this as a useful way of illustrating the process of coming to terms with a loss over a long period of time and this theory has also been helpful to me during my own experience after miscarriage. I am also attracted to the notion of the integrated memories of a loved one becoming an "inner representation" (Klass, et

al., 1996, p. 39) as this strikes me as being a surprisingly appropriate metaphor for miscarriage and again I have explored this idea more fully, in relation to my Shadow Child, in my Reflexivity Chapter.

Contemporary bereavement theories and the complexities of miscarriage

However, in undertaking this research, I have come to realise that continuing bonds after a miscarriage is complex because there is no external reality. A woman who has experienced miscarriage may find it difficult or inappropriate to imagine a baby that existed inside her for only a short time. This suggests that maintaining an ongoing relationship with the child requires creativity and a leap of the imagination and each woman's response to this will be different.

Continuing bonds

It is important to acknowledge at this point in my analysis, that none of my participants tell me about imaginings or fantasies that are similar to my experience of having a "Shadow Child," although similar phenomena is reported in the literature (e.g. Powning, 1999; Kirton, 1998). Nonetheless, I do feel that Tess and Lucy describe in their own unique ways some form of continuing bonds with their babies after miscarriage. They both go on to have other children after their miscarriages and I think that they sustain bonds with the lost baby by recognising that their subsequent child is present in their family, through adoption or birth, as a consequence of that loss. This is a bond that will always continue, although I would suggest most of the time it is not much dwelt upon by my participants. This process is not necessarily straightforward and requires some equivocation and balancing of conflicting feelings and emotions. However, it seems to be an effective way to integrate

loss after miscarriage into present life and to a certain extent continue the bond with the lost baby. As Lucy says:

‘It’s about how you manage and what you do about it. If I’d still been a quivering wreck in the corner then I wouldn’t be adopting but I tried to get help and that was what mattered’. (Lucy, 20/556-8)

The process of adoption has helped her to manage her grief and take back control of her life. Paradoxically, I feel it is through the presence of her adopted son that Lucy maintains bonds with her lost babies and come to an acceptance of her miscarriages.

During our interview, Dee envisions what it would be like if the child she miscarried had been born and how it would feel for her daughter to have a sibling ten years younger:

‘If I try to imagine what it would be like to not only have C but another one ten years younger that would have been really, really awkward’ (Dee, 13/407).

The verb tenses above suggest that Dee is not only imagining a living child in the present, she is also considering the impact of the baby on her family twenty years ago. Perhaps, thinking about how it might have been if the miscarried baby had lived, is part of the process of continuing bonds. However, Dee goes on to say, ‘I’ve lost a child that was not going to have a life really’ (Dee, 8/254). Perhaps, knowing a chromosomal abnormality was the cause for her miscarriage makes the loss more concrete and means there is less need for Dee to establish and maintain a relationship with an imaginary child.

Finding a balance

It is also significant that Tess places stress on the importance of the passage of time for coming to terms with her miscarriages. She tells me:

‘It was raw then, raw pain and grief. It takes a huge amount of time’ (Tess, 32/936-942).

Over time, she has found a way to adjust to her loss and the presence of her third son has helped in this process significantly. She is able to sum up very neatly her acceptance of what has happened when she says simply:

‘It’s balanced with what I have rather than what I’ve lost’ (Tess, 21/620).

The word ‘balanced’ feels important. Tess accepts that life is unpredictable and can take many directions. She still feels sorrow in the present about her miscarriages but this is counteracted by the presence of her fourteen years old son. Tess appears to be saying that how she feels now, in the present, is most important. Her focus has to be on her immediate contentment, not on the sorrows of the past.

I can see similarities here, in both Lucy’s and Tess’s accounts, with the Stroebe and Shut (1999) model of coping with bereavement which I describe in my Literature Review. Here the focus is on finding a balance between the process of grieving and the more practical tasks related to getting on with life. There is still wistfulness about what might have been but this is counteracted by being satisfied with what they have in the present. Lucy and Tess both emphasise the importance of regaining this sense of balance and of focusing on their more immediate family concerns. Over fifteen years later, they can still have moments when they feel sorrow for their miscarriages. However, I have the impression that it is no longer something that they dwell on very much in their current lives.

During my research interviews, it is clear that for Lucy and Tess, sadness is elicited through the opportunity to talk and remember. Tess expresses this quite movingly towards the end of our interview when she reflects on the process of being allowed to spend some time just telling me about her miscarriage. She says:

‘I think you have given me a gift, in the talking about it and in the revisiting it. Maybe I was ready to be given the gift in a way I wasn’t earlier’ (Tess, 32/936-942).

Rosenblatt (1996) describes these types of triggered memories as “grief recurrence” and states that:

“People may often welcome grief recurrence, and even if there is a sad or bitter side to it there may also be a sweet affirming and to be cherished side” (p. 55).

In my experience, initiating memories after a miscarriage is bitter sweet but also precious, as this process of reviving memories can be another way of continuing bonds. However, I would suggest that it is more bearable to do this after a substantial period of time has elapsed since the loss.

Silverman and Nickman (1996) refer to the “paradox of letting go and remaining involved” (p. 351). Here, the bereaved move on, discovering new directions but at the same time maintaining an inner connection with the deceased. However, my findings show that maintaining this inner connection can be more complicated after miscarriage. In this context, it is significant that none of my participants tell me about naming their babies after miscarriage or express any desire to know their babies’ gender. This is expressed by Dee when she tells me:

‘So it’s interesting because I think of it as a baby but I don’t think of it with a gender or a name’ (Dee, 13/407).

Layne (2003) argues that when a death occurs and there is no body, as in the case with miscarriage, then naming the baby can play an important role in validating the death and having it acknowledged as a loss of a real person. Allen and Marks (1993) also comment

on how some of the women in their study felt that after a miscarriage, it was difficult to have any recognition by society that a baby had ever existed without knowledge of the baby's gender. For this reason, pregnancy-loss support groups, predominately in America, have encouraged parents to name their babies as a part of remembering and commemorating the loss and in order to make it more publicly recognised (Layne, 2003; Parsons, 2010). However, this is not the case for my participants and I reflect on my own experience in my research diary below.

Research Diary: 3rd January 2012

Reading Dee's statement that she thinks about her miscarriage as losing a baby but one without a gender or a name really resonates with me as this has always been my experience. I have never felt the need to give my baby a name or to speculate about its gender. As I have discussed in the analysis of my first bracketing interview it is sufficient for me to think about it as a Shadow Child. I like the idea of an insubstantial baby existing in a place that is just beyond my touch, a baby that belongs to me but one that I can never really know. My baby's existence, in this inaccessible region, strangely gives me comfort. Occasionally, when it has been suggested to me that I should give the baby a name, I have always found this uncomfortable. This makes me think that I do not need recognition that the baby existed as a person. I am happy to imagine a Shadow Child. This analysis also leads me to speculate about whether the fact that neither Dee nor I went on to have subsequent children after our miscarriages made a difference in our attitudes. I think for me, the fact that there were no further babies, has allowed me to find a place in my life for and to have a relationship with my Shadow Child unencumbered by any complex feelings around the birth of a later child. Although, I recognise that at the same time, I occasionally find it comforting and consoling to dwell a little on a more concrete image of my baby

when I find myself imagining what might have been my baby's future had it ever been born.

However, I am mindful that since I wrote this entry, I have become more aware that perhaps, my Shadow Child does have a gender and I discuss this possibility in my Reflexivity Chapter.

Susan's and Janet's experiences of coming to terms with loss

However, it is difficult to apply the concepts of sustaining bonds and integrating memories to Susan's and Janet's experience. Throughout her interview, I ask Susan, at intervals, how she is feeling about her losses now in the present and immediately this triggers unpleasant and traumatic memories that take her back to the time of her abortion. Very near the end of our interview, when once again Susan is telling me about her abortion, I comment on this:

'Researcher: The memory is very vivid I think down all those years. That's the feeling I'm getting here. We're sitting talking about something as if it happened yesterday' (Susan, 26/796-798).

Susan then tells me that even over twenty years later, she still feels her abortion was, 'the catalyst for everything' (Susan, 27/836). This leads her to think about the fact that she has lost three children:

'I don't think that anybody makes the decision to have an abortion or has a miscarriage without it having an effect. Even if they say it is not...The thing is you know – there could be a chance that I should have five children not two' (Susan, 26/814-820).

By reflecting upon the implications of her three experiences of reproductive loss, Susan has a sudden realisation about how different her family dynamic might have been. She had the potential to have five children. However, I do not get a sense here that she has maintained bonds with these lost children or integrated them into her experience of family life. I sense that, many years later, Susan is still struggling to accept having an abortion when she was eighteen. She is now in her late fifties and the feelings of loss and guilt are ever present. Even though I have a distinct impression that she perceives these losses as children, her negative emotions appear to overshadow any ability or even desire to maintain bonds as it would be just too painful. It could be argued, that in the light of bereavement theory (Rando, 1985; Rothaupt & Becker, 2007), Susan is experiencing unresolved grief for her abortion and this still impacts on her ability to come to terms with her miscarriages.

Whilst developing this super-ordinate theme, I have consistently found Janet's interview the most difficult to analyse and interpret. I think this is because I perceive Janet's experiences as containing so many contradictions and conflicts. For most of my interview with Janet, she tells me that she does not accept her miscarriages as the loss of children. However, very near the beginning of her interview, when she recounts her anger with her consultant, she does use the phrase 'losing three children' (Janet, 2/48). It is as if in a moment of high emotion her guard slips. Throughout Janet's interviews, I have a sense that she is giving me a subliminal message that the experience of miscarriage can never be equated with that of stillbirth. She is clear that her stillbirth was a huge bereavement but she is far more ambivalent about her miscarriages. As she looks back twenty years, and thinks about her miscarriages once more, we talk about how she feels now and her attitude becomes starkly apparent:

Janet: If I look at those two- if I look at the miscarriages as children, I'd had three dead children.

Researcher: And that's too painful to contemplate?

Janet: To even think about' (Janet, 12/350-52).

To acknowledge three dead children is unbearable for Janet. Unlike the other women in this research, Janet does not choose to think of her miscarriages as lost babies or 'dead children.' I acknowledge the importance of respecting this choice even as I struggle to untangle and interpret her painfully complicated feelings. Janet's response to miscarriage is inevitably linked to her emotions around stillbirth because for Janet having a miscarriage cannot compare to the distress of giving birth to a dead baby. A little later she tells me:

'I can't give myself permission to see it as bereavement at all because...I want to pretend it didn't happen anyway' (Janet, 13/3).

There is so much ambiguity in this extract. Significantly, Janet refers to her miscarriages as 'it' which depersonalises them to a certain extent. It would seem that over time, the experience of having two miscarriages has become conflated into one. Furthermore, I find her use of the word 'permission,' in this context, thought provoking. Once again, I believe that Janet is suggesting she has an element of choice over what she views as bereavement and can therefore control the extent of her feelings about the loss. Rosenblatt (1996), in his work on grief recurrence, suggests that if grief can be triggered by reminders then to a certain extent it can be controlled by avoiding people, places and objects that might bring back memories. I wonder here, if Janet avoids any pain associated with her miscarriages because they trigger the distress of her stillbirth and that feels intolerable. Therefore, it is preferable for her to imagine they never happened. Research by Rosenblatt and Burns

(1986) also suggests that experiencing a series of similar losses may interfere with the memory of one particular loss. They go on to state:

“It is also possible that a collection of losses can be so overwhelming that some individuals defend against the strong feelings of sadness, anger and so on by acting as if the losses were insignificant” (p. 243).

This may be an explanation for the equivocation in Janet’s statements and her desire to act as if her miscarriages had not happened. She tells me:

‘If I’m honest – it’s not that I don’t let myself because it just doesn’t even enter – until we’ve just talked about it – it’s never really entered, entered my head and I think it’s about that. I can’t see myself as having had - it’s strange because I can see myself as having six pregnancies’ (Janet, 13/384-87).

Perhaps the loss of so many children only occurs to Janet during the course of our interview and she experiences it as shocking. Her emotions may have lain dormant and out of her awareness for many years. Previously, under the theme *The effects of loss on subsequent pregnancies*, Janet describes being able to separate being pregnant from the actual process of giving birth. Therefore, she can accept being pregnant six times but she is not prepared to consider the idea that she had three dead children. Right at the end of her interview, Janet returns again to this idea. She tells me quite forcibly that she is not prepared to accept miscarriage as meaning the loss of a child:

‘Which is where we go back to the beginning. I don’t acknowledge those two’ (Janet, 27/ 780).

We have come full circle and I sense the level of Janet’s conflict about her loss. Janet is telling me quite pointedly that she has given very little attention to her miscarriages over

the years and there is something quite cold and formal about her word, 'acknowledge.' This contrasts poignantly with the far more colloquial expression 'those two' which creates a feeling of intimacy and tenderness that I find quite heart breaking but also ambiguous. I know on one level she is referring to her miscarriages but during the interview, and later from reading her transcript, I also infer that she might mean two children.

Janet's experience of stillbirth has understandably overshadowed any feelings she has about her miscarriages. It is possible, that in coming to terms with her stillbirth, she has engaged so deeply in phases of grief (Parkes, 1972/1996; Worden, 1983/2010) that there has been no time or energy left for grieving her miscarriages. She has no need for continuing bonds because she does not recognise her miscarriages as the loss of individual children. Perhaps, for Janet, miscarriage is more about the loss of control over her body, and a sign of infertility. I also need to recognise that Janet does eventually have three healthy sons and their presence has possibly helped to overcome long ago, any sorrow she had for her miscarriages.

The dilemmas I have faced in engaging with this super-ordinate theme have brought home to me the reality of working with the hermeneutic circle (Smith et al., 2009). I have struggled to interpret a small extract from Janet's transcript, whilst setting it in the framework of the complete transcript. At the same time, I have been aware of Janet's experiences provoking my own prejudices and assumptions and this has been challenging. Therefore in an attempt to be transparent about how I have come to my conclusions, I include my reflections in two diary entries produced below. I think they make it apparent how my attitudes to Janet has changed and progressed during the year it took to fully develop this theme.

Research Diary March 2013

Analysing what Janet has said during her interview under this theme has been very difficult. I would certainly not want her to read my interpretations of her interview here as I am unsure how she would react. I am more convinced, as I read Janet's transcript that she is often talking about her stillbirth rather than her miscarriages. I also have a felt sense of her underlying anger towards her miscarriages in her determination not to recognise her miscarriages as lost children. This is so very different from my experience that I have found myself being extra vigilant not to allow my own bias to colour my interpretation. It is hard for me to accept Janet's attitude here about her inability to recognise her miscarriages as lost children and it is beginning to colour my perception of her whole interview to the point where I am left wondering why she volunteered to do this interview. I think I have become aware of my own anger here too which it important for me to acknowledge. I also have to accept that Janet does not perceive her miscarriages as bereavement in the same way as I do.

Research diary May 2014

I have just had a discussion session with my supervisors and it has really caused me to focus on this part of my analysis of Janet's interview again. I am painfully aware now of the danger that I might be projecting my own feelings around my experience of miscarriage on to Janet. I feel my own attitudes may have been coloured by a desire to perceive no difference between the impact of miscarriage and stillbirth on the women in my research. I am mindful of the fact that both Reagan (2003) and Layne (2003) write about the influence of the pregnancy- loss movement in America from the beginning of the 1990s and the fact that through this movement, women are positively encouraged not to make this distinction. This is also borne out by research done by Peppers and Knapp

(1980) and Swanson, Chen, Graham, Wojnar and Petras (2007) where they state that the depth of feeling after a reproductive loss is not dependent on the gestational age of the baby when it is lost. There is a part of me that wants this to be true and another that recognises that this is certainly not Janet's experience. It has been so important for me to validate the experience of miscarriage as the loss of a child that it has been hard for me to accept Janet's point of view at face value and there is a temptation to find some deeper and implicit interpretation that is closer to my own experience. Yet at the same time, I am aware of an inner struggle. The truth is that I can imagine nothing worse than giving birth to a fully developed dead baby.

Paradoxically, it is through my exploration around the theory of 'continuing bonds' that I have come to a deeper realisation that the impact of miscarriage is dependent on how far a woman imbues her pregnancy with personhood and sees her miscarriage as the loss of a baby. This situates my research firmly in the feminist debate around pro-choice and pro-life attitudes to pregnancy loss (e.g. Letherby, 1993; Reagan, 2003; Parsons, 2010), even though I have been perhaps unconsciously avoiding the arguments in my analysis so far. I intend to discuss this in my Literature Review but my thoughts here, after a re-examination of parts of Janet's transcript, make her experience less theoretical and more concrete. Even though I feel that sometimes the complexities and dilemmas around the pro-abortion debate has led to a silence in feminist writing about the impact of miscarriage on women, it is important that I do not allow this to undermine Janet's perception of her experience of miscarriage because as Reagan (2003) states:

'Having one's grief denied offends; demanding grief and specific behaviours from those who do not conform to the new norm also offends' (p. 369).

Janet is very clear that she has a choice around whether or not she views her miscarriages as 'lost children' and I respect that. I am pro-choice in the sense that I fully accept and acknowledge the rights of women to decide the extent of their relationship with their unborn baby and to set the parameters of their own grief response to miscarriage, or indeed, not to grieve at all. There are also links here to the challenges I face as a practising Catholic woman undertaking research in this area as I have discussed before. I also wish to acknowledge that there have been difficulties and limitations for me in undertaking my Literature Review late in this research. I have not fully recognised or acknowledged my biases as it is only relatively recently that I have become more informed of the wide range of opinions within the feminist literature on reproductive loss.

Theories regarding how we grieve and mourn continue to be developed in the twenty first century, much of it being developed from the experience of counsellors and their clients who have found the more traditional models of grief unsatisfying or inappropriate to work with (Machin, 2008). However, I have not found a particular theory that helps me to illuminate my participants' process of coming to terms with miscarriage, apart from the concept of "continuing bonds" which I believe does so in a limited fashion. I think that for the past 21 years, since I had my miscarriage, I have been engaged intuitively in continuing the bonds with my baby. I have done this through my ongoing relationship with my Shadow Child, and indeed through the process of undertaking this research. However, it has become clear to me, whilst undertaking this research, that my participants do not necessarily describe 'continuing bonds' in the distinct way I think I experience it.

I perceive miscarriage as a messy business and my findings show that its impact and aftermath may last a lifetime. Therefore, I accept that it is unreasonable to expect that bereavement theory and grief models will present me with a tidy explanation for how this

experience can be understood, worked through and processed. Certainly, for my participants in this research, the process of coming to terms with miscarriage over many years appears to be complicated, inconsistent and still ongoing but as I explore in my next theme it can also be transformative.

Sub-ordinate theme: Miscarriage as a life-changing experience

As I have shown in the previous theme, the process of coming to terms with loss after miscarriage is lengthy and rarely straightforward. However, for Janet, Lucy, Tess and to a certain extent Susan, the experience of reproductive loss is ultimately perceived as a life-changing experience.

Lucy sums this up eloquently when she says:

‘Not only did I lose a baby but I lost me. I lost who I had been. I had to re-discover myself’ (Lucy, 17/433).

This concept of major life experiences leading to positive and sometimes dramatic change has also been my experience. If I had not had a miscarriage 21 years ago, I would probably not have become a counsellor who currently teaches at a university and is undertaking research into women’s experience of miscarriage. Yet, conversely, Dee’s outlook does not appear to change. Throughout her interview, there is very little inconsistency about how she feels towards her miscarriage, regardless of whether she is recounting her feelings from the past, or focusing on how she feels in the present. This might be because Dee views her miscarriage as ‘a physical experience rather than an emotional one,’ (Dee, 6/210).

Therefore it did not impact on her psychologically. She had a definitive reason for her miscarriage, ‘I think the fact that there was a big issue with the baby was a really helpful

factor' (Dee, 16/513), which might mitigate might her distress. Furthermore, and most significantly, she does not view her miscarriage as a traumatic experience (Dee, 6/26).

Post-traumatic growth

I argue in my first superordinate theme, *Memories of the initial Impact of Miscarriage*, that having a miscarriage is a traumatic experience for most of my participants, with the possible exception of Dee. Less easy to identify, is Janet's experience of trauma as I suspect she is talking about her stillbirth rather than her miscarriages at points under this first super-ordinate theme. Therefore, it seems appropriate to consider whether the process of change and development some of my participants report in this third super-ordinate theme may be described as a form of post-traumatic growth (Calhoun & Tedeschi, 2006)

Calhoun and Tedeschi (2006) state that the idea of human suffering leading to change and transformation has been present in many cultures, religions and literatures throughout the world from ancient times. However, in the past twenty years there have been more systematic attempts in Psychology to focus on the phenomenon of post-traumatic growth through both quantitative and qualitative empirical research methods. Through using qualitative research data, Calhoun and Tedeschi (2006) define three broad categories for growth: "changes in the perception of self, changes in the experience of relationship with others, and changes in one's general philosophy of life" (p. 5). I would argue that these are present, to a certain extent, in most of my participants' accounts. There is also a link here with bereavement theory and transition models where there is the notion that bereavement can be the catalyst for confronting the need to change and to forge a new identity (Klass et al., 1996; Machin, 2008; Maker & Ogden, 2003; Murphy & Merell, 2009; Rando, 1985; Silverman & Nickman, 1996). Similarly, there is a connection to the theories of Parkes (1972/1996) and Worden (1983/2010) that bereavement may challenge our ideas of the

assumptive world in which we live and I consider these theories more fully in my Literature Review.

Malacrida (1998) writes about the assumptive world of women during pregnancy. She argues that Western women in the twentieth century have a strong certainty that they are in control of their own reproductive destinies. Therefore, after a reproductive loss such as miscarriage, the world can suddenly seem a very, perilous and uncertain place. Perhaps, as Cote –Arsenault and Morrison-Beedy (2001) argue the realisation that pregnancy does not guarantee a live baby is the biggest challenge to a women's assumptive world after reproductive loss. Likewise, my earlier findings suggest that facing this challenge may lead to psychological distress, including, the development of anxiety and phobias such as agoraphobia, which both Lucy and I have suffered from after our miscarriage.

The theory of post-traumatic growth takes this notion of the assumptive world being turned up-side down after a traumatic event such as miscarriage, a step further. In his model of bereavement, Parkes (1972/1996) suggests that after a loss, a new set of assumptions about the world need to be developed and that over time a new identity can be established.

However, the theory of traumatic growth claims that for some people there is not just a moving on but a process of positive change and transformation that comes about through a struggle to make meaning after a traumatic experience such as reproductive loss. This requires a person to reorganise their beliefs about the world, about who they are and what they want to be (Calhoun & Tedeschi, 2006). I consider that some of my participants describe experiences very similar to the categories of post-traumatic growth described above.

Near the end of their interviews, both Susan and Lucy reflect on how their experience of reproductive loss has changed the way they relate to other people and consequently the way they view themselves. Susan tells me:

‘But I don’t think they’ve made me a more bad person. If anything I’ve got empathy for people who are in that situation...They enable you to help other people that are struggling. So I don’t judge people anyway in general’ (Susan, 26/809-813).

Having an abortion, followed by a stillbirth and miscarriage has caused Susan to feel a huge amount of guilt and shame in her life and therefore she wants to make it clear to me near the end of our interview that she does not feel she is a ‘bad person’. She also stresses that her ability to empathise with other people has been enhanced through her own suffering.

In a similar way, Lucy recognises that having miscarriages has made her less judgemental and more understanding of others in similar situations:

‘It’s changed who I am...I am more open now. I’m more honest which can be annoying for some people but I’m not as judgemental...I can accept that I can be wrong...I can accept that I make mistakes...It’s made me more tolerant. It’s taken a long, long, long, long time. I did the counselling because counselling helped me and I thought if I can just help one person whose been where I’ve been, one person in the whole world then that’s enough’ (Lucy, 24/264-694).

Lucy reflects on her ability to relate more openly and honestly with other people and to be more accepting of herself. Her own experiencing of undertaking counselling has inspired her to make a change of career and train to become a counsellor. She feels able to

empathise with other people much more deeply and recognises how desperately others need this understanding and compassion in similar situations.

This has also been Tess's experience. In a similar way to Lucy, Tess reflects on how her life has been altered by the experience of miscarriage as she ultimately changes her career direction and becomes a counsellor and an academic:

‘I wouldn't be doing it if I didn't have the miscarriages. Had I not lost the three I wouldn't be doing what I'm doing. It was a high cost but you can't do the 'what ifs' can you? What if the first had never happened? My life would have been very different and I would have gone on and been a clinical psychologist' (Tess, 21/604-6011).

Yet, Tess perceives she paid a heavy cost for these transformations. This is in line with the literature on post-traumatic growth that recognises that people reporting such growth may continue to experience both the pain of the trauma and the growth emerging from it as co-existing (Tedeschi, Calhoun, & Cann, 2007). This seems an appropriate way to describe the experience of my participants and I can readily identify with it. The growth that comes from loss does not necessarily mitigate the sadness. Nevertheless, I believe, that my participants' experiences demonstrate that it is possible to experience both simultaneously and in a balanced way.

Lucy also places emphasis on the length of time it has taken for her to reach this level of self-awareness and self-acceptance. Linley and Joseph (2004) found that research generally shows that there is a link between the passage of time after a traumatic event and an increase in positive life changes by those who report experiencing them but further

research is needed in this area. Lucy considers that ten years after her miscarriages, she is much more able to accept and live with the limitations caused by her agoraphobia:

‘It’s part of who I am now...It’s how I manage my life. I can’t ever imagine not being agoraphobic’ (Lucy, 14/339-43).

Lucy has managed to forge a new identity for herself. She lives successfully with her agoraphobia whilst working for the NHS and managing her family. At the end of her interview she sums this up with impressive clarity:

‘It’s changed who I am and my life’ (Lucy, 29/830).

This process of rehabilitation and transformation has been long and arduous for Lucy but there is a definite sense that she now perceives these changes in her life, as mainly positive and fruitful.

Significantly, like Lucy and Tess, Janet also reveals that she became a counsellor after her experiences of reproductive loss:

‘Each experience of life is different so maybe it helped me to understand...and if somebody wants to tell me what it is for them. And maybe that’s why I went into counselling’ (Janet, 17/491-495).

For Janet, it is important to recognise the idiosyncratic nature of life and to understand that we can never fully appreciate someone else’s perception of a life changing experience and yet we can try to listen and to empathise. It is this growing realisation that leads her into training as a counsellor in her fifties, many years after her miscarriages and stillbirth.

Counsellor training

It is interesting to observe that, after their experience of miscarriage, three of my five participants chose to retrain as counsellors; this was also my experience. In the context of looking at the theories around post-traumatic growth, through the eyes of my participants, I am left wondering if there is something about counsellor training that is attractive to some people who have experienced a traumatic loss. Burnett (2007) suggests that the impetus to become a trainee counsellor may lie in a person's interest in their own experience of growth from trauma. This idea is also present in Woskett's (1999, p. 110) powerful metaphor of the counsellor as 'the wounded healer'. I also perceive that for my participants, there is a desire to help others and a wish to develop their self-awareness. For both Lucy and Tess, these aspirations come after experiencing personal counselling.

In the humanistic approach to counselling, there is also an emphasis on facilitating change and growth which is described in Rogers' (1967) seven stages of process model. This conceptualisation of the progress of change is defined by Barrett –Lennard (as cited in McMillan, 2004, p. 20) as a process of transformation 'from woundedness to hope,' which seems a very appropriate metaphor for the concept of post-traumatic growth after an experience such as miscarriage. It is an image I am attracted to as a person-centred counsellor and it is possible that this idea influenced Lucy, Tess and Janet, when they made their decisions to train to become counsellors. There is also likelihood, that in becoming counsellors and offering ourselves in the support of others, we are gaining a degree of control over our lives after experiencing reproductive loss as something uncontrollable.

In complete contrast to the other women in my research, Dee expresses the opinion that having the baby, rather than the miscarriage, would have been more life changing for her and the whole family:

‘ No, I was thinking, I’ve got enough really...I suppose looking back and this will be in my head, looking back into it, I think had the baby survived, our family would have been very different I think. It could have been very difficult for the boys because they were going off to university. I would have a toddler and couldn’t be involved in the same way...so it would have been very unsettling for the whole family and even more unsettling if the baby had been disabled’ (Dee, 14/445-472).

Throughout her interview, Dee appears to be more focused on the effect of the miscarriage on her whole family rather than on her own personal wellbeing. It is particularly significant here that she emphasises the fact that she feels her family was complete. She makes no comment about her miscarriage making her a better or more fulfilled person in the long term. She is more concerned about the long term effect on her family of possibly having a disabled child and how this might mean having less time to devote to her older children.

However, I believe that most of the women in this research perceive the whole process of becoming pregnant, experiencing reproductive loss and ultimately giving birth as life changing. Whether the pregnancy fails or is ultimately successful, my participants feel that their lives are changed irrevocably. For the most part, they see this life changing process as ultimately positive and rewarding and one that leads them in new and different directions, although as Tess reminds me, the price they pay is high.

Sub-ordinate theme: Commemorating miscarriage and bearing witness

It seems almost self-evident that in agreeing to take part in this research my participants want to bear witness to, and talk about their memories of the experience of miscarriage many years after the event. However, at this point in my research, I am surprised that Lucy is the only one of my participants who can actually remember dates on which her miscarriages occurred. For her it is symbolic that her son's adoption took place, a few years later, on the same date that her second miscarried baby was due. This is the miscarriage that she describes as 'the significant one' (Lucy, 22/620) and it seems so fitting that her son was legally adopted on that day.

When I ask Dee if she ever thinks about her miscarriage on the day the baby would have been born, I am a little surprised by her reply because despite her assertion that her miscarriage did not have a huge impact on her life, even in the immediate aftermath, she tells me that she does remember thinking about it a year after her miscarriage:

'I did think about it the first year on the day it would have been born but I can't honestly remember what that day was' (Dee, 11/363).

This suggests to me that perhaps Dee's miscarriage did have an impact on her at the time and possibly that early impression has faded over the years. It is interesting that, just a little earlier in our interview Dee begins to calculate how old her baby would be now:

'It would have been about 25 now...I have just worked it out in my head because I knew I was coming up to my 40th birthday...and I suppose that 25 when you're 65 that's fine isn't it' (Dee, 10/331-343).

In this part of her interview, I feel something different in Dee's attitude to her miscarriage which is intriguing. I sense that she is developing a closer relationship to her baby as we talk. She appears to take pleasure in thinking about her baby being grown up, which is reminiscent of the process of continuing bonds which I discuss earlier under the theme *Complications and contradictions in coming to terms with the loss*. She appears to realise that the age gap does not seem as great as it felt when she was pregnant twenty years ago. One of the reasons that Dee had found this pregnancy difficult to accept was that she felt too old to be a mother again and there was too big a gap between the expected baby and her youngest child. Now, it seems that in talking about it during the research interview, she has come to the conclusion that in retrospect it does not feel that the age gap would have been such a problem once the child was grown up. I also sense that she is comfortable with imagining how it might have been to have this child twenty five years later and this feels like a form of commemoration.

Keepsakes

During my interviews, I asked all my participants whether they have any special way of commemorating their miscarriage or whether they have an object that helps them to remember their baby. Significantly, this is the only time in the interview process that I ask all my participants the same question. This is because having something that reminds me of my baby is very important and I wanted to know if other women feel the same after miscarriage.

Layne (2003) describes how in modern Western society we use consumer goods to construct a personhood for our babies during a pregnancy and after a loss. They may also be used within the family to memorialise the baby. Certainly, from my experience, when a woman discovers she is pregnant often the first thing she does is buy or make something

for the baby. By doing this it makes the pregnancy feel more real. After a pregnancy loss, these goods, which are often clothes, bedding or soft toys, remain behind and may be used to symbolize the lost baby's presence in some way and they act a reminder that the pregnancy did once exist. In this way, bonds are sustained with the lost pregnancy and the lost child. Furthermore, there is a link here to the theory of "continuing bonds" (Klass et al., 1996) which I discuss in the previous theme, *Complications and contradictions in coming to terms with loss*. The keeping of mementos after a miscarriage in order to preserve memories appears to be a common response (Allen & Marks, 1993; Layne, 2003). However, in the light of these findings in the literature, and from my own experience, I have been surprised, and a bit disconcerted to find that my participants do not have keepsakes of their miscarriages in quite the same way that I do. I reflect on this in my diary below.

Research Diary January 2013

Beginning to analyse this theme has given me a good deal of food for thought. Firstly, I want to reflect on why it was so important for me to ask my participants about whether they commemorated their miscarriages. I think there is a link here once again to the story of my baby's blanket and how important it has become in this research. It remains powerful proof that my baby existed. I am surprised by the fact that my participants do not tell me more about items that they have kept that remind them of their baby. However, it has occurred to me that I only recognised the full significance of my baby's blanket when I began this research and did my first bracketing interview. This had been out of my awareness for so long and I am curious about whether other women have had the same experience. Looking at the initial results of my theming it would appear that my experience is not the same as my participants in this respect.

I have recently come to an awareness of all the ways I maintain links with my lost baby and my need to remember my baby in tangible ways. As well as the blanket over my computer chair, I have rosary beads that my husband bought me a year after my miscarriage. I have a book of poetry that I have written, my thesis from my MSc and of course this research for my PhD. Relatively recently, I bought a little bronze statue of an angel holding a baby from a website that I came across when I began to explore miscarriage forums and memorials on the internet for my research.

I used to keep a candle in my bedroom that I was given during a short memorial service we had a few months after my miscarriage. However, now many years later, I do not look back at that with fondness so I have put the candle away. In retrospect, I think it was not appropriate to hold a public service after my miscarriage. I think I was persuaded to do this by a well-meaning therapist when I was too vulnerable to resist. It has not brought me comfort only discomfiture when I recall how contrived it felt. There is still a part of me that feels that miscarriage is too private an event to commemorate in public and when I reconsider my feelings now there is a sense of violation. I cannot fully explain why. Perhaps, I am of the old school that believes in keeping pregnancy secret for as long as possible and that a loss like miscarriage is best mourned in private and intimate circles. I have to confess to being a little shocked when young friends show me very early scans of their babies saved on their mobile phones. Or perhaps, I am just hyper aware of the possibility of something going wrong. I can see the paradox here when I am arguing that miscarriage is often disenfranchised and stigmatised in Western society. For this reason, it seems important to record my feelings and assumptions about commemorating miscarriage and I will make them transparent in my research at some point.

Lucy is the only one of my participants who has specific keepsakes and I was deeply moved by Lucy's response to my question about commemoration. She tells me about three empty photograph frames she keeps in her bedroom as memorials to the three babies she lost through miscarriage:

'I've got three little photograph frames empty...and I always thought I would get round to putting photos in them and then one day I was looking at them and I thought I don't want to. They're staying empty. They are symbolic of what should have been there' (Lucy, 24/676-9).

The poignancy here comes from the emptiness of the photograph frames; the space that can never be filled. I am struck by the bravery of Lucy in confronting this powerful image every day. In my view, these picture frames are an affecting testimony to her feelings of barrenness and desolation that she experienced after her miscarriages. In a paradoxical way, they allow her to sustain a relationship with her lost babies and perhaps her willingness to have this reminder in full view suggests that the immediate pain of her miscarriages has diminished over time.

In response to my question about keepsakes, Janet begins by telling me about a photograph she has of her aunt, who died when she was five years old, from diphtheria. Her husband does not wish for it to be displayed in their home but for Janet it represents a link with her still born daughter:

"I was brought up with this photograph but S won't let me put it up at home but it was my Dad's sister who died of diphtheria when she was a little girl, the only girl in our family...and everyone wanted a girl to replace this girl and then I was born" (Janet, 18/509-525).

There is a predominance of boys born into Janet's wider family and she has three sons. Therefore, it seems appropriate that she connects this picture with her daughter who died at birth. Possibly, in Janet's mind, girls are more fragile and less likely to survive than boys. This creates a link in her mind between the loss of her daughter and the impact that the early death of her aunt had on Janet's childhood. There is something poignant in the fact that Janet would like to display the photograph but her husband feels it is inappropriate. It is possible that he wishes to spare her from what he considers to be a painful memory. I am left wondering whether, out of Janet's awareness, the picture also represents a tenuous link to her miscarriages because it is a representation of a lost child. It intrigues me that it was this image that came to her mind when I asked about mementos connected to her miscarriage.

When I ask Tess about whether she has any keepsakes, she tells me that she has kept her hospital bracelets and the sympathy cards she received after her miscarriages. As she reflects more deeply, she tells me about being envious of a friend whose daughter can visit the grave of her stillborn baby:

'He said to me that his daughter had had a stillbirth, which must be infinitely worse than my experience, but I remember being jealous because she had a grave and somewhere to go. There was nothing to mark and I was in too much of a state to think' (Tess, 18/509-13).

I find this memory upsetting. It illustrates so completely Tess's desire to have a memorial in the early years after her miscarriages. However, during this part of the interview she begins to think more about how she feels about commemoration now and it seems that many years after her miscarriages, she is more ambivalent:

‘I suppose for me I have three healthy boys and I think, well, do I need it? It just crosses my mind from time to time. I suppose I wish I had done it then. Well I suppose I don’t know whether having a fixed point maybe keeps you stuck with something’ (Tess, 18/530-35).

There is the suggestion that she would have liked a memorial at the time of her miscarriage but now her feelings have changed. She implies that if she had a fixed place for a memorial, like a grave, she would not be able to move on from her losses; that she would be somehow trapped or held back. Tess feels it is more important to value the healthy family she has now rather than dwell on the past.

When I ask Susan about keepsakes, I do it rather clumsily and she is very surprised and upset:

Researcher: Did you keep anything to remind you?

Susan: I never thought I’d want to remember anyway...I’d be trying to do the opposite...That made me feel quite shocked that did. It made me feel quite shocked.

Researcher: It’s really upset you, me saying that, hasn’t it? (Pause)

Susan: (Crying) I think it would be a reminder.

Researcher: And memories in this case don’t give you comfort?

Susan: No, God! No!’ (Susan, 21/664-71).

This is a very distressing part of our interview and, at the time, Susan’s reaction took me quite by surprise. I think it is Susan’s memory of her abortion that she is finding so painful and I failed to be sensitive to that. When I asked the question ‘Do you keep anything to

remind you?’ I was thinking about her stillbirth and miscarriage but in her mind, she links her losses to the abortion. We talked about this a little more and she recalled that she had bought terry towelling nappies for the baby she lost but had used disposable nappies after her son and daughter were born. She goes on to remember how her son had used these nappies as a comforter:

‘He loved them, absolutely loved them which was really nice and actually I still have one that I rolled up and sewed up’ (Susan, 22/69-204).

This is a bitter sweet memory but feels like a cherished connection with her stillborn daughter; although I recognise that probably, Susan had only made this link for the first time during the research interview. Susan’s experience of reproductive loss is private and not something she usually talks about to anyone:

‘And the commemoration thing...I think I’m a bit funny about that. I think whatever I feel it’s just in here (touching her stomach). I suppose it’s a bit of a tucked away thing isn’t it. It isn’t something that anyone knew about’ (Susan, 21-22/653-70).

The images Susan uses, suggests that she keeps her memories hidden in an internal, secret place. Unlike Lucy and Tess, she does not wish to have her losses outwardly accepted and recognised.

In the light of the research literature and my own experiences, I am surprised that my research participants do not talk about buying items for their babies in the same way as Layne (2003) describes above. Even, Lucy’s photograph frames do not appear to have a direct association to her babies in the way that an item of clothing might do. However, it is

as if Lucy has created her memorial spontaneously, at a time when it felt right to remember.

Rituals to mark the loss after miscarriage

It is well documented in the literature that because of the nature of miscarriage and the difficulty Western society has in recognising it as a loss that there are no set rites or rituals that women can use to help them mark their loss (Hey et al., 1995; Layne, 2003; Malacrida, 1998; Seftel, 2006). Letherby (1993) writes that anthropological research shows that rituals after miscarriage acknowledging the miscarried baby as a real person result in reduced grief and distress for the mother.

This is echoed by Seftel (2006) who describes pregnancy-loss practices in traditional societies where objects are used “to express, contain and redirect grief” (p. 137). She gives an example from Japan where women are encouraged to use stone statues to represent the lost baby. These are then cared for and dressed suggesting that having something ritualistic to look at and touch becomes a focus for grief, and helps with the healing process. She argues that having an open and acceptable way of doing this is denied to women in Western society. I find this moving as I remember very clearly after my own miscarriage that I wanted to buy a doll so that I could have something to hold and dress. However, I felt that I could not give into this urge as it would seem too strange to my family and friends. I thought that they would not understand my need and might even interpret this as a sign of madness.

Layne (2003) writing powerfully about the taboos and silences surrounding pregnancy loss states:

“At the level of popular culture, one of the clearest indicators of the culturally sanctioned non-existence of these events is that there are no greeting cards for such occasions” (p. 69).

I find this a shocking statement and there is a part of me that recoils in horror at the thought of being sent a specially designed card expressing sorrow on the occasion of my miscarriage. I think my response to this quotation is similar to my feelings about holding a memorial service that I describe in my research diary entry above. It is also analogous to Susan’s shocked reaction to my question about keepsakes. Perhaps my response to this is an illustration of how deep the taboos around marking miscarriage prevail in our society. I am undertaking research into miscarriage and trying to raise awareness of women’s experience but at the same time I am repulsed by the thought of such an obvious recognition. I can offer no explanation for this other than as a member of Western society I am subject to the same cultural responses as everyone else, even though in undertaking this research I am striving sometimes to fight against them.

This brings home to me the struggle that some women who have miscarried need to engage in to have their losses recognised and how it is all too easy to disenfranchise ourselves. For this reason, perhaps women who have miscarried have to use their imaginations and create their own individual ways of remembering, as in the examples of Janet and Lucy above. Now, in the twenty-first century, there is a growing movement on the internet where women are finding creative ways to commemorate their lost babies and participating in online support groups and forums (Sejourne et al., 2010) which I discuss in my Literature Review. However, this was not available to my participants at the time of their miscarriages and they make no mention during their interviews of subsequently accessing these forums.

Clearly, a younger generation of women have found new and inventive ways to commemorate their miscarriages and in this way, perhaps they are beginning to break down the prohibitions and restrictions around discussing miscarriage in modern Western society. It occurs to me that women have had to take individual responsibility for keeping their baby's memories alive after a miscarriage and this is recognised in the literature (Malacrida, 1998; Wojnar et al., 2011). This has been my experience but I still have very ambivalent feelings around the need for privacy and public recognition. Speakman (1995) sums this dilemma up for me clearly when she writes:

“It makes our losses an even greater tragedy when we have to fight for the right to mourn, as sadly many women do. We need our experiences to be recognised as valid, even if it is not necessarily understood, and so we should not have to hold back from expressing our need to grieve...Being assured of the validity of our experience by those close to us and accepting it ourselves, is perhaps the most important part of the grieving process, of being able to let go of the pain whilst integrating the loss into the rest of our lives” (p. 178).

I have also struggled to find a way of having my grief publicly recognised after my miscarriage, whilst guarding my vulnerability and preserving, to a certain extent, my privacy. Writing this thesis has played a role in this, as I feel that I can present my participants' and my own experiences, within a well-recognised and ethical framework of academic research.

Motivations for taking part in the research

Significantly, it is a need for validation that my participants refer to when they talk about their motivations for taking part in this research and this is also recognised in the literature (e.g. Reagan, 2003; Layne, 2003; Rowlands & Lee, 2010). Janet sees taking part in this

research as a way of making sense of what happened to her and as a way of giving a voice and expression to her experience of reproductive loss. She tells me:

‘Validate – it’s a really good word- really good. You know this has happened. It’s not something I should keep quiet. It’s not something now... that’s going to, you know, open up raw wounds’ (Janet, 21/618-22).

Janet’s stillbirth and miscarriages happened over twenty-five years ago and yet she still wants to have her feelings acknowledged and heard. Her grief, particularly about her stillbirth, is not new but still needs recognising. She is clear that the experience of reproductive loss and in particular stillbirth is not something to be hushed up or kept secret. She makes this clear when she says towards the end of our interview:

‘I want to say this is what happened. This is my life; this is where I am now. This is what made me and I’ve got there through this’ (Janet, 21/618-22).

The above feels like a powerful valedictory statement. Here Janet is bearing witness to her experiences and making them heard.

After the difficult moments between us described above, when I ask Susan about commemoration, I feel compelled to ask Susan why she agreed to take part in this interview and her answer is touching:

Researcher: I’m wondering what made you talk to me today...because it is obviously painful?

Susan: Because it’s helping you.

Researcher: Well, thank you.

Susan: In helping you to look into this, I would help anyone to learn more' (Susan, 23/716-22).

I have commented on this quotation before in my Methodology Chapter but it also has relevance here. It feels to me as if taking part in this interviewing process helps Susan come to a deeper understanding of what has happened to her. There is also a reparative element to this because by talking to me she feels as if she is indirectly helping other people who have been through something similar. Memories for Susan are exceedingly painful but I also sense that she finds an element of healing in talking about them for altruistic purposes.

Dee gives no specific explanation during her interview as to why she agreed to talk about her miscarriage. However, my sense is that she wants me to know that not all women experience miscarriage as traumatic or hugely distressing. This seems to fit with what Dee calls her 'philosophy of life' (Dee, 17/530). She tells me at the end of the interview that she believes, 'all things work together for those who love God' (Dee, 17/520). This might help to explain why, despite some inevitable equivocalness and contrariety in her perceived account of miscarriage, throughout this analysis and discussion, Dee appears to be the least affected of all my participants by her experience of reproductive loss.

Towards the end of our research interview, I ask Tess why she agreed to take part in my research. In a similar way to Janet, Tess begins to tell me why it was important for her to undertake this interview:

'I needed to talk about it. Maybe I wanted to talk about it and maybe it feels a bit grand, but it is about validating the experience...I wonder whether you gave me permission to talk about it. And I've never ever, I'm going to get emotional now,

other than with this first counsellor, nobody has ever given me permission to talk about it...and maybe it's about legitimising my miscarriages, loss. You know I wonder whether society actually does recognise, culturally recognise the emotional impact on women' (Tess: 31-32/919-945).

It feels significant that both Tess and Janet use the word 'validation.' This suggests that they both wish to have their experiences of reproductive loss recognised and understood as unique and genuine. Cote- Arsenault (2003) states that in her research into perinatal loss, women commented on how few places there are in which they feel able to talk about such losses and to have them heard and acknowledged. When they are offered such an opportunity they see it as a way of remembering their babies and as a significant part of their grieving process. This might be one of the main reasons why my participants agreed to bear witness so eloquently to their experience of miscarriage. They see it as a chance to tell their stories and have them heard and I hope that I have left my participants, in the words of Finlay (2011), "richer for the experience" (p. 201). At the very end of her interview, Tess sums this up in what is one of the most expressive and gratifying moments in all my research interviews. She comes to the realisation that in taking part in my research she is creating a way of remembering her babies lost through miscarriage:

'Gosh! I do so like – more than like- I've run out of words, the notion of this being a memorial' (Tess, 33/976-7).

This is the last sentence of Tess's interview; it is my final research interview and a fitting end to the whole research process. It brings home to me the importance of giving women the opportunity to bear witness to their perceptions of miscarriage many years after the event. I am also reminded of the responsibility I have as a researcher to facilitate this and to present these research findings with sensitivity and accuracy so they become a fitting

memorial for all the babies lost through miscarriage and remembered throughout this research.

Reflections

All the women in this study appear to have come to an acceptance of their miscarriages, to a certain extent, and have managed to integrate what happened to them many years ago into their current lives. They have found a balance between what was lost in the past and the concerns of the present, which are more pressing and immediate. None of the women spend much time dwelling on their miscarriages many years later. However, when they do look back down the years there is still some sorrow and regret over what they experienced. Apart from Dee, my participants tell me that the experience of reproductive loss has been transforming, leading to career changes and a desire to work in areas such as counselling where they can draw on past experiences to help and support other people. From Dee's perspective, having a baby at that point in her life would have been more life changing than the experience of miscarriage. Nevertheless, there is a sense throughout this theme that in mourning a reproductive loss, my participants are acknowledging just how life changing pregnancy can be, whether there is a successful outcome or not.

None of my participants tell me about specific ways they have of remembering or commemorating their miscarriages and most of them cannot remember a specific date on which it happened. Susan is particularly shocked at the thought of having something specific as a keepsake and is adamant that she has no desire to be reminded of her stillbirth or her miscarriage. However, she does tell me about using the terry towelling nappies she had bought for her still born baby as a comforter for her son. That memory, along with Lucy's description of her three empty photograph frames predominantly stays in my mind.

They are poignant images and reminders of how my participants have assimilated their experiences of reproductive loss into their lives.

Throughout this super-ordinate theme, Janet and Tess are very clear about the need to talk about their experiences, to have them validated in some way and to have their voices heard. All my participants tell me that they agreed to take part in my research out of a desire to help other women who have experienced miscarriage but also to bear witness to their own experience. I sense that Dee offered to take part in this study because she suspected her attitude might be different from my other participants. Although she makes it clear in her interview that she is fully sympathetic and accepting of another point of view and that this was her own unique experience in a particular context.

I am left with a strong sense that all the women in this research make sense of their experience of miscarriage in their own very distinctive ways. As Ingram et al. (2000) suggest:

“Grief work is an idiosyncratic phenomena which involves individuals identifying their own tasks of mourning negotiated through the process of everyday living”
(p. 73).

I feel privileged to suggest that participating in this research has been part of that unique process and has been transformative for my participants and for me as a researcher. As I have documented above, throughout this analysis, I have been deeply affected by my participants’ accounts of their experience of miscarriage and I suspect so will others who reads this research. Throughout the interview process, and in my subsequent immersion in the transcripts for this analysis, I have encountered my participants at a deep interpersonal level. In this respect, I feel that I have met successfully Finlay’s (2012) sixth facet

necessary for genuine phenomenology, ‘A potentially transformative relational approach’ (p. 16). These profoundly moving encounters have given me new insight into the experience of miscarriage and I hope I have been able to convey some of the richness and variety of this experience in the above analysis and discussion of my findings.

Summary

I suggest that at this point in a thesis it would be customary practice to include a summary of my findings in an overall conclusion to this chapter. However, inspired by Finlay’s (2011, p. 16) reminder that phenomenology should evoke “lived experience,” I decided to use a more dramatic way of closing this chapter by presenting my findings through poetic inquiry. Here, the researcher reframes her data in poetic form keeping as close as possible to the participants’ original experience (Grbich, 2013).

I believe this method allows me to distil my participants’ perceptions of their experience of miscarriage many years after the event, in a way that is both evocative and intimate for the reader. Seftel (2006), in her exploration of how women can manage creatively their trauma and grief after pregnancy loss, writes:

“The gift of the artist, or anyone embracing their own creative process is the willingness to explore “a grief without a shape” and the dark beauty of one’s own original imagery” (p. 173).

This brought home to me just how many of the phrases that my participants use in their interviews are redolent with meaning and imagery and there is a connection here to Smith’s (2011, p. 7) notion of the researcher as a diver for pearls, which I have described in my Methodology Chapter. Tess’s poignant description of waking up in hospital after her miscarriage and telling the nurse that she had lost her baby and the nurse replying ‘I know

love, I know' has stayed with me throughout this research. Therefore, I decided to use this phrase as a refrain in a poem that would aim to capture the lingering and more haunting moments in my participants' interviews. In my view, poetry is an accepted way of distilling emotion by expressing it in a reductive and concentrated form and therefore, it seems a natural medium for phenomenological research. Every line in the poem is an actual quotation from one of my participants and each is a "shining gem" in its own right (Smith, 2011). I have not changed my participants' words in any way; I have just arranged the lines for best effect. There are three stanzas in this poem and each stanza aims to reproduce the essence of each of my three super-ordinate themes. The poem speaks for itself.

Giving Voice – women’s experience of miscarriage

*It is just one of those things
Just a routine procedure
You’ve got two children, be happy with that
It’s nature’s way of dealing
With a baby that cannot survive
Just one of those things*

*I’ve lost my baby
Hold my hand
I’m not allowed to grieve*

I know love, I know



*I am pregnant but I’m not having a baby
It is the most anxious nine months of my life
Why did I do it again?
Why did I risk it?*

*It’s like sitting on a cliff
Waiting to fall off*

*I am being tested all the time
I can’t look forward
Something might go wrong
Do you remember me losing my baby?
If I talk about it
It might happen again*

I know love, I know



*I want to pretend it didn't happen
I never thought I'd want to remember
A baby with no gender or name
Yet the grief was massive
And I guess it's still there*

*Not only did I lose a baby, I lost me
I lost who I had been
It's changed who I am
I had to re-discover myself*

*It's not something I should keep quiet.
I needed to talk about it
Maybe wanted to talk
Nobody has ever given me permission*

*Photograph frames stay empty
Symbolic of what should be there*

*This is my life
This is where I am
Each experience
A part of me*

*Yet I would swap this wisdom
This philosophy
This memorial*

I know love, I know.

CHAPTER 6: GENERAL CONCLUSIONS

At the beginning of this research I asked the question: *What are women's perceptions of the experience of miscarriage decades after the event.* I chose to use IPA (Smith et al., 2009) because I wanted a methodology that allowed me to focus on the idiographic nature of my participants' lived experience, to tell their individual stories and offer an interpretation of their overall experience. This has proven to be a complex task because of the partly retrospective nature of my study. I have attempted to describe and interpret not only my participants' past memories of miscarriage but also their perceptions of miscarriage in the present. As I describe in my Reflexivity Chapter, these perceptions from the past and the present have been interwoven throughout each individual account and the whole process has often felt like unpicking several complex old tapestries and then weaving all these old multi-coloured threads into one brand new and intricate tapestry. I have also used extracts from my bracketing interviews and research diaries so that the reader can plainly see my involvement in the process of generating themes and in the subsequent discussion of my data. If the reader imagines metaphorically turning to the back of this newly created tapestry canvas, hopefully they can see clearly the formation of my stitches and where I have chosen to tie knots and reattach the threads.

In this chapter, I briefly outline the key findings in my research which have emerged from a detailed analysis of the super-ordinate and sub-ordinate themes presented in my Findings and Discussion Chapter. I also comment on where these findings have converged with and diverged from findings in the extant Literature. I reflect on some of the limitations of this type of qualitative research and I make a series of recommendations for future research in the area of women's perceptions of miscarriage. Finally, I end with a reflection on the

importance of my research and how far I feel my aims for this research have been achieved.

Overview of key finding

All the women in this study had their miscarriages at least fifteen years ago. Therefore, my findings are based, not only on my participants' perceptions of the experience of miscarriage long ago but also from them reflecting on how they are still affected in the present by the experience. It is this longitudinal perspective that makes my research unique as there has been very little research into the long term effects of miscarriage on women or into how they make meaning of the experience many years later.

My research shows that for the majority of the women in this study miscarriage was a complex event. Initially, after a miscarriage, they recall experiencing a myriad of complicated feelings including trauma and anxiety and these feelings were often misunderstood or not recognised by those closest to them. The private nature of miscarriage has meant that over the years, my participants have had very little opportunity to talk about their feelings and perceptions of miscarriage. Now, many years later, when I ask them to tell me about their experiences, it triggers memories not only of their miscarriages but of other reproductive losses such as abortion and stillbirth. I am struck by the vividness of their recall of past events and the psychological effect that miscarriage still appears to have for some of my participants in the present.

Physical nature of miscarriage

My findings show that for most of the women in my study miscarriage was initially experienced as traumatic, with memories of pain, bleeding and the loss of fetal tissue. Some of my participants tell me about their distress in attempting to reconcile this loss of

fetal tissue with the picture of the baby that they carried in their imagination. The very private nature of miscarriage sometimes led to a reluctance to share this experience with others. This was compounded by misunderstanding and insensitivities from friends and family and a lack of compassion from health professionals which is still remembered many years later.

The short term and long term psychological effects of miscarriage

I have argued that because of the experiences described above, miscarriage can have both short term and long term psychological effects on some women. The sudden and unexpected nature of miscarriage may challenge a women's assumptive world. What is happening inside her own body can feel out of her control and this is experienced as traumatic. For some of the women in my research who had more than one miscarriage, this effect is cumulative and their memories conflate into each other emphasising the harrowing nature of the event and the psychological impact. This challenges the findings of Klier et al. (2002) that previous reproductive loss does not increase the risk of psychological stress.

Anxiety

All of my participants recollect experiencing some level of anxiety during and after their miscarriages. They look back on it as a stressful life event which accords with the literature (e.g. Frost & Condon, 1996; Klier et al., 2002; Brier, 2004; Carter et al., 2007; Nikcevic et al., 2007). In the literature, anxiety after miscarriage is also linked with depression and grief (e.g. Stirtzinger & Robinson, 1989; Lee & Slade, 1996). However, here women are recalling their miscarriages after a far shorter time perspective than in my research. This ranges from a few weeks to up to two years compared to more than fifteen years in my study. I suggest that although my participants did initially experience some levels of grief

and depression, it is the anxiety, linked to trauma and shock that they recall most intensely over fifteen years later.

My participants also recall the longing for another child after their miscarriages and except for Dee, they all tried for another baby quite soon. Exceptionally, Dee does not remember her miscarriage as being a particularly anxiety provoking experience. However, this might be because her pregnancy was not planned and she feared that a new baby was going to have a big impact on her family dynamic. Moreover, she was the only women in my research who was offered a medical cause for her miscarriage and having a reason for the miscarriage might have made it easier for her to make sense of what had happened (Frost et al., 2007).

The anxiety that my participants felt during subsequent pregnancies is remembered as causing strain on their relationship with family and friends. They recount problems with partners not understanding the compulsion to have another baby, as with Tess, and muse on the difficulties for children understanding what miscarriage means, which was Dee's and my own experience. Three of the women in my research go on to have successful pregnancies and Lucy eventually adopts her second child but this success is not achieved without a struggle. My participants remember being prepared to take risks and to surmount many obstacles to satisfy this longing which was distressing for themselves and those close to them. They also recall living with the fear that something would go wrong again in subsequent pregnancies and the months of acute anxiety that this caused. These feelings are also consistent with the literature (e.g. Bergner et al., 2008; Cote- Arsenault & Morrison-Breedy, 2001; Firtl et al., 2009; Geller et al., 2004). However, it is significant that my participants still recall this anxiety many years later.

I believe that these experiences of anxiety produced longer term psychological consequences for most of my participants. Lucy, Tess and Susan have all recounted their continuing struggles with anxiety many years after their initial miscarriage and in Lucy's case this has led to her experiencing chronic agoraphobia which is still ongoing. Similarly, this has been my own experience. Although, as I point out in my Literature Review, these findings do not accord with the research by Geller et al., (2002) which argues that miscarriage does not increase the risk for agoraphobia. However, it is clear that more research is needed in this area.

My research also seems to show that the extent of the psychological response to miscarriage may be determined by the level of attachment to the pregnancy and the closeness of the relationship a woman has developed with her unborn child and this is also borne out in the literature (e.g. Letherby, 1993; Parsons, 2010). There is also an important link between the perceived extent of my participants' losses and the strength of their memories many years after the event.

Attitudes of other people

My participants all had their miscarriages during the 1990s. This was a time when the psychological effects on women who had experienced miscarriage were becoming more recognised. The pregnancy-loss movement in America and the Miscarriage Association in the United Kingdom were beginning to raise awareness of the emotional effects of miscarriage on women and throughout the 1990s it was becoming more acceptable for women to talk about miscarriage and have their feelings of loss recognised as genuine bereavement (Layne, 2003). Guidelines for good practice by health care professional dealing with women who experienced miscarriage had been drawn up in the United Kingdom and further training was being called for (e.g. Moulder, 2001). However, major

shifts in health culture and in society's views in general take time, and therefore, it is not entirely surprising that the women in my study remember indifferent treatment during and after their miscarriages by health professionals and sometimes thoughtlessness from friends and family.

They still recall over fifteen years later, insensitive comments from those close to them, particularly in the early days after their miscarriage. They felt that miscarriage was not always recognised as the loss of a baby especially if it occurred in the first few months of the pregnancy. They were sometimes offered misguided reassurance from family and even health professionals that miscarriage was a normal way for nature to deal with fetal abnormalities and that they could soon try again. If they already had children, sometimes the view was that they should count their blessings and not tempt fate with another pregnancy.

There is an implication that the baby lost through miscarriage is not valued by society (Malacrida, 1998) and this may result in women feeling socially isolated, enhancing the stigma surrounding their experiences. I believe that in attempting to elude other people's platitudes and lack of understanding women may avoid talking about their miscarriages which can result in them minimising their loss and colluding in their own perceived disenfranchisement. Women also lack a language to talk about miscarriage (Jonas-Simpson & McMahon, 2005) which can make it harder to have their voices heard and their experiences validated. This was certainly the experience of most of my participants and it appears to have had a clear impact on their psychological well-being, not only at the time of their miscarriages but to a certain extent, many years later.

Attitudes of health professionals

In my opinion, one of the most shocking findings in my research has been the indifferent attitudes and lack of compassion of some health professionals recollected by the majority of my participants during their miscarriages. I concede that there were examples of individual kindness recounted by my participants but my overall sense is that these were the exceptions. It is important to acknowledge that these events took place over twenty years ago and perhaps reflect society's different attitudes to miscarriage at the time. During the 1990s there was an emphasis on normalising miscarriage. It was seen as a common event and women were encouraged to become pregnant again and move on with their lives as soon as possible (Letherby, 1993). However, there was a growing understanding in the contemporary literature, often written by women who had themselves experienced miscarriage, that miscarriage could cause psychological distress for some women (e.g. Hey et al., 1989; Malacrida, 1998; Moulder, 2001; Letherby, 2003; Layne, 2003). Alongside this, was some appreciation by health professionals that more support and counselling services were needed, although this was not necessarily being put into practice (Prettyman & Cordle, 1992). Yet, sadly, contemporary research leads me to conclude that the poor experiences my participants remember from that time are still happening today (e.g. Robinson, 2014; Evans, 2012).

Living with the experience of miscarriage in the present

Woven throughout these memories are accounts of how my participants make meaning of their miscarriages in the present. This is achieved in individual and idiosyncratic ways but there are some commonalities. They have all moved from the initial shock and trauma many years ago to an acceptance in the present of what happened in the past. Their previous experience of miscarriage appears to have made them resilient and able to look

towards the future with optimism. There is some similarity here to the process of coming to terms with loss described in traditional bereavement models (e.g. Parkes, 1972/1996; Stroebe & Shut, 1999; Worden, 1983/2010). However, I have found applying these models to loss in miscarriage problematical because there has been no dynamic relationship with the deceased outside of the women's body and I have considered this in more detail in my Findings and Discussion Chapter.

There is a view, as I discuss in my Literature Review, that some women may experience miscarriage as movement through the phases of separation, transition and incorporation (Murphy & Merrell, 2009) rather than as bereavement. I have been struck by how similar these three phases are to the three super-ordinate themes in my findings. In the first super-ordinate theme **Memories of the Initial Impact of Miscarriage**, my participants tell me about their separation from their pregnancy through miscarriage and the physical and psychological effects of this abrupt severance. In my second super-ordinate theme **The Longer Term Consequences of Miscarriage** some women recall the process of becoming pregnant again after miscarriage and their subsequent precarious transition into motherhood. Finally under my third super-ordinate theme, **Making Sense of Miscarriage in the Present** my participants describe how they have incorporated the experience of miscarriage into their lives after a long process of time. Explaining miscarriage as going through a process of transition might allow for feelings of loss without necessarily viewing it as bereavement and may well be closer to Janet's understanding. However, it could be argued that models of transition are just bereavement models by a different name.

Miscarriage is life-changing

For all the women in my research, with the possible exception of Dee, miscarriage has been a life-changing experience. I believe that the strength and resilience that my

participants found to overcome their loss and move on with their lives has been transformative. In this sense, I argue that their experiences have features of post-traumatic growth (Tedeschi & Calhoun, 1996), a concept I describe in more detail in my Findings and Discussion Chapter. For Janet, Lucy, Susan and Tess, the experience of miscarriage challenged their view of the world as a safe and predictable place to be. They told me about having to forge a new way of being in an unsafe world, a place where they no longer felt in control of their bodies and where the fear of the unexpected was much more in their awareness. This led them eventually to make changes in their personal relationships, to become more self-accepting and to pursue careers that were seen as more fulfilling.

Finally, when talking about their motivations for taking part in this research all my participants expressed a need to have their experiences of miscarriage validated and a desire to let other people know about these experiences. They spoke about using the interview process to have their voices heard but also about reaching out compassionately to others. They hoped that by sharing these sometimes painful memories, they could help other women to feel less alone and also increase understanding for those who are supporting women going through miscarriages.

Unexpected divergence from findings in the literature

What I have found particularly noteworthy in this research has been some of the unexpected divergences in my participants' accounts compared to those described in the literature. As I have stated earlier, during the 1990s there was growing awareness of the needs of women who experienced miscarriage. Women were forming support groups and writing self-help books on miscarriage where they were encouraging women to name their lost babies and to view miscarriage as a significant bereavement comparable to stillbirth and neonatal death (Allen & Marks, 1993; Layne, 2003). It was seen as good practice to

offer women mourning rituals such as candlelight ceremonies and there was a growth of hospital chaplains performing memorial services for families who had lost babies through miscarriage (Lovell, 1997, 2001). Indeed the lack of appropriate rituals to commemorate miscarriages in Western society has been a constant refrain in the literature from the 1990s to the present day (e.g. Allen & Marks, 1993; Layne, 2003; Seftel, 2006; Rowland & Lee, 2010).

Yet, significantly, none of my participants talk about a desire to remember their babies in this way. Not one recalls giving their baby a name or taking part in any form of memorial service and they do not appear to feel this as a loss. Many years later, they cannot recall very clearly the dates of their miscarriage or the particular date their baby would have been born, except for Lucy who met her adoptive son for the first time on the delivery date for the baby she lost after her second miscarriage. They do not appear to have felt the need to create their own rituals to help them remember their babies or to use creative writing such as poetry to help them to come to terms with their loss. Or if they did, they do not choose to tell me about it during their interviews.

My participants speak very little about maintaining bonds with their babies. They do not tell me much about keeping mementos and show little interest in remembering their babies through the use of consumer goods such as clothes and blankets described by Layne (2003). The exception is Lucy who displays three empty photograph frames to represent her three miscarriages. In fact, Susan finds the idea of having such keepsakes painful. This is in contrast to the literature that suggests that if women are denied rituals to mark their miscarriages then they will often develop their own as a way of mitigating and coming to terms with their grief (Seftel, 2006). This was my experience and has led to my interest in the theories around continuing bonds (Klass et al., 1996; Rando, 1985). I am aware that I

have chosen to maintain bonds with my baby through keeping my baby's blanket, by the creation of my Shadow Child, in undertaking creative writing and indeed through researching this thesis. However, similar types of activity are not described by any of my participants. Nonetheless, they make it clear that by participating in my research they bear witness to their experience and create a memorial to their lost children.

Similarly, none of my participants make any reference to the prevailing debates during the 1990s between the pro-choice and pro-life movements that were supposedly instrumental in shaping thinking about miscarriage at the time when my participants miscarried (Layne, 2003). They appear to have had no concerns about acknowledging the personhood of their unborn child at the time of their miscarriages or years later when they were interviewed. My participants all talk about losing a baby and not once in their interviews do they refer to the loss of a fetus or an embryo. However, Tess does remember being upset by her doctor's use of the term "spontaneous abortion" which was an expression actively being discouraged in favour of "miscarriage" during the 1980s and 1990s (Moscrop, 2014).

For my participants, it would seem that they remember their miscarriages at a very personal and private level. It is something they kept hidden at the time and shared with few people. In fact, I am surprised that none of my participants tell me much about having emotional support even from close female friends. This confirms my findings that fifteen to twenty years ago miscarriage was something that very often women chose not to talk about.

Limitations of my research

I have already discussed in detail the strengths and weaknesses of IPA in my Methodology Chapter. I have presented the arguments for using a small sample size of five participants in my research and considered the question of generalizability. Through my use of IPA, I

have committed to produce in-depth accounts of each of my participants' experience of miscarriage but I acknowledge that this process is slow and time consuming. I have sometimes found the volume of rich data generated to be overwhelming and I have become at times so absorbed and engrossed in the project that it has been difficult to recognise that the process of analysis and discussion needed to be drawn to an end, if only because I was in danger of breaching the word limit for this thesis. I have also found difficulties in presenting this quantity of data and my emergent themes visually. I have used traditional tables but I feel that they do not always sufficiently capture the essence of each of my participants' experiences and the overall soul of this research. I hope that my use of poetry to present my findings mitigates this a little.

Likewise, I have considered the limitations of undertaking unstructured interviews in my Methodology Chapter, and I acknowledge that the success of my interviews was very dependent on my skills as a researcher and the ability and willingness of my participants to talk to me about their miscarriages without being restricted to specific questions. These concerns have led me to explore the ethical issues that have arisen whilst undertaking my research. In particular, I have considered the specific problems that may arise from undertaking research on a sensitive topic such as miscarriage for both the participants and the researcher. I have been consistently aware of the vulnerability of my participants and how talking about reproductive loss might impact on them. I have tried to balance their desire to talk with a respect for their privacy and have taken heart from their willingness to acknowledge that being part of this research has beneficial effects. In addition, I have looked at the ethics of interpretation and the difficulties in explaining the interpretative process.

I am convinced that good qualitative research is very dependent on the skills and abilities of the researcher; however, because of its subjective nature, it can be very difficult to evaluate. I have set out the criteria against which I would wish my research to be assessed in my Methodology Chapter but ultimately only my readers can judge how successful I have been. Inevitably, in my experience, this reliance in qualitative research on my abilities to be creative with the research design, to be a skilful interviewer, to clearly present my themes and ultimately to set out my criteria for how my work is to be appraised, whilst at the same time practising reflexivity, requires enormous effort and commitment. There is no doubt in my mind that feeling these pressures has placed limitations on my research. Sadly, I also have a suspicion that despite these exacting demands required of me as a qualitative researcher, my findings on women's experience of miscarriage may not have the same weight and acceptance in the scientific community as they might have if I had undertaken to use quantitative research methods for this study (Rohleder & Lyons, 2015). Nevertheless, I take heart from the fact that I have done my best to produce persuasive and compelling data which will hopefully raise awareness of the complexities surrounding women's long term experience of miscarriage.

Recommendations for future research

The findings from this study have led me to conclude that there are still many areas for further research into the experience of miscarriage for women. There is a need to explore specifically the longer term psychological effects of miscarriage and in particular whether the experience of miscarriage is linked to trauma, anxiety and generalised phobias such as agoraphobia. It would be useful to know for how long women report these effects and whether they are present for some women for a lifetime. Following on from this, more research is needed into how health professionals might support the whole family after a

miscarriage and into how families might support each other (Kavanaugh et al., 2004). I believe there is also a need for more research into whether some children in a family are psychologically affected by miscarriage and how they can be helped to understand more fully what has happened in an age appropriate way.

Future research could also explore the effectiveness of psychological interventions in reducing anxiety after miscarriage and continue to develop research similar to Frost et al. (2007), that looks at other mitigating factors that might reduce the psychological impact of miscarriage for some women.

Building on the work of Firtyl et al. (2006), future research could also explore more fully the extent to which fear and anxiety is present in subsequent pregnancies and it would be of interest to know whether counselling or other types of psychological interventions might help mitigate this type of fear and anxiety. Research could also explore to what extent heightened anxiety in subsequent pregnancies might affect the well-being of women, their relationships within their family and in particular, their relationships with children born after miscarriage.

Statistics show that 50 – 60 % (Lamb, 2002) of women become pregnant again within the first year after a reproductive loss and I would like to understand in more depth why women seem to put themselves under such pressure to conceive again so quickly. This type of research could also lead to a better understanding of the concept of baby hunger or “baby fever” (Rotkirch, 2007). In general, I would be interested to find out more about what motivates women to want to conceive and have a child in 21st century Western society. Possibly, small scale qualitative studies where women are asked this question might be the place to start (Foster, 2000).

I am also interested in the concept of post-traumatic growth and how it might develop after miscarriage. There has been research into post-traumatic growth after the loss of a child (e.g. Engelmeyer & Marwit, 2010; Polatinsky & Esprey, 2000) but not specifically after miscarriage. I think this would be a significant area to develop because miscarriage is such a common event.

There is certainly more research needed into the attitudes of health professionals towards miscarriage and into the seemingly intractable problem of health professionals treating women who have miscarriages with apparent insensitivity and a lack of understanding. In very recent research, Robson (2014) is still calling for better training for health care professionals in this area and it would be useful to know why in the 21st century this is still needed. What support and training is actually being offered?

It is clear from my Literature Review, that for the past thirty years, researchers have invariably been calling for more psychological help and support for women after miscarriage and at the same time stating that more research needs to be done in this area. Volumes of evidence has been produced suggesting that there is a need for better training of health professionals and more psychological intervention required for women, yet nothing solid is implemented and apparently nothing is ever firmly embedded or routinely implemented in the health service.

Most recently, the Cochrane Report (2012) states that there is still a lack of evidence to support counselling as an effective intervention after miscarriage, even though research shows this is what women themselves want (e.g. Adolfsson et al., 2006 & Wong et al., 2003). Despite this, the NICE guidelines (2012) state that after a miscarriage, women should be offered information and access to counselling and it is expected that the psychological impact of miscarriage be taken seriously. Therefore, it is no wonder, that

amidst these contradictory positions, there is dissatisfaction from women that these guidelines are not being implemented (Cambell, 2012; Robson, 2014). A recent report commissioned by the Maternal Mental Health Alliance (MMHA, 2014) states that up to 20% of women experience mental health problems in pregnancy or the first 12 months after birth and yet only 40% of these are diagnosed, with just 3% experiencing a full recovery. Shockingly, it also found that no specialist services for perinatal mental health existed in 40% of areas in England and Scotland, rising to 70% in Wales and 80% in Northern Ireland and that fewer than 15% of the UK has comprehensive provision. Thus it is highly likely, that the needs of women who have miscarriages are becoming lost in this huge unmet requirement for mental health provision for women.

At this point, I sadly add my voice to the many who over the years have called for more research into this area. Optimistically, I would like to see research into what women say they would find most helpful after miscarriage. Also, I feel more investigation is needed into how psychological provision, and particularly specialist counselling, could be made accessible to women. There needs to be a strategic and integrative approach for psychological support throughout a woman's whole reproductive journey. This could start before conception, through pregnancy, carry on after delivery and even continue during the menopause.

Despite these constant calls for more psychological intervention to be made available to women after miscarriage, it is astonishing that miscarriage is a neglected area in the counselling and psychotherapy literature. Therefore, I would like to see research into why this is the case. It would be helpful to know how frequently issues around miscarriage are brought to counsellors, either as the presenting issue or indirectly, and what counsellors' attitudes are to women who have miscarriages. Furthermore, it would be beneficial to find

out how counselling organisations, including the BACP, could become more involved in supporting the recommendation in the NICE Guidelines (2012) that counselling should be offered to women after miscarriage.

Another interesting extension to my research would be to discover whether the growing use of social media has altered perceptions and attitudes towards miscarriage. We now live in a society where women can share the news of their pregnancies and also their miscarriages through social networks such as Mumsnet and Facebook. There are already articles on the internet advising women on the etiquette for announcing their miscarriage on social networks websites (e.g. Czukas, no date). On these websites, friends and relatives can immediately offer their condolences and support. Links can be set up to provide further information about miscarriage which hopefully might lead to a better understanding. In this sense, it seems as if younger women have found a way through social media to respond to the previous silence around miscarriage. Perhaps, we are moving towards the modern equivalent of the greeting card that Layne (2003) previously lamented did not exist to mark miscarriage. It would be useful to discover whether this apparent openness is reducing the secrecy which has previously been associated with miscarriage and whether women perceive feeling less guilt, shame and disenfranchisement by announcing their miscarriages on such public forums.

Women are also using the internet to create memorials to their lost babies and to connect to internet discussion forums where a wide range of help and support is available. Research has already begun into how women use discussion forums to access immediate support and information after pregnancy loss which is not always provided by health professionals (e.g. Betts, Dahlen & Smith, 2014; Gold, Boggs, Mugisha & Palladino, 2012). This is a growing and important area that needs to be researched more fully as it has wide reaching

implications for how a new generation of women may wish to access help and support after miscarriage.

Final reflections

Overall, I feel that my research has met the aims that I first described in my introduction. By producing a comprehensive account of my participants' perceptions of their experience of miscarriage many decades after the event, I have raised awareness of the long term psychological effects of miscarriage. Hopefully, this might lead to a more compassionate understanding of the needs of women who miscarry from health professionals and by society in general. From a counselling perspective, I am pleased to see a short article in a current copy of *Therapy Today* (April 2015, p. 7) reporting on an announcement of increased funding for perinatal mental health. This suggests that my call for more psychological therapies for women who miscarry is very timely.

I have learnt so much about my own experience of bereavement from writing this thesis and the research process has provided another way to integrate loss into my life. In many ways, I feel that I am so connected with my participants' experiences that we have all undertaken this research journey together. However, I have also discovered that embarking upon qualitative research is not for the faint hearted. It demands dedication along with commitment and places a burden of responsibility on the researcher to treat participants' data respectfully so that the aims of the research can be fulfilled appropriately and ethically. In particular, I have found it challenging to confront my own assumptions about miscarriage. It has been difficult to accept that even though I believe that miscarriage is a taboo subject my participants are not describing it as such. Yet, this realisation is a real-life example of the power of reflexivity. This valuable insight must ultimately give my

research authenticity and validity. Completing my thesis has been full of joys, sorrows and contradictions and this has mirrored my process of coming to terms with miscarriage.

Over the years, it has been a strain to face the challenge of writing about my own miscarriage and at the same time to do full justice to the experience of my participants who have given me such a generous gift. However, it will be a price worth paying if the voices in this research are heard and I raise awareness of the possible long term impact of miscarriage on women. Yet, although my research is nearing its end, I am under no illusion that this process of making meaning from loss will continue for both me and for my participants. As Tess so eloquently puts it:

‘God, you think you’ve cried all the tears you can for the loss but you haven’t. It doesn’t go away. I think I’ve dealt with it, it’s sorted, it’s all finished but this tells a very different story’ (Tess: 33/969-70).

The process of living with our experience of miscarriage will continue for us all and this thesis can only provide a brief insight into that experience for my readers; although I hope it has been an enlightening one.

Finally, I am aware that over the last few months I have struggled with how to bring my thesis to a fitting end. I discussed this fear with my therapist and in true Gestalt style she said to me “Don’t push the river; it can flow all by itself”. Since then, I have reflected on the meaning behind my inability to draw things to a close. Gradually, it has dawned on me that I need to end this research gently. There are going to be no fanfares or trumpet blasts and no need for profound statements or grand gestures. I have written this thesis in the cracks of my life, in small snatched parcels of time and I want this reflected in my ending. This mirrors the process of coming to terms with my loss. I have taken many little steps

towards acceptance that have sometimes been almost imperceptible, lost in the hustle and bustle of getting on with living. Yet occasionally, the importance of one of these steps will make itself known as happened to me recently.

A few days ago, I was struggling to open a drawer that had something wedged at the back. I removed the obstruction and my eye was caught by a small red gift box and a little pamphlet that I had put into this drawer and forgotten about. I opened the box first and inside was a hand painted glass window decoration of a Madonna and child from Gloucester Cathedral. A friend had given it to me for my birthday a few years ago. I had not wished to display it then but from today it hangs in the window above my desk illuminated by the beautiful spring sunshine. The mother gazes intently and absorbingly into the eyes of her child and it is a very peaceful image. This gives me only pleasure and reminds me of how healing the process of writing this thesis has been, particularly over this last year. The pamphlet comes from the Metropolitan Cathedral of Christ and King in Liverpool which I visited a year ago. It is entitled “Forever in our thoughts” and I found it in the Children’s Chapel where there is a candle burning perpetually dedicated to all babies who have been lost through stillbirth, miscarriage and abortion and whose final resting place is unknown. When I first came across this memorial, I took home the pamphlet in the hope that I would read the prayers and poems inside but I found them too unbearably moving. Now, reading these again, they offer me hope and comfort. The last words in the pamphlet, taken from Isaiah 60: 20 have particular resonance:

Your days of grief will come to an end.

I the Lord, will be your eternal light,

More lasting than the sun and the moon.

They remind me that to everything there is a season, a time to be born and a time to die. This is also true for my Shadow Child who has been a consistent and soothing presence during this stage of my journey. This is the right moment to say a tender goodbye; to take one last wistful glance as she walks out of the shadows and into the everlasting light. I am thankful to have had her for just a little while and I know that now I am ready to give her back.

FINIS

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APPENDIX A

Master Table of Themes for the Group

WOMEN'S PERCEPTIONS OF THEIR EXPERIENCE OF MISCARRIAGE DECADES AFTER THE EVENT

MASTER TABLE OF THEMES FOR THE GROUP

**SUPER-ORDINATE THEME 1.
MEMORIES OF THE INITIAL IMPACT OF MISCARRIAGE**

1. *The physical process of miscarriage* Page/line number

Janet: I went to the loo and lost the baby basically	1/13
Janet: I just had these incredible stomach cramps.	1/13
Dee: I had the most horrendous pains like the worst period pains.	5/123
Dee: I could feel it slipping away. I called the nurse and they came and basically caught it.	5/130-32
Lucy: I just went to the loo and lost it. It was just a bit unreal really and I just knew I had lost it.	1/9
Susan: Yea in my mind it was (a baby). It was a lump. I felt the lump coming out.	24/742
Tess: Ultimately I can't remember how I lost the baby – in the toilet...and not complete either. It was horrible. And er I took this, whatever out of the toilet and rang my GP.	12/340-42
Tess: The process with the first one was very, very quick. Almost before you knew what had hit you one minute you were pregnant and the next minute you weren't.	2/35-37

2. *The early psychological effects of miscarriage*

Tess: I think it's left me hyper-sensitive to anxiety. I do a lot to avoid being anxious.	23/687-8
Tess: I can't remember the sequence of events. I was so anxious and emotional by that point...where the first was crystal clear- this one feels very different.	12/331-333
Lucy: I was worried after the first miscarriage. It was a good job people didn't leave their kids outside Sainsbury's like they used to do a few years ago because I was worried that I might pinch someone else's	20/575-6
Lucy: And that's the space I think I was trapped in for a long time, that metaphorical toilet	17/426
Lucy: I think I just shut off...didn't like the world, didn't like what was happening to me, couldn't deal with the emotions I felt.	11/308
Dee: What did help enormously was they did some tests on the placenta and the fetus...and I was told about five weeks later that the baby had an extra chromosome...it would probably have been Downes...it made me feel better about it	7/224-29
Susan: I was really frightened about it but I think I just had this image of a baby. I just found that really difficult.	24/733-34

3. Attitudes of other people towards miscarriage

Janet: Then you have all these things from people don't you...platitudes from people.	16/459
Janet: When you're with people, when you're giving people unhappy news about you...then you feel you're taking care of them in the situation and that's difficult.	13/418-20
Dee: I almost feel guilty that I wasn't more distressed because people expect it'	
Dee: It would be interesting to say to them now do you remember me losing the baby. I'm not sure it would be something that would actually feature.	9/282-84
Lucy: I put in a letter to them, which did end up in the bin, you'd have shown me more understanding if I had lost my handbag.	9/266-67
Lucy: And people use to say, "Oh well you've got one." Alright you've got two kids; which one shall I bump off because you've got another one?	8/219-20
Tess: I'm wondering talking to you, does it lie with miscarriage because certainly when I think back I wasn't allowed to grieve.	27/786-8
Tess: It wasn't really a baby. It was only a collection of cells and that was from the majority of people.	16/449-52
Tess: Er well you've got two children be happy with that...That's the message we got. We honestly got the message – it was only eight weeks. Well you've got two children. Or well there are people who have seven or eight miscarriages.	26-27/771-88).

4. Perceived attitudes of health professionals

Janet: He said, "Have you any live children?" And it was absolutely horrific. It was like someone cutting you with a knife.	2/43-46
Janet: He was really nice and really, really thoughtful and it came across he was empathic...He used to hold my hand.	3/62-65
Tess: A senior house officer talking to the nurse about Star Wars as if I was just a lump of meat...he just said there's no heart beat and there was no compassion in it...for him it was just a routine procedure.	7/181-7
Tess: I remember the theatre nurse- she didn't do a huge amount but it was just somebody stroking my face and in the fuddle coming round from the anaesthetic saying, "I've lost my baby", and she's saying, "I know love I know".	25/724
Lucy: This really stupid radiographer, who should have known better, I'm sure they have training in these things, said never mind have fun trying again.	7/189
Susan: I found it quite shocking when I had the miscarriage...it's though you've come to have your tooth out or you've got a broken toe. They're buzzing around just waiting for the baby to come out of you. I just thought it was dreadful because I was petrified.	23/725-733
Dee: I mean in the hospital the nursing staff have been trained to be aware of all the emotions and so on and they were very loving and caring and supportive.	13/423

**SUPER-ORDINATE THEME 2.
THE LONGER TERM CONSEQUENCES OF MISCARRIAGE**

1. Reproductive struggles and the longing for another child

Page/ line number

Janet: Why did I do it again? Why did I risk it? When I look back and I risked it twice more after that for some...I don't know. I don't know what is in you to do that. Where it comes from.	15/436-447
Susan: I may well have wanted another child after T...but they said there is no way you can carry another baby. You must not get pregnant again.	10/227-280
Susan: I did feel that I am being tested all the time. And this kind of thing always feels like there are more tests. Yea and I think even now I could lose her. I've gone through all these other things to get here and it could still happen.	17/487-89
Tess: I honestly don't know why I put myself through it but I'm glad I did because we've got this lovely young man but I don't know why and common sense would say don't do it. I don't know why.	25/741-744
Tess: They were going to listen and I saw this professor, a big name man, a lovely chap and he said yes we will refer you on to my researcher, who was just a wonderful, wonderful woman. Yes, and that makes me emotional (crying)... It's like heard at last isn't it...I eventually got pregnant again.	21/560-62
Lucy: I didn't feel it; then all of a sudden once it was in my head everybody in the whole world seemed to be pregnant.	2/32
Lucy: Like for me it was as if I had lost the potential for an O and the thought of ever losing O...	8/224

2. The effect of reproductive loss on subsequent pregnancies

Janet: You want to be optimistic; you want to look but it's like I can't look that far forward in case something goes wrong.	151/421-2
Janet: There was nowhere were it felt safe. I had got the idea I was pregnant but I wasn't going to have a baby.	14/4113/76-7
Lucy: You sort of think like right this is even more precious because you lost the last one.	5/124
Lucy: You go to the loo, you're thinking I hope there is nothing there. I hope there's no blood.	5/132
Lucy: Like sitting on a cliff waiting to see if you're going to fall off.	6/150
Susan: You just thought this is all going to go wrong again. I was really worried that it was all going to go wrong.	16/461-2
Tess: I said a baby with Downes That's fine. I'll cope with that. I can't lose another baby.	23/670
Tess: I think it was the most anxious nine months of my life.	22/643

3. *The impact of miscarriage on family life*

Janet: Yes they know all about it everything. They were brought up with it. We are quite open as a family.	12/331-2
Janet: In fact I didn't tell my mother about them. When my mother died...she was very poorly at the end and I did tell her.	6/163
Dee: We had got our heads round it. We were making plans. We were looking at what we would need and thinking we will have to swap bedrooms around and so on.	10/329-32
Dee: I had three grown up children... so it wasn't that we were desperate for a family. We were a family and this would have just been an extra little one.	10/329
Dee: So it would have been unsettling for the whole family and even more unsettling if the baby had been disabled.	14/445-472
Lucy: I do remember earlier times thinking my family deserves better than this- I'm not good enough for them. I felt they would be better off without me.	26/759-61
Lucy: But that baby should be J. I would never have not wanted to have J and if I hadn't been through this I couldn't have had J.	29/845-6
Tess: It took a long time to get pregnant. The third time caused a serious rift in our relationship. I was by that time obsessed.	9/255-6
Tess: (Talking about grief) It's still there but then it gets balanced out by this child is there. We wouldn't have him. He wouldn't be who he is. Our family wouldn't be how it is.	19/542-53
Susan: It's a bit tucked away thing isn't it because nobody is ever- it isn't something that anybody knows about if you know what I mean. It was just me and my husband at the time.	22/699-703

**SUPER-ORDINATE THEME 3.
MAKING SENSE OF MISCARRIAGE IN THE PRESENT**

1. Contradictions and complications in coming to terms with the loss

Janet: Even now it's about accepting what the past is but not letting it sort of rule today...It's almost if I can learn from it but not go back into it all the time.	20/596
Janet: If I look at those two- if I look at the miscarriages as dead children, I'd had three dead children (Researcher: And that's too painful to contemplate?) To even think about.	12/350-52
Janet: I can't see it as a bereavement at all because... I want to pretend it didn't happen anyway.	13/3
Dee: If I try to imagine what it would be like to not only have C but another one ten years younger that would have been really, really awkward.	13/407
Dee: I had lost a child that wasn't going to have a life really.	8/254
Dee: I think of it as a baby but I don't think of it with a gender or a name.	13/407
Tess: It's balanced with what I have rather than what I've lost.	21/620
Tess: I think you have given me a gift, in the talking about it and in the revisiting. Maybe I was ready to be given a gift in a way I wasn't earlier.	32/936-42
Susan: I don't think that anybody makes the decision to have an abortion or has a miscarriage without it having an effect. Even if they say it's not...The thing is you know – there could be a chance that I should have five children not two.	26/841-820

2. Miscarriage as a life changing experience

Janet: Each experience of life is different so maybe it helped me to understand...and if somebody wants to tell me what it is for them, that's what it is for them and maybe that's why I went into counselling.	17/491-495
Lucy: Not only did I lose my baby but I lost me. I lost who I had been. I had to rediscover myself.	17/433
Lucy: It's changed who I am...I am more open now, more honest which can be annoying for some people...I did the counselling because counselling helped me and I thought if I can just help one person whose been where I've been, one person in the whole world then that's enough.	24/264-694
Lucy: It's changed who I am and my life.	29/830
Susan: But I don't think they've made me a more bad person – if anything I've got empathy for people who are in that situation. They enable you to help people who are struggling. So I don't judge people anyway in general.	26/809-10
Tess: So had I not lost the three I wouldn't be doing what I'm doing. It was a high cost.	21/604
Dee: If I try to imagine what it would be like to not only have her (daughter) but another ten years younger that would have been really, really awkward I think.	14/459-61

3. *Commemorating miscarriage and bearing witness*

Janet: Validate – it’s a really good word- really good. You know this has happened. It’s not something I should keep quiet. It’s not something now...that’s going to – you know- open up raw wounds.	25/719-22
Janet: I want to say this is what happened. This is my life; this is where I am now. This is what made me and I have got through this.	21/618-22
Lucy: I did the counselling because counselling helped me and I thought if I can help just one person who has been where I’ve been – or not even where I’ve been but who needs help- one person in the whole world then that’s enough because someone helped me.	24/692-22
Lucy: I’ve got three little photograph frames empty...and I always thought I would get round to putting photographs in them and then one day I was looking at them and I thought I didn’t want to. They’re staying empty. They’re symbolic of what should have been there.	24/676-9
Susan: Interviewer: I’m wondering what made you talk to me today because it’s obviously painful. Susan: Because it’s helping you. In helping you to look into this. I would help anyone to learn more.	23/716-22
Susan: And the commemoration thing...I think I’m a bit funny about that...I suppose it is a bit of tucked away thing isn’t it. It isn’t something that anyone knew about.	22/653-70
Dee: I did think about it the first year on the day it would have been born but I can’t honestly remember what that day was.	31-32/919-36
Dee: I suppose the other thing that sort of feeds into that slightly is that we are Christians – we have a predisposition to want to look for God’s hand in what happens.	11/363
Tess: I needed to talk about it. Maybe I wanted to talk about it and maybe it feels a bit grand but it’s about validating experience...I wonder whether you gave me permission to talk about it...and maybe it’s about legitimising my miscarriages, loss yea.	15/492-94
Tess: I suppose for me I have three healthy boys and I think well do I need it?...I suppose having a fixed point maybe keeps you stuck with something.	18/530-5
Tess: Gosh! I do so like- more than like-I’ve run out of words, the notion of this being a memorial.	33/976-7

APPENDIX B

An example of transcription and analysis (page 13 of Janet's transcript).

An example of transcription and analysis (page 13 of Janet's transcript).

Emerging themes	Original Transcript	Exploratory comments
<p>Things just need to be dealt with</p> <p>Pain can be prioritised</p> <p>The need for self-preservation</p>	<p>R: So could you tell me a bit more about ...</p> <p>J: If I say it was something to deal with does that sound really <u>hard</u>?</p> <p>R: No, something to deal with.</p> <p>J: Just to get on with and it was almost like that – and it wasn't very nice – but it wasn't as bad as – so therefore I will <u>prioritise my pain</u>.</p> <p>R: You prioritise your pain?</p> <p>J: So my pain - I can't actually see that as pain in the same way <u>as the other</u>.</p> <p>R: You can't or you don't let yourself or ...</p> <p>J: I don't – I don't and that's it. And I don't know why that is – unless its <u>self- protection</u>.</p> <p>R: Protection. So what are you protecting yourself from?</p> <p>J: Pain maybe.</p> <p>R: Pain – the pain of?</p> <p>J: The pain of <u>emotion of attachment</u>.</p> <p>R: Of not allowing yourself to</p>	<p><i>"Something hard" –she fears sounding hard, cold and emotionless.</i></p> <p><i>"Something to deal" with sounds as if the pregnancies were separate from the mother's experience – miscarriage is just dealt with not emotionally engaged with.</i></p> <p><i>An element of choice here?</i></p> <p><i>Here there is the idea of prioritising pain and the notion of self-protection.</i></p> <p><i>Does the "other" here refer to her stillbirth? Is Janet trying to protect me? Miscarriages are not as bad as stillbirths – is this what she means?</i></p> <p><i>The pain of emotional attachment is important – protects her from emotional attachment.</i></p> <p><i>Can you choose whether you allow yourself to feel pain? Or detach yourself from pain?</i></p> <p><i>The idea is just occurring to her</i></p>

<p>The pain of attachment to unborn children</p>	<p>attach...</p> <p>J: To 3 dead children.</p> <p>R: Dead children.</p> <p>J: If I looked at those 2 – if I looked at the miscarriages as children I'd had <u>3 dead children</u>.</p> <p>R: And that's too painful to contemplate?</p> <p>J: To even think about...</p> <p>R: So you don't...</p> <p>J See them as that.</p> <p>R: You don't let yourself see them as that?</p> <p>J: No</p> <p>R: Or do you really genuinely believe...</p>	<p>that she has had three dead children! This is too painful to think about.</p> <p>Is this the idea she is protecting herself from?</p> <p><i>Do we have a choice about how we view an experience?</i></p>
<p>Some things are too painful to think about</p>	<p>R: And that's too painful to contemplate?</p> <p>J: To even think about...</p> <p>R: So you don't...</p> <p>J See them as that.</p> <p>R: You don't let yourself see them as that?</p> <p>J: No</p> <p>R: Or do you really genuinely believe...</p>	<p>"Entered me" – what does this mean? Important!</p> <p>(The word "Pain" is used 7 times on this page)</p>
<p>Miscarriages are not about losing babies</p>	<p>J: I think if I'm honest – it's not that I don't let myself because it just doesn't even enter – until we've just talked about it- <u>it's never really entered me</u> - entered my head and I think it is about that. I can't see myself as having had. It's strange because I can see myself as having <u>had 6 pregnancies</u>.</p>	<p>She can't see herself as having lost 3 children but can see herself as having 6 pregnancies.</p>

APPENDIX C

Participant Information Sheet

Participant Information Sheet

Study Title

Women's perceptions of their experience of miscarriage decades after the event: an interpretative phenomenological analysis.

Aims of the Research

The aim of this study is to use Interpretative Phenomenological Analysis (IPA) to explore women's perceptions of their experience of miscarriage decades after the event. I.P.A. is a research approach that explores how people make sense of significant life experiences. During my research I aim to interview in depth six to eight women about their experience of miscarriage and explore their accounts in order to try to reveal how women think and feel as they work through what it means to have a miscarriage. I will do this by looking at the transcripts and trying to find themes within them. I hope my study may help a little in promoting understanding of miscarriage and that it will contribute to the debate over how women manage their complex feelings about miscarriage even many years afterwards.

Invitation

You are being invited to consider taking part in a research study exploring women's perception of miscarriage many years after the event. Lois de Cruz, who is a PhD student at Keele University, is undertaking this project.

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with friends and relatives if you wish. Ask if there is anything unclear or if you would like more information.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign two consent forms, one is for you to keep and the other is for my records. You are free to withdraw from this study at any time up to the date of submission and without giving a reason.

What will happen if I take part?

If you agree to take part I will arrange to meet with you to talk about your experience of miscarriage. I will ask you to describe your miscarriage and your feelings at the time it happened. We will then go on to talk about whether your feelings have changed over time and if there was a process that facilitated any change. Finally we will think about how you feel about your miscarriage now.

What do I have to do?

We will arrange to meet, probably at a private room in the Psychology Department at Keele University. I will then ask you some questions about your experience of

miscarriage and I will record the interview on my digital voice recorder. The interview will last about one hour. You will be able to stop the interview at any time.

What might be the benefits of taking part?

I am hoping that this research will give a deeper insight into how women cope after a miscarriage many years after the event and will therefore be helpful for counsellors and those working in the Health Service who deal with women who have experienced miscarriage. I hope my research will also make a contribution to a deeper understanding of how women process their feeling after miscarriage and to theories about loss and bereavement in general.

What if there is a problem?

If you feel you need more support or someone to talk to about the way you feel information is provided below.

The Miscarriage Association

(Provides support and information for those suffering from the effects of pregnancy loss).

Web Page: miscarriageassociation.org.uk

Email: info@miscarriageassociation.org.uk

Help line: 01924 200799 (Mon-Fri 9am –4pm)

BACP

(Provides information on counselling support).

Email: bacp.co.uk

If you have other concern about any aspect of this study, you should speak to me, Lois de Cruz, and I will do my best to answer your questions.

I can be contacted at the address and number below:

Lois de Cruz

School of Psychology

Dorothy Hodgkin Building

Keele University, Keele,

Staffs ST5 5BG

Telephone: 01782 733319

Email: l.m.de.cruz@ilcs.keele.ac.uk

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to Nicola Leighton who is the University's contact for complaints regarding research at the following address: -

Nicola Leighton

Research Governance Officer
Research & Enterprise Services
Dorothy Hodgkin Building
Keele University
ST5 5BG

How will information about me be used?

During your interview I will record your answers to my questions on my digital voice recorder. I will then transcribe the interview in to a file on my computer. I will then analyse it and look for themes. You will not be identified by name. Each respondent will be allocated a code or you can choose a name to be known by.

Who will have access to information about me?

I will store the raw data from your interview on a password-protected computer. I will not identify you by name. Only my supervisor (Dr Maggie Robson) and I will have access to this raw data. It will be destroyed once the research is completed and submitted to the exam board.

Contact for Further Information

Lois de Cruz
School of Psychology
Dorothy Hodgkin Building
Keele University, Keele,
Staffs ST5 5BG

Telephone: 01782 733319

Email: l.m.de.cruz@ilcs.keele.ac.uk

Dr Maggie Robson
School of Psychology
Dorothy Hodgkin Building
Keele University, Keele,
Staffs ST5 5BG

Telephone: 01782 733578

Email: m.a.robson@psy.keele.ac.uk

One copy of the Information Sheet to be retained by the participant.

APPENDIX D

Participant Consent Form

CONSENT FORM

Title of Project: Women's perception of their experience of miscarriage decades after the event.

Name of Principal Investigator: Lois de Cruz

Please tick box

- 1 I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- 2 I understand that my participation is voluntary and that I am free to withdraw at any time.
- 3 I agree to take part in this study.
- 4 I understand that data collected about me during this study will be anonymised before it is submitted for publication.
- 5 I agree to the interview being audio taped.
- 6 I agree to allow the data collected to be used for future research projects
- 7 I agree to be contacted about possible participation in future research projects.

Name of participant

Date

Signature

Researcher

Date

Signature

CONSENT FORM

(For use of quotes)

Title of Project: Women's perception of their experience of miscarriage decades after the event.

Name of Principal Investigator: Lois de Cruz

- | | Please tick box |
|--|--------------------------|
| 1 I am happy for any quotes to be used | <input type="checkbox"/> |
| 2 I don't want any quotes to be used | <input type="checkbox"/> |
| 3 I want to see any proposed quotes before making a decision | <input type="checkbox"/> |

Name of participant

Date

Signature

Researcher

Date

Signature

APPENDIX E

Letter of approval from the research ethics committee

Ethical Approval



K E E L E
UNIVERSITY

ACADEMIC SERVICES DIRECTORATE
RESEARCH SERVICES

18 January 2010

Ms Lois de Cruz
School of Psychology
Dorothy Hodgkin Building

Dear Lois

Re: 'Women's perceptions of their experience of miscarriage decades after the event.'

Thank you for submitting your revised project for review.

I am pleased to inform you that your project has been approved by the Ethics Review Panel.

Amendments to your project after a favourable ethical opinion has been given or if the fieldwork goes beyond the date stated in your application (October 2010) you must notify the Ethical Review Panel via Michele Dawson..

If you have any queries, please do not hesitate to contact Michele Dawson in writing to m.dawson@uso.keele.ac.uk

Yours sincerely

pp Dr Nicky Edelstyn
Chair – Ethics Review Panel.

cc RI Manager

APPENDIX F

List of conference papers based on my PhD thesis

List of conference papers based on my PhD thesis

April 2015: "Reaching for the moon": using reflexivity in my PhD Journey. Keele School of Psychology Research Forum

March 2015: "It's changed who I am and my life": the psychological impact of miscarriage. Key note lecture at 9th Annual Keele Conference

March 2014: "Reaching for the moon: my PhD Journey" Keele Qualitative Research Conference

March 2013: "Miscarriage and the emotional life" 7th Annual Keele Conference

May 2012: "Bracketing or embracing: reflections on the stance of the qualitative researcher" BACP Research Conference Edinburgh

March 2012: "Unseen and unheard: women's experience of miscarriage many years after the event" 6th Annual Keele Conference

March 2011: "Bracketing or Embracing: reflections on the stance of the qualitative researcher" 5th Annual Keele Counselling Conference

March 2010: "Up close and personal: the role of the bracketing interview in interpretative phenomenological analysis and its impact on the researcher." 4th Annual Keele Counselling Conference