

Women's narratives of miscarriage and their role in identity construction.

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NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

Abstract

Rationale and Aims: Literature surrounding miscarriage is broad in scope, yet existing research into women's narrative identity constructions following miscarriage is significantly under-explored. Few studies have utilised narrative methodology to gain insight into how women story their experience of miscarriage and how sense-making processes influence identity construction. Consequently, the complexities and nuances of these processes have not been adequately explored. The current study aimed to address these gaps and limitations to enrich understanding of how women construct their experience of miscarriage, and to offer recommendations for clinical psychology and broader healthcare practices.

Methods: This qualitative study utilised narrative inquiry to explore how six women between the ages of 25-50 who are involuntarily childless storied their lived experience of miscarriage. A cross-sectional design was employed using retrospective individual interviews. Interviews were audio-recorded, transcribed and analysed according to thematic, structural, interactional, performative and discursive aspects of storytelling.

Discussion: Summaries of individual accounts are presented, followed by collective storylines which represent stories of change, challenge, and growth. The ways in which participants appeared to draw on and resist wider social narratives are presented, which offers insight into the aspects of self that were invited forward and silenced.

Implications: This research produced new knowledge about how women construct experience of miscarriage. Important recommendations for clinical practice are offered, which has the potential to influence developments in NHS maternal mental health services across England, as well as to raise awareness and inspire action at the community and individual level.

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“I tell, therefore you are.”

Margaret Atwood, *The Handmaid's Tale*.

CHAPTER ONE

Introduction and Systematic Literature Review

1.1 Chapter Overview

This introductory chapter outlines the process behind my arrival at the research topic. The epistemological positions that have framed this research will be presented, including my use of language. Key concepts such as constructions of miscarriage, identity and narratives will be introduced. Relevant background literature will be outlined, followed by a systematic review of literature specific to miscarriage narratives. The current study will be positioned within research gaps, which will provide a rationale for its clinical relevance. Lastly, the research aims will be presented.

1.2 Arriving at the Research Topic

Research can be viewed as a tool through which to amplify voices, increase awareness and empower social change. Faced with this opportunity, I recognised the privileged position associated with becoming a researcher, albeit balanced with the responsibility to select a ‘worthy topic’ (Tracey, 2010). I felt drawn to the paradox of miscarriage – something that implicitly resides in collective knowledge whilst requiring united complicity in maintaining the silence that surrounds it. It is a word that hides in plain sight. I saw research as a way to counter this silence – a platform through which stories could be shared; “stories become tellable and available when there is someone to listen, and when others amplify and make space for the story in a given cultural context” (Wells, 2011, p. 32). Being vocal and sharing stories is in itself an act of protest against a world that refuses to speak openly about miscarriage (Tommy’s, 2021). Thus, it was hoped that this research, and the stories at its centre, could pave the way for tangible change.

1.3 Locating the Research

This research is located in a UK context and is broadly concerned with how miscarriage, infertility and involuntary childlessness come to be understood, experienced and responded to within society. More specifically, it relates to how women make sense of lived experience of miscarriage and the role of this process in constructions of identities. As subsequent sections will outline, this research did not intend to seek cross-cultural comparisons or transcultural generalisations. To have attempted to do so would have been beyond the scope of the study and raised practical, ethical and epistemological challenges.

1.4 Epistemological Position: A Social Constructionist Lens

The way in which research has been appraised, utilised and conducted over time has been somewhat dictated by normative epistemologies of ‘knowledge’ (that is, ‘*what do we know, and how do we know it?*’). Western/European conceptualisations of knowledge are rooted in rationalism and empiricism movements, which gave rise to positivist frameworks that centre on reason, logic and objectivity as the cornerstones of enquiry (Ryan, 2006). Such philosophies create and normalise power dynamics through the establishment of ‘truth’ (White et al., 1990).

The epistemological lens of this project has been informed by social constructionism – a theory of knowledge underpinned by the co-creation of meaning through social processes (such as language), which form the basis for shared assumptions about reality (Burr, 2015). The theory aligns to the belief that knowledge is made, not found (Rorty & Richard, 1989) and emphasises the importance of situating knowledge in context. This stance juxtaposes dominant models of explanation, which (it claims) can only ever offer partial understandings of the world. Social constructionism invites ‘rethinking thinking itself’ (Ndlovu-Gatsheni, 2018), thereby creating space to value multiple ways of knowing. This epistemological

decolonisation (Ndlovu-Gatsheni, 2018) can be said to increase access to knowledge production and consumption.

This epistemological orientation had several implications for the current study (Willig, 2012). Firstly, a social constructionist approach offered different insights to dominant medicalised constructions of miscarriage, which tend to neglect the phenomenological aspects of experience (McCreight, 2004). Secondly, conceptualising knowledge as co-constructed has consequences for researcher positionality. Traditional assumptions about the researcher's ability to achieve neutrality are replaced with a stance that places them in the research frame (Randall-James, 2018). Thirdly, social constructionism understands knowledge as embedded within power structures that determine what kinds of knowledge are accessible, legitimised and privileged. Power dynamics are inevitably present within research contexts; researchers have power to influence what/how others know by the ways they approach the creation of knowledge (Willig, 2012). Therefore, the need to attend to the role of researcher and power dynamics between 'researcher' and 'researched' was required.

1.4.1 Feminist Narrative Theory

Further to a social constructionist stance, feminist narrative theory as defined by Herman et al. (2012) was considered an important position from which to approach this study. It is important to distinguish this lens from branches of radical feminist discourse (e.g. Trans-exclusive Radical Feminism), which are not accepted or drawn upon by this research.

Feminist research and epistemologies map onto a continuum of approaches (Maruska, 2010), though are often associated with post-structural, critical and social constructionist positions (Gannon & Davies, 2007). Such epistemologies can be said to critique systems of thought that centre on grand narratives in an attempt to generalize human experience (Barker, 2016).

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Knowledge is therefore understood as partial, contextual, and contingent on systems of power.

Feminist research, like many other forms of research, is concerned with social structure, inequality and social change (Roberts, 2013). This approach has implications for the way research is conducted, as identified by Roberts (2013) (see also Chase, 1992). Firstly, it resembles a commitment to the visibility of minority/underrepresented groups within social research. Secondly, it invites deconstruction of gendered experience (and its relationship to social reality). Lastly, it centralises the experience and enactment of power and powerlessness in the research process. According to Lloyd (1994 in Dwyer & Buckle, 2009), this means not intentionally drawing boundaries between researcher and researched.

The feminist movement has been criticised for its noticeable absence on the issue of miscarriage (see Letherby, 2002), which has been argued to contribute to the ‘cultural denial’ of pregnancy loss (Layne, 1997). Parsons (2010) suggested that this is due to the challenges associated with assigning personhood to ‘the beings lost in miscarriage’ and the perception that this may solidify anti-choice politics, which relies heavily on the presence of foetal/embryonic personhood. Feminists have ‘studiously avoided’ anything that might imply such a presence, as if acknowledging that there was something of value lost, that a miscarriage is worth grieving, that this would create tensions for the debate (Layne, 1997). Miller (2015) warned against the risks of not joining the conversation on miscarriage, stating that “it is essential that academic and public discussions of miscarriage include a wide variety of voices and perspectives, especially those most likely to represent women’s interests” (p. 142).

Situating the current study within socio-political spheres was considered necessary, particularly when drawing on powerful cultural master narratives and discourses that inform

the narrative environment (Gubrium & Holstein, 2009). It is important to consider how anti-choice rhetoric might influence and contextualise individual constructions of pregnancy loss. Furthermore, Eurocentric attitudes towards women, fertility and miscarriage are inherently related to “patriarchal dimensions of biochemistry and of Judeo-Christian traditions” (Layne, 1997, p. 301). Therefore, the ways in which religious narratives and dominant power structures (including institutions and practices of medicine) may shape bodily experiences also deserve consideration (see Osmond & Thorne, 2009; Hardy & Kukla, 2015; Carolan & Wright, 2017).

1.5 Use of Language

According to a social constructionist perspective, language does not describe the world in a neutral way (Burr, 2015). Rather, it is a tool through which our interactions with the world are filtered, understood and communicated. Thus, the language available to us plays a crucial role in how we construct experience in a particular context.

Critical engagement with language has been central to the research process. Western constructions of miscarriage have tended to reside within medical frameworks, which has had implications for the development of language (see Hutchon, 1998) and relates to the ‘scientisation of death’ in modern society (Frost et al., 2007). The term ‘miscarriage’ has been argued to locate blame within the person carrying the pregnancy, and thus has consequences for the moral meaning of miscarriage (Miller, 2015). Medical terms such as ‘spontaneous abortion’ are argued to be confusing due to connotations with planned termination (McCreight, 2008). Similarly, ‘pregnancy loss’ has received online criticism for conveying a sense of insignificant carelessness akin to losing one’s keys.

Despite these valid contentions, the terms ‘miscarriage’ and ‘pregnancy loss’ have been used throughout the study, in line with existing literature and participants’ preferences. Medical

terminology of ‘foetus’, ‘spontaneous abortion’, ‘product of conception’, etc. has been eschewed where possible. It was not considered appropriate to conceptualise all participants as ‘mothers’ or their loss as the loss of a ‘baby’ (as in McCreight, 2004) because not all participants constructed their identity or their loss in this way.

The intrinsic relationship between language, discourse and power (Wells, 2011) was held in mind throughout the study. In line with the epistemological positions, the research will be presented in first and third person in order to account for my presence in the co-construction and re-presentation of stories (as well as the overall research narrative) (Randall-James, 2018).

1.6 Setting the Scene: Introducing Key Concepts

1.6.1 Medically-situated Constructions of Miscarriage

Definitions and Diagnosis

Miscarriage is typically understood as the natural death of a baby, embryo or foetus during pregnancy (Miscarriage Association, 2020). However, discrepancy between cultures and healthcare systems can be observed. The World Health Organisation (2017) defines miscarriage as a loss or death in the first 28 weeks gestation (with a loss on or after 28 weeks defined as a stillbirth), whereas in the UK these parameters shift to 24 weeks (NHS, 2018b). The loss of three or more consecutive pregnancies is defined as recurrent miscarriage (Stirrat, 1990; Royal College of Obstetricians and Gynaecologists, 2011). Appendix A presents a more extensive glossary of terms.

Individuals who are experiencing signs of miscarriage can be referred to Early Pregnancy Units or maternity services at hospital (NHS, 2018b). According to clinical guidelines (NICE, 2019), miscarriage is typically diagnosed using an ultrasound scan, though one scan cannot

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always guarantee a correct diagnosis (particularly at early gestation). Follow-up checks such as further scans and monitoring hCG levels¹ are advised until a definitive diagnosis is obtained (NHS, 2018b; NICE, 2019).

Prevalence and Aetiology

It is widely acknowledged that miscarriage is the most common complication of early pregnancy (National Collaborating Centre for Women's and Children's Health UK, 2012). An estimated thirty to forty percent of all conceptions end in miscarriage (Hurt et al., 2012). Or, one in four confirmed pregnancies (Miscarriage Association, 2020). Approximately eighty percent of miscarriages are thought to occur in the first trimester (Hurt et al., 2012; ACOG, 2015).

The cause of miscarriage is not usually identified (NHS, 2018b). Risk factors are thought to include: chromosomal abnormalities, exposure to toxins, extremes in age, extremes in weight, physical health difficulties/diseases, lifestyle factors, previous miscarriages, ethnicity, and problems with the sperm, placenta, cervix or uterus (Garrido-Gimenez & Alijotas-Reig, 2015; BMJ, 2021; Lancet, 2021). Risk is believed to increase in older parents, particularly when maternal age surpasses thirty-five and paternal age surpasses forty (Royal College of Obstetricians and Gynaecologists, 2011; ACOG, 2015).

Physical Signs and Symptoms

The most common physical sign that someone is having a miscarriage is vaginal bleeding, which can be extensive and painful, and last days or even weeks depending on chosen treatment (NHS, 2018b). Vaginal bleeding does not always mean that a miscarriage will

¹ Human chorionic gonadotropin (hCG) is a hormone normally produced by the placenta and can be detected in urine or via blood tests during pregnancy.

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occur; whilst risk of miscarriage is increased, there is still a high chance of the pregnancy continuing (Sotiriadis et al., 2004). Other symptoms might include: cramping in the lower abdomen and lower back pain (which can range from mild to severe); rhythmic contractions; the expulsion of coloured mucus; tissue clots; and lack of foetal movement (Van den Akker, 2011; NHS, 2018b). Some people do not experience any symptoms. The first sign that something has ‘gone wrong’ is often communicated at the first scan (McCreight, 2008).

Prognosis and Interventions

There is no way to stop most miscarriages once they have started (NHS, 2018b). In the case of ‘threatened miscarriage’, bed rest is routinely recommended. Approximately one third of people are prescribed drugs such as progestogens (though a high proportion of GPs do not believe pharmaceutical treatments affect outcome) (Sotiriadis et al., 2004). When a miscarriage is ‘inevitable’, several options of treatment are available, depending upon factors such as the stage of the miscarriage (Bourne & Bottomley, 2012), risk of infection (Lancet, 2021), and emotional needs (Smith et al., 2006). These are outlined in Table 1 (NICE 2019; NHS, 2018b).

Once miscarriage is ‘complete’, individuals are not typically seen for follow-ups. In the case of recurrent miscarriage, hospitals might perform additional testing and refer individuals to specialist clinics for further investigations (NHS, 2018b).

Table 1. *Treatment Options*

Expectant Management	Otherwise called observation or ‘watchful waiting’. It is typically selected by individuals who require little to no medical intervention. The uterus will pass tissue naturally, which can take up to 4 weeks.
Medical Management	Medication stimulates the uterus to pass the pregnancy tissue, and usually works over several days.
Surgical Management	A surgical procedure called dilation and curettage (‘D&C’). The cervix is dilated and an instrument inserted that uses suction and/or a gentle scraping motion to remove the pregnancy tissue from the uterus. D&C is recommended for people who do not want to wait for spontaneous passage of the pregnancy and for those with heavy bleeding or risk of infection.

Psychosocial Impacts

Like all ‘illness experiences’, pregnancy loss is “...a social experience that goes beyond physiology” (Corbet-Owen & Kruger, 2001, p. 412). Van den Akker (2011) suggests that the psychosocial effects of miscarriage can be more severe and longer-lasting than physical effects. However, responses to miscarriage are varied and idiosyncratic. Miscarriage may not necessarily be associated with negative impacts (Corbet-Owen & Kruger, 2001; Lotay, 2018).

Psychosocial and mental health implications (in particular, depression and anxiety) following miscarriage are well-documented in the literature (DeFrain et al., 1996; Lee, Slade & Lygo, 1996; Cumming et al., 2007; Adolfsson, 2011; Meaney et al., 2017). Mental/relational wellbeing in subsequent pregnancies can be impacted, particularly in the case of recurrent

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miscarriage (Serrano & Lima, 2006; Bailey et al., 2019). Research also suggests that the grief and distress following miscarriage can interrupt parent-child attachments, parenting behaviours, and romantic relationships (Klier et al., 2002). Feelings of isolation, separation, and withdrawal of social support are also commonly reported (McCreight, 2008). Factors that are said to increase vulnerability to significant psychological distress following miscarriage include previous history of mental health issues, recurrent miscarriage and lack of social support (Van den Akker, 2011).

Psychosocial Support Following Miscarriage

In the first instance, NHS services signpost to third-sector organisations, which offer a range of support including information, support groups and counselling (NHS, 2018b). Healthcare professionals are also advised to encourage individuals to accept support from family and friends (NICE, 2020). Individuals are not typically able to access psychological support via the NHS unless they have received a diagnosis of Post-Traumatic Stress Disorder associated with miscarriage. In such cases, clinical guidelines recommend trauma-focussed Cognitive Behavioural Therapy or eye movement desensitisation and reprocessing (EMDR) Therapy (NICE, 2020).

1.6.2 Identity

This study assumed a relational definition of identity, that is, as co-constructed and continuously negotiated through social processes (McAdams, 1985; Lindemann, 2016). Conceptualising identity as relationally-constructed and role-based (Horstman et al., 2020) creates space for its complexity and multiplicity. Rather than understanding identity as fixed, intrinsic aspects of self, it can be viewed as fluid, contextual and multifaceted. This aligns with the social constructionist position that there is no single truth about who we are; we can

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tell multiple stories about ourselves rather than occupying one stable identity at all times (Barker, 2016).

An individual's 'social location' consists of their ascribed social identities (Goffman, 1959; 2009) (such as race, class, gender, sexual orientation and ability, etc.), and people operate within dominant social discourses about what these identities mean (Freedman & Combs, 1996). Identities have been defined by those with the power to speak for them (Lindemann & Nelson, 2001) and these cultural, ideological and normative processes shape and maintain systems of power/oppression that structure experience (Barker, 2016). Consequentially, cultural context and discourse provide a framework for, but can also limit, individual meaning and identity constructions.

The concept of intersectionality (Crenshaw, 1989) describes the complex interaction between social identities assigned to individuals/groups in a given context. Treating people as unified groups based on one characteristic over-simplifies the diversity of human experience by not taking into account how multiple identities interact with systems of power. Thus, caution was taken to avoid conceptualising 'woman' as a stable, coherent identity category (Butler, 2003). This invited a deconstructive, critical appraisal of essentialist notions of gender which, like any other social identity, is culturally constituted (Barker, 2016) and socially-negotiated (Butler, 2003).

1.6.3 Narratives

The way in which 'narratives' are defined, operationalised, and examined can vary depending on the cultural context and disciplinary framework (Reissman, 1993; Solomons, 2017).

Within the Western tradition, narratives can be thought of as a story or an account of events "...that have a valued end-point; that include events relevant to that endpoint; that incorporate events in a coherent order, typically in relation to a linear conception of time; and

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that provide a sense of explanation” (Wells, 2011, p. 5). Squire (2008) described how narratives ‘re-present’ experience in a way that is sequential, meaningful, and related to transformation or change.

Constructionist frameworks align to the notion that people are storytellers by nature (Willick, 2006). Narratives can be understood as a means for individuals to make sense of themselves and the world (Bamberg, 2011; 2016a), particularly as they attempt to reconcile ‘violations of normality’ into a coherent story (Wells, 2011). The telling of stories about ourselves and our lives can also be understood as an attempt to construct and present narrative identity (Bamberg, 2011) – that is, a sense of self, who we want to be, or how we want to be seen by others (Solomons, 2017). Narrative practices therefore offer insight into the identity work carried out by individuals (Bamberg, 2016b). This aligns to a broader conception of narrative as itself an event, a multidimensional purposive communication from a teller to an audience (Herman et al., 2012).

1.6.4 Normative Motherhood Identity

The transition to motherhood has attracted exploration from multiple disciplines including anthropology, sociology, and existential and cultural psychological perspectives (e.g. Bailey, 1999; Prinds et al., 2014; O'Reilly, 2014). Becoming a mother is widely perceived as a pivotal and paradoxical life transition – a potentially existentially changing event, a spiritual experience (Prinds et al., 2014). Aspects of identity can be transformed during the transition to motherhood, resulting in an altered sense of self, reorganisation of values, and shift in social roles (Bailey, 1999; Smith, 1999; Prinds et al., 2014). Research has suggested that women draw on available social discourse during this transition in order to maintain a coherent sense of self (Bailey, 1999). Consequently, socio-cultural ideologies surrounding

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constructions of both 'women' and 'motherhood' have been suggested to influence women's experiences of infertility (Wells & Heinsch, 2020).

Wells and Heinsch (2020, p.80) argued that, in contemporary pronatalist societies, motherhood and childbearing are constructed as inevitable fulfilments of the female identity (see also Letherby, 2002). Women's mothering has also been described as a central and defining feature of the social organisation of gender (Roberts, 1993). Roberts (1993) put forth that systems of racism and patriarchy interact in the social construction of motherhood (see also Fineman, 1991; Feldstein, 2018). 'Institutionalised motherhood' (Rich, 1976), by demanding of women maternal 'instinct', naturalises events such as pregnancy and birth, thereby upholding an 'enforced identity' (Roberts, 1993) and perpetuating normative assumptions about fertility trajectories and the transition to motherhood (see also Cabell et al., 2015). This could be argued to solidify perceptions of what is the normal and natural maternal experience (Calhoun et al., 1980; Katz-Wise et al., 2010; O'Reilly, 2014; Shloim et al., 2015), resulting in the stigmatisation of women who violate or deviate from these (feminine) 'ideals' (Roberts, 1993; Wells & Heinsch, 2020).

The literature has consistently suggested the need to expand narrow discourses on female fertility (Wells & Heinsch, 2020) by disrupting normative maternal patterns, normalising an acceptance of multiple mothering roles and identities, and welcoming additional/alternative meanings associated with motherhood (Abbey & O'Reilly, 1988). Some recent efforts have been made to explore ways of mothering that question the normalcy of Euro-Western ideals. For example, O'Reilly (2014) explored adoptive mothers, aboriginal mothering, disabled mothers, refugee mothers, migrant mothers, older mothers, young mothers, mothering in poverty, queer mothering, single mothers, stay-at-home mothers, working mothers, step mothers, and rural mothers, amongst others. Despite such efforts, however, society's 'gender

conservatism' (Feldstein, 2018) and prevalent construction of 'mother' (including what constitutes a good mother and a bad mother) continues to facilitate control of all women (Roberts, 1993). Feldstein (2018) described a widespread assumption within liberalism that social problems – ranging from unemployment to racial prejudice – could be traced back to bad mothering. Social discourse can, therefore, be said to encourage women to be in constant pursuit of a closer proximity to the myth of the perfect mother (Abbey & O'Reilly, 1998).

Women who fail to meet these ideals of motherhood – for example, 'unfit mothers', 'illegitimate mothers', and women who do not become mothers – continue to face stigmatisation and are considered deviant or criminals (Roberts, 1993). Thus, childlessness (voluntary or involuntary), in its violation of the motherhood narrative, can often be positioned as a (deliberate) resistance in the face of strong social norms (Cabell et al., 2015). Furthermore, the medicalisation of infertility as a 'female biological fault' can also be argued to reinforce socio-cultural discourse surrounding 'deviant' women, as well as influence women's experience and internalised narrative of infertility (Wells & Heinsch, 2020). So, miscarriage and infertility can be understood to rupture the expected transition to motherhood, the 'natural progression of life' (Horstman et al., 2020) and also disrupt culturally-constituted, normative motherhood identities (Cabell et al., 2015).

1.7 Background Literature

Figure 1 outlines certain patterns in miscarriage-related research over time, which provides a backdrop to the current study. Focal areas for earlier research related to highlighting gaps in knowledge and situating miscarriage research within socio-political perspectives (Reinharz, 1988; Layne, 1997; Cosgrove, 2004). The decades that followed saw a rapid increase in research, characterised by broader exploration of reproductive wellbeing, unmet needs in women's health (Cecil, 1994b; Allen & Sesti, 2018; Mann & Stephenson, 2018), as well as

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areas such as grief, mental health and psychosocial aspects. An overview of background literature relevant to the current study is presented below.

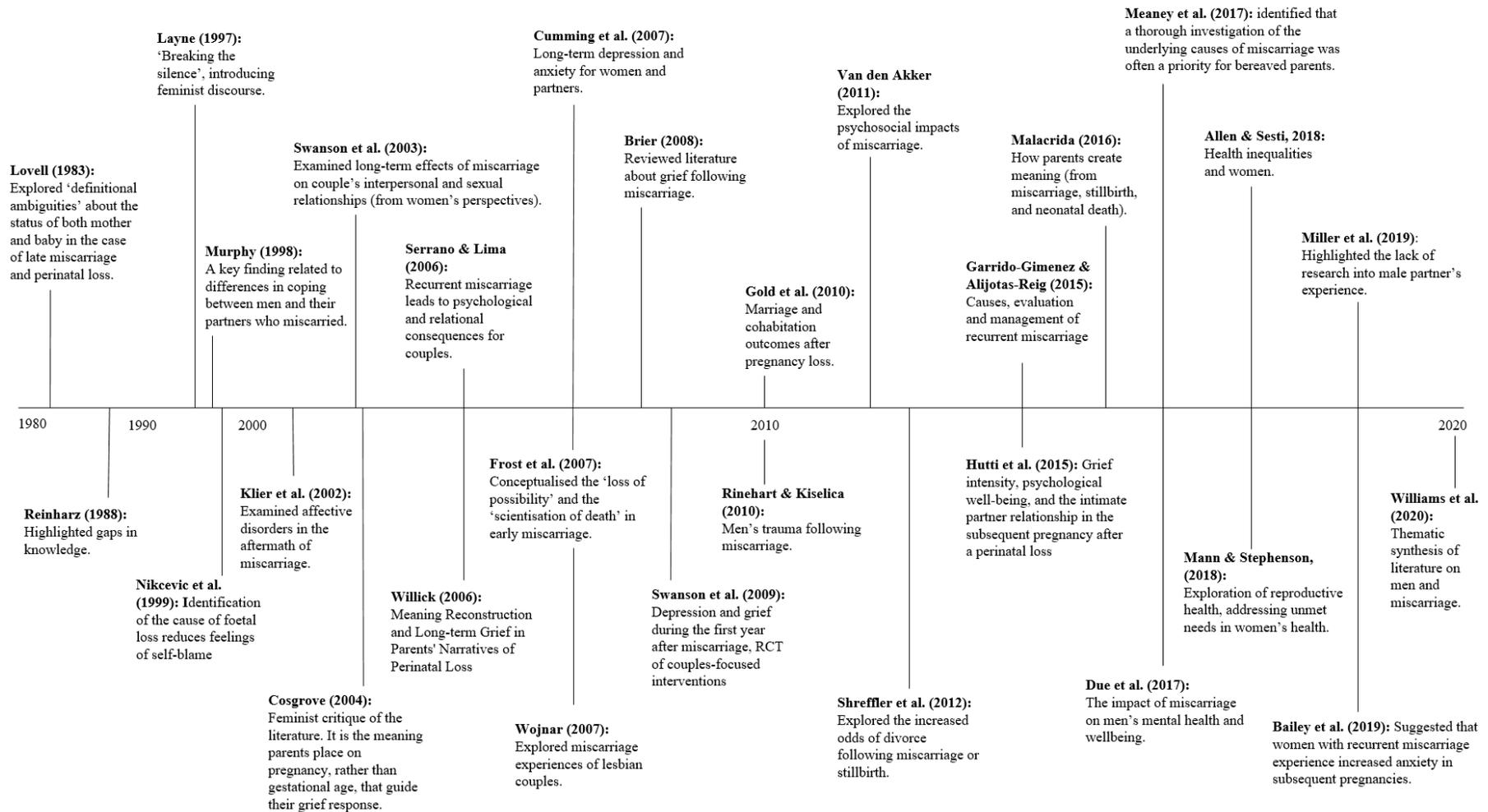
A significant proportion of existing literature relates to grief and bereavement following pregnancy loss. Sociological research conceptualised miscarriage as the loss of possibility (Frost et al., 2007) or a “prospective and symbolic loss” (Brier, 2008, p. 451). Studies have suggested that the denial and silence surrounding death in modern Western culture has resulted in fear, shame, decreased public support and lack of internal grief scripts in relation to miscarriage, which is not recognised as a ‘social loss’ (Malacrida, 2016).

Frost et al. (2007) considered the strategies employed by women to make sense of miscarriage. The authors suggested that the absence of cultural scripts in relation to pregnancy loss leads to women giving meaning to their loss as ‘what might have been’. They reported that some women constructed narratives of blame in relation to modern medicine failing to prevent the loss or provide credible explanation, whereas others appeared to internalise blame (Frost et al., 2007). Some studies have considered the role of self-blame and guilt in exacerbating grief responses and mental health implications (e.g. Nikcevic et al., 1999).

As suggested in Figure 1, the 2000s saw an increase in relational/couple-oriented research (see also Horstman & Holman, 2018; Holman & Horstman, 2019). (Male) partner’s experience of miscarriage also gained tract (e.g. Murphy, 1998; Rinehart & Kiselica, 2010; Williams et al, 2020). For instance, Miller et al.’s (2019) Australian-based study conducted qualitative interviews with men whose partners had miscarried. Participants reported feelings of devastation, powerlessness, fear and shock. Perceived loss of identity was also commonly reported (though not sufficiently explored); participants described a primarily supportive role following miscarriage and felt reluctant to burden their partner with their grief. This was

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Figure 1. *Timeline outlining trends in miscarriage research.*



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partnered with a perceived lack of support from healthcare providers and social networks.

What appears to be missing from this research area is exploration of the impact of miscarriage on non-heterosexual couples and wider family, with a few exceptions (Day & Hooks, 1987; Cecil, 1994a; Thomas, 1995; Wojnar & Swanson, 2006; Wojnar, 2007; Fein et al., 2019). It has been argued that this ‘pervasive heteronormativity’ doubly marginalizes the experience of same-sex couples (Peel & Cain, 2012).

Whilst exploration of narrative construction, meaning-making and identity change following miscarriage are implicitly present in the research-base, studies directly exploring these areas are scarce. A relatively small body of literature has examined narratives and/or identity constructions related to miscarriage (e.g. Letherby, 1993). Willick (2006) adopted a narrative approach to understand the processes of meaning reconstruction and ‘self-changes’ stemming from grief following perinatal loss². She identified that meaning-making strategies were influenced by the ‘medical establishment’ and social networks, which either served to disenfranchise parents’ losses or comfort them in their grief (Willick, 2006). Parents reported both positive and negative ‘self-changes’ that occurred through the grief process. This built upon earlier studies such as Frost and Condon (1996), who argued that miscarriage can lead to a perceived loss of part of self, which has a negative impact on personal identity.

Hardy and Kukla (2015) investigated how engaging with online communities shapes narrative identity for many women. In their mixed methods study, they suggested that women often constructed multiple narrative identities simultaneously that are fore-fronted in different contexts, some of which may be relatively stable and others that might be more ‘fleeting or strategic’ (Hardy & Kukla, 2015). The authors also drew on the idea that ‘medical meanings’ mediate bodily experience and impose narrative structure on embodied lives (Hardy & Kukla,

² Definitions can vary but perinatal loss tends to refer to the period from 22 weeks gestation to 1 week after birth.

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2015). This is consistent with earlier research (Lovell, 1983), which suggested identity construction and meaning-making are influenced by the ways that hospitals deal with and define the loss. Lovell (1983) claimed that both roles of ‘patient’ and ‘mother’ are lost simultaneously following pregnancy loss, and this was linked to a lack of physical or psychological space for a maternity case without a baby.

Miller (2000) claimed that the ‘event’ of childbirth, and the associated process of women becoming mothers, are publicly defined. She described the ‘medicalisation of childbearing’ whereby a natural event is situated within a pathological illness model, which has repercussions for the ways in which women experience and make sense of miscarriage (Miller, 2000). Lay narratives that surround this period of transition influence individual biographies and lead to the construction of counter narratives (Miller, 2000).

Research from non-Western or European contexts also offers valuable insight into meanings attributed to miscarriage. In her South African-based study, Watson (2006) examined the integration of a woman’s femininity and sense of self with biological reproduction – her role and/or ability to bear children. She deconstructed implicit cultural assumptions that link a woman’s ‘value’ with her ability to ‘bear fruit’ (Watson, 2006). Leith (2009) raised similar themes in relation to Western discourse. Watson’s (2006) study is consistent with Reinharz (1988 in Malcrida, 2016, p. 3), who suggested that miscarriage can be considered “...a symbol of failed maternal virtue, of failed womanhood, and as a test of character”. The implication of these constructions is that women are held liable for pregnancy loss through their lack of virtue or inadequacy. Malcrida (2016) argued that such ‘miscarriage lore’ serves to restrict women’s actions and emotions. Pronatalist discourse, she argued, has led to the construct of motherhood and childbearing as a status passage whereby women become ‘real

women'. Hence, mothering represents one of the only ways in which women can access, and exercise, power (Grittins, 1993 in Malacrida, 2016).

Wembah-Rashid's (1996) study in Tanzania likened pregnancy loss to disease (parallels can be drawn to how miscarriage is situated within illness discourse in Western contexts – see Lampman & Dowling-Guyer, 1995). Personalistic and naturalistic causal beliefs were explored, and tied to cultural master narratives about good behaviour being rewarded by God. These constructions can be said to reinforce beliefs about a woman's actions or morality being responsible for pregnancy/loss (Wembah-Rashid, 1996). Similarly, Savage (1996) explored cultural narratives in Cameroon and suggested that women avoided excess physical work and abided by dietary restrictions in order to prevent foetal deformations and pregnancy loss.

In summary, miscarriage literature has followed certain trends in relation to research areas, some of which have been outlined here to contextualise the current study, relating to: grief and loss, mental wellbeing, relational factors, meaning-making, identity (re)construction and cultural narratives. The systematic literature review that follows explored literature relevant to the current research questions in more depth in order to further contextualise and situate this study.

1.8 Systematic Literature Review

1.8.1 Overview

This section details the process and findings of the systematic literature review in order to present a comprehensive synthesis of peer-reviewed research relevant to the current study. It begins by specifying the aims and scope of the literature review, followed by the search strategy employed. The method for identifying potential studies and the criteria for including

or excluding them from the review is also detailed. A summary of data extraction will be presented followed by a narrative synthesis of the analyses and conclusions. A quality evaluation of the included research will be summarised according to Tracey's (2010) criteria, alongside general considerations about the quality of the review. This section closes with critical reflections and gaps in the literature, which form the basis of the rationale for the current study.

1.8.2 Aims and Scope

This study aimed to explore women's narratives of miscarriage and their role in identity construction. The aim of the systematic literature review was to identify and synthesise relevant literature in order to respond to the following review question: *what is already known about how people story their experience of miscarriage?*

As described by Popay et al. (2006), an initial focus for the review was identified, followed by a 'mapping' of the available relevant literature, before a specific question for the review could be formulated. For example, literature focused specifically on women's narratives of miscarriage were too few, thus the question had to be broadened. Equally, limited studies had investigated narrative identity construction, and so this aspect was also removed from the review question. These re-formulations involved changes to the search strategy (such as eligibility criteria) accordingly. The scope of the resulting literature review facilitated a clear, narrow focus on relevant literature that could inform the study that followed.

The process of becoming better acquainted with the literature made apparent that certain terms (i.e. 'experience of miscarriage', 'narratives', 'meaning-making') had attracted a relatively substantive body of research and had been operationalised in various ways. The search strategy was therefore designed to maximise relevance of the studies included in the

review. Studies that were relevant to the study but that did not meet criteria for inclusion have been outlined in section 1.7.

1.8.3 Review Strategy

Search Tools

The search strategy was planned according to the review question and aims as well as key terms identified from the background literature. The SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, and Research type) (Cooke et al., 2012) was utilised to inform and standardise the search strategy (see Appendix B). This offered an alternative to more frequently applied tools as it is generally considered better adapted to searching for qualitative research (Methley et al., 2014).

Final search terms are outlined in Table 2 below. Initial searches (Appendix C) included terms related to ‘women’ and ‘identity’. As outlined above, these terms were omitted as the review question evolved. Some medical subject headings (MeSH) terms initially included (e.g. ‘spontaneous abortion’) were also later excluded due to eliciting high instances of unrelated literature pertaining to biomedical or abortion-related research.

Table 2. *Summary of final search terms*

Miscarriage	Miscarriage* OR “pregnancy loss*”
Narratives	Narrative* OR stor* OR meaning* OR sense* OR understanding OR belief OR accounts OR experience OR descriptions
Qualitative	Qualitative OR “qualitative research” OR “narrative analysis” OR “narrative inquiry”

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Boolean operators (i.e. AND, OR, and NOT) and truncation and wildcard symbols (i.e. * and ?) were utilised to operationalise terms and optimise searches by ensuring variations of terms were included.

Literature Search

The initial searches were conducted in July and October 2020 across four databases: PubMed, SCOPUS, Ovid and PsychInfo. These were selected primarily based on their clinical relevance to Psychology and/or the social sciences as opposed to biomedical literature, for example. The searches were supplemented by hand-searches on Google Scholar, citation searches of acquired texts, and from exploring the grey literature (e.g. unpublished theses and book chapters). A final search was conducted in April 2021 to ensure any developments since the initial search were incorporated.

Eligibility Criteria

Eligibility criteria (Table 3) were applied to search results and were largely based on SPIDER criteria and the review question/aims. Other parameters applied included language, publication status and date of publication. The decision to only include qualitative methodology was considered in line with the epistemological underpinnings of the project and also represented an interest in gaining rich insight into how people understand their experience. The decision to focus on research from the last twenty years was in line with a social constructionist epistemology, which recognises the importance of the cultural, historical and political context on the ‘narrative environment’ (Squire, 2008).

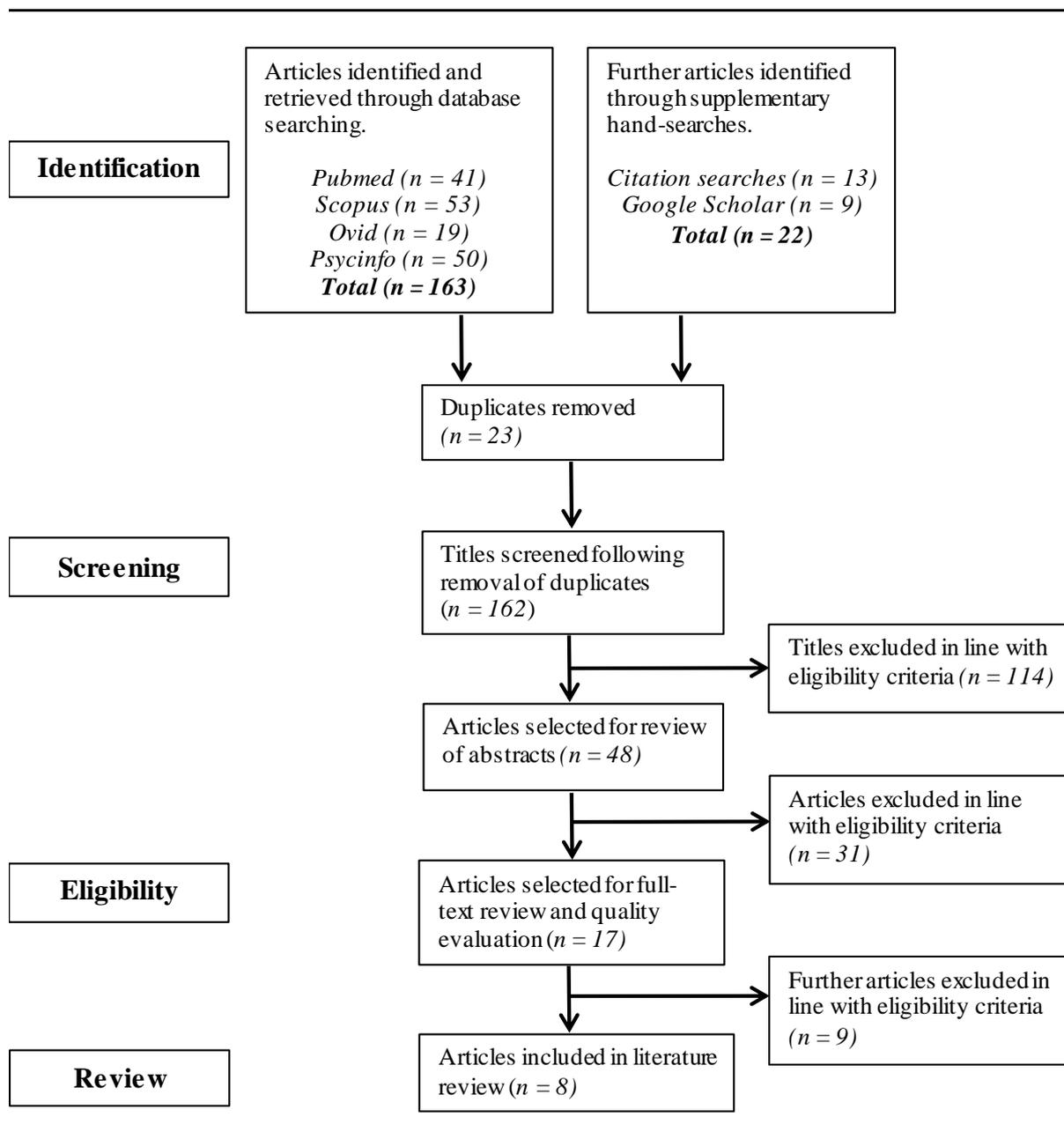
Table 3. Eligibility Criteria for Literature Review

Inclusion Criteria	Exclusion criteria
Available in English language (including translated papers)	Papers not available in English
Peer-reviewed research	Unpublished work or grey literature
Published between year 2000 – 2021	Papers published prior to the year 2000
Qualitative research methodology	Quantitative or mixed-methods methodology
Main focus on miscarriage (as opposed to other forms of pregnancy loss)	Sole focus on other forms of pregnancy loss (e.g. termination/abortion, stillbirth, ectopic pregnancy or neonatal loss)
Focus on narratives or meaning-making	Primary focus on descriptive experience rather than sense-making process
Abstract and full-text availability/access	Biomedical perspective
	Non-human subjects

Search results

In total, 185 papers were found. Duplicate results were excluded, following which 162 results remained. The results were subjected to a staged screening process based on eligibility criteria, comprised of title screening, abstract screening and lastly full-text review. No additional papers were included following the final search. The systematic review process and outcomes of each stage are detailed in Figure 1 below. Overall, eight papers were included in the review.

Figure 2. *The Systematic Literature Review Process (Moher et al., 2009)*



Data Collection

It is considered best practice to extract detailed contextual and methodological information for each study included in the review (Noyes et al., 2019). It is also important to organise and present information gathered through systematic reviews in a way that is comprehensive,

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methodical and replicable (Siddaway et al., 2019). Data extraction was guided by a tool suggested by Noyes et al. (2019) (Appendix D), which supported the collection of standardised information for each study relating to: context, design, methods used, sample and participants, key conclusions and research quality. The approach was able to accommodate different qualitative paradigms and methodologies.

Quality Assessment

Tracey's (2010) criteria for evaluating the quality of research was utilised to assess the papers included in the systematic literature review. The framework proposes eight key markers of quality in qualitative research: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence. Definitions of these criteria are summarised in Appendix E.

Tracey's (2010) framework was selected because it is specific to qualitative research and invested in promoting the quality and rigor of qualitative paradigms. It was also considered complimentary to the values/position of the current study, for example, promoting qualitative research to facilitate "...dialogue with power holders who might otherwise regard qualitative research as just a good story" (Tracey, 2010, p. 849). In comparison to other quality frameworks commonly used in qualitative research (e.g. Elliot et al., 1999), it is also relatively recent and therefore more likely to reflect up to date research practices and values, though there is some degree of overlap.

Although it is acknowledged that applying 'unvarying' criteria to qualitative research paradigms is potentially problematic (especially relating to a social constructionist lens), Tracy (2010) argued that critiquing these criteria whilst also finding them useful are not mutually exclusive. In line with critical and constructionist perspectives, Tracey (2010) proposed that researchers will inevitably fall short and deviate from best practice; rather than

engaging in efforts to disguise ‘research blemishes’, the key is to be transparent both with ourselves as researchers and with our readers.

Synthesis

According to Grant and Booth (2009), (qualitative) systematic literature reviews typically utilise narrative synthesis to present results. As described by Popay et al. (2006), narrative synthesis refers to an approach that primarily relies on words and text to tell the story of included studies. Analysis may present data using chronological, conceptual or thematic approaches (Grant & Booth, 2009).

Narrative synthesis was considered congruent with key assumptions and methods utilised in the current study. It was also considered most appropriate to maintain the integrity and richness of qualitative data. Guidance (Noyes et al., 2019; Siddaway et al., 2019) was drawn upon to support the process of synthesis. This was to ensure a systematic and transparent approach, and to minimise bias introduced by the included studies and decisions made by the reviewer (Popay et al., 2006).

1.8.4 Data Extraction

Data was extracted from the included studies and organised by the researcher. This information is presented in Table 4.

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Table 4. *Summary Table for Included Studies in the Literature Review*

Author/Title	Aims	Context & Participants	Method	Key Conclusions
<p>Rice (2000). <i>When the baby falls!: the cultural construction of miscarriage among Hmong women in Australia.</i></p>	<p>To explore traditional Hmong explanations about miscarriage.</p> <p>To examine the role of cultural beliefs and ethnomedical practices in response to miscarriage in Hmong society.</p>	<p>Recruitment: Australia-based, Hmong language, community centre and personal network.</p> <p>27 Hmong women who were refugees from Southeast Asia.</p> <p>Traditional healers (3 shamans, 2 medicine women and 1 magic man).</p>	<p>Qualitative methodology.</p> <p>Thematic analysis.</p> <p>Individual interviews and observation of shamanic rituals/ceremonies.</p>	<p>Two key themes:</p> <ol style="list-style-type: none"> 1. Natural explanations (women's body and behaviour). 2. Supernatural explanations (role of spirits).
<p>Corbet-Owen & Kruger (2001). <i>The Health System and Emotional Care: Validating the Many Meanings of Spontaneous Pregnancy Loss.</i></p>	<p>To examine how the meaning of pregnancy loss is co-constructed by patients and health professionals within the medical system.</p> <p>To determine the meaning pregnancy loss had for women.</p> <p>To determine emotional needs after loss.</p>	<p>Recruitment: South Africa-based, purposive sampling, Afrikaans and English languages.</p> <p>8 (heterosexual) women interviewed.</p> <p>3 lost pregnancies that were described as 'unwanted pregnancies'.</p>	<p>Qualitative methodology.</p> <p>Constructionist Grounded Theory.</p> <p>Open-ended interviews.</p> <p>Transcribed with use of translator.</p>	<p>Meaning of pregnancy (loss) varied according to familial and socio-economic systems and influenced emotional needs:</p> <ol style="list-style-type: none"> 1. Short-term emotional needs: validation of physical and emotional experience; collaboration and negotiation in decision-making; access to knowledge and information; sensitive and personal care. 2. Longer-term needs: the need for mourning, the need for creating memories and

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				remembering (or not), the need for hope, the need for connection, the search for meaning.
<p>Abboud & Liamputtong (2002). <i>Pregnancy loss: What it means to women who miscarry and their partners.</i></p>	<p>To examine the experiences of miscarriage of women and their partners.</p>	<p>Recruitment: Australia based. Six women aged 22-45 and their partners who had experienced between 1-7 miscarriages (time since miscarriage between <1 year and >1 year). Number of living children ranged from 0 – 3+. Participants identified as Lebanese, Syrian, Filipino, or Egyptian. All Christian.</p>	<p>Qualitative methodology. IPA. In-depth, semi-structured individual interviews.</p>	<p>Six themes identified:</p> <ol style="list-style-type: none"> 1. Shock and Surprise: The News of Pregnancy and Miscarriage 2. Physical and Emotional Experiences of Pregnancy Loss 3. Why me? The blame 4. Communication between couples 5. Making memories 6. Post miscarriage – what happened?
<p>McCreight (2004). <i>A grief ignored: narratives of pregnancy loss from a male perspective.</i></p>	<p>To describe the experiences of men whose partner had experienced pregnancy loss.</p> <p>To examine medical attitudes towards bereaved fathers.</p>	<p>Recruitment: Northern Ireland based, self-help groups and 10 hospitals. 14 males aged 21-43, Irish, heterosexual (time since miscarriage 2 months – 20 years). 32 nurses and midwives.</p>	<p>Qualitative methodology. Narrative approach. In-depth interviews, observation, field notes. Content/thematic analysis of narrative data using NVivo.</p>	<p>Three key themes:</p> <ol style="list-style-type: none"> 1. Self-blame 2. Loss of identity 3. The need to appear strong and hide feelings of grief and anger

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<p>McCreight (2008). <i>Perinatal loss: a qualitative study in Northern Ireland.</i></p>	<p>To describe experiences of women who have experienced miscarriage or stillbirth.</p> <p>To explore how women emotionally reasoned to loss.</p> <p>To examine care received from medical staff.</p>	<p>Recruitment: Northern Ireland based, self-selected from 6 pregnancy loss self-help groups. 23 women (aged 19-60). 8 experienced stillbirth, 6 experienced miscarriage, 8 experienced both stillbirth and miscarriage. Two had children, 1 was pregnant at time of interview.</p>	<p>Qualitative methodology. Narrative approach. In-depth interviews, observations and field notes. Triangulation. Content analysis to identify themes.</p>	<p>Three key themes explored:</p> <ol style="list-style-type: none"> 1. Emotional responses to pregnancy loss (such as grief, denial, anger and self-blame) 2. The medicalisation of perinatal grief 3. Burial arrangements
<p>Carolan & Wright (2017). <i>Miscarriage at advanced maternal age and the search for meaning.</i></p>	<p>“To recognize the miscarriage experience as a significant event for women over 35 years of age and to allow women who have had this experience to provide insight into how this loss was experienced and interpreted.”</p>	<p>Recruitment: USA based. 10 women aged 35 years and older (ranged from 35-47 years) who had experienced miscarriage in last 2 years. Ethnicity – 9 Caucasian and 1 Mexican-American. All were heterosexual and married (average length 10 years).</p>	<p>Qualitative methodology. Ambiguous loss and feminist ecological frameworks. In-depth interviews. IPA analysis.</p>	<p>Two key themes (and subthemes):</p> <ol style="list-style-type: none"> 1. The experience of holistically grieving what was once there (challenges of the body; feelings of grief; previous losses; seeking support, gendered differences). 2. The experience of searching for meaning (unexpected and shocking; meaning of pregnancy, motherhood and miscarriage; loss of mother-to-be status; relationships with others).

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<p>Littlemore & Turner (2020). <i>Metaphors in communication about pregnancy loss.</i></p>	<p>“To explore the ways in which metaphor is used to describe the experience of [pregnancy] loss, its effects on people’s conceptions of themselves and their bodies, and the implications this has for recovery”.</p>	<p>Recruitment: based in England, 3 UK-based pregnancy loss charities. Interviewed 35 people in total: 16 individuals who work for pregnancy loss charities; women who had experienced stillbirth (9), miscarriage (11) and termination following diagnosis of foetal abnormality (11); 3 male partners and 1 friend.</p>	<p>Qualitative methodology. Semi-structured interviews. Metaphor analysis using Metaphor identification Procedure (MIP). NVivo to support with themes/categories.</p>	<p>4 key themes organised metaphor categories:</p> <ol style="list-style-type: none"> 1. Embodied experience 2. Relationships with the body 3. Experiencing a different reality 4. Recovery
<p>Horstman, Holmanb & McBrideb (2020). <i>Men’s Use of Metaphors to Make Sense of Their Spouse’s Miscarriage: Expanding the Communicated Sense-Making Model.</i></p>	<p>To understand how male partners use metaphor to ‘make sense’ of miscarriage.</p>	<p>Recruitment: USA-based. 45 cis-gender men (aged 26-55) in heterosexual marriages. Ethnicity – 40 White, 1 Hispanic, 1 African American, 1 Asian, 1 Indian.</p>	<p>Qualitative methodology. Thematic Analysis. Semi-structured interviews. Triangulation and member checking.</p>	<p>Two broad supra-themes identified:</p> <ol style="list-style-type: none"> 1. Metaphors of miscarriage 2. Metaphors of husbands’ role in pregnancy loss

1.8.5 Review Synthesis

The systematic literature review aimed to respond to the review question: *what is already known about how people story their experience of miscarriage?* Eight papers were included in the review, as summarised in Table 4. The studies explored narratives and sense-making from multiple perspectives including women, men, couples, healthcare professionals and cultural. The studies are synthesised below according to these perspectives, so as to investigate “...similarities and differences between the findings of different studies as well as exploration of patterns in the data” (Consumers & Ryan, 2020, p.2).

Women’s Perspectives

Five studies explored miscarriage narratives from women’s perspectives (Rice, 2000; Corbett-Owen & Kruger, 2001; McCreight, 2008; Carolan & Wright, 2017; Littlemore & Turner, 2020).

Rice (2000) interviewed women belonging to the Hmong community in Australia to provide insight into the narratives of immigrant women living in Western societies. She suggested that explanations of the cause of miscarriage in Hong culture could be categorised into the natural and supernatural world. The natural world relates to a woman’s body and behaviour including illness and strenuous physical activity, which is strictly prohibited and thought to distress or ‘disconnect’ the baby. It is believed that this would cause the baby to stop growing and ‘fall out’. Supernatural constructions of miscarriage centre on being ‘struck by spirits’. This can occur by chance/carelessness (e.g. bumping into spirits) or as punishment (e.g. offending spirits). Behaviours that are believed to anger spirits include crossing or washing in the river whilst menstruating.

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Rice (2000) suggested that “the supernatural world acts as a social control agent to control the woman’s body and behaviours” (p. 100). However, none of the participants had personal experience of miscarriage. Whilst it is important to gain insight into how women draw on social discourse to understand pregnancy loss, this represents a significant limitation to the study. As such, the study should be valued with a critical and cautious lens.

Similarly to Rice (2000), Corbet-Owen and Kruger (2001) explored women’s constructions, though they aimed to focus on how meaning is co-constructed between patients and healthcare professionals (henceforth HCPs). The authors suggested that HCPs influence how women experience pregnancy loss, but operate according to professional/cultural assumptions about how women *should* respond, which can lead to a failure to provide appropriate emotional care. Corbet-Owen and Kruger (2001) highlighted the importance of understanding how individuals negotiate the meaning of their loss within their social systems, in order to better comprehend their experience and emotional needs.

In presenting their findings, Corbet-Owen and Kruger (2001) categorised participants (perhaps crudely) according to those who described their pregnancy as wanted and not wanted. Pregnancies described as wanted were said to be highlighted by ‘metaphors and intensifiers’, and associated with normative values/status (e.g. being a successful person or a dutiful partner). The authors critically drew on essentialist notions of femininity, through which constructions of ‘womanhood’ and ‘motherhood’ are enmeshed and naturalised. They suggested that, if pregnancy is tied to what is natural and normal, powerful and dutiful, it can be expected that pregnancy loss may be associated with feeling defective, abnormal, weak or inadequate (Corbet-Owen and Kruger, 2001, p. 416). Participants described feelings of marginalisation, failure and guilt, which had left them feeling disconnected, empty, and alone.

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For pregnancies described as unwanted, women spoke to feelings of uncertainty and ambivalence relating to pregnancy, though Corbet-Owen and Kruger (2001) reflected that these participants seemed more reluctant to talk about the meaning of pregnancy loss. This was suggested to indicate decreased significance attached to the loss, or attributed to the perceived social taboo around feelings of ambivalence, relief or happiness when a loss occurs.

Regardless of the meanings attached to the pregnancy, participants reported similar needs following the loss (including the need for validation, sensitive care, and the search for meaning). Corbet-Owen and Kruger (2001) briefly explored the role of medical professionals in meeting these needs, though perhaps fell short of exploring their role in meaning co-construction as initially stated. The study also operationalised a broader definition of 'pregnancy loss' to incorporate miscarriage and stillbirth. Despite these limitations, Corbet-Owen and Kruger (2001) challenged hegemonic social discourses (reflected to some extent in the literature-base) that expect pregnancy loss to be a negative experience by representing feelings of ambivalence and relief.

McCreight (2008) utilised a narrative approach to provide rich insight into how women in Northern Ireland storied miscarriage and/or stillbirth. She suggested that women placed emotions at the centre of their narratives, which related to themes of grief, denial, anger, guilt and self-blame. Participants spoke of the search for meaning, which typically involved a search for causality to explain the loss. The absence of medical explanation can exacerbate internalised blame and lead to 'moral claims', which are often reinforced by HCPs (McCreight, 2008). Making sense of pregnancy loss was said to involve challenging 'medicalisation' and marginalisation.

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Participants narrated unhelpful interactions with medical staff, which was argued to represent a failure by HCPs to acknowledge emotional aspects of pregnancy loss. McCreight (2008) challenged medical ideologies/practices that problematize and pathologise emotion or perceive it as needing resolution, which undermine the need for expression/validation in a 'social arena'. She argued that models of care for women are needed that take account of their right and longing to freely interpret, assume ownership, and received acknowledgement of their experiences. Similarly to Corbet-Owen and Kruger (2001), her study incorporates experiences of stillbirth, which risks conflating potentially different experiences.

Carolan and Wright (2017) conducted phenomenological interviews to investigate the experience of miscarriage at 'advanced maternal age'. They utilised an ambiguous loss framework to explore the 'unresolved social role' of women and the value placed on motherhood. They also drew upon feminist theoretical perspectives when considering the medicalisation and 'social silencing' of miscarriage in social spheres. The authors formulated two main themes: 'holistically grieving what was once there' and 'searching for meaning'. Each theme related to physical, emotional, temporal and social aspects of experience.

'Holistically grieving' was comprised of subthemes including challenges of the body (the 'mind-body connection', accepting the loss and experience of infertility), experience of previous losses (which limited hope for the future), and seeking support (gendered differences in grief response and emotional needs). Carolan and Wright (2017) conceptualised 'the search for meaning' as related to beliefs about death and meanings assigned to forms of loss, both of which are rooted within cultural, religious and familial values. Participants conceptualised 'making sense' as a process that increased a sense of control over the 'chaos'.

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Similarly to Corbet-Owen and Kruger (2001), some participants in Carolan and Wright's (2017) study positioned the ability to conceive at the centre of femaleness. Consequentially, miscarriage was positioned as a 'disruption' to motherhood and represented a shift in status or loss of belonging. In response, some women found comfort in conceptualising their miscarriage within spiritual/religious beliefs, though this was also associated with increased ambiguity and unhelpful social responses (i.e. references to 'God's will'). The temporality of narratives was also important; participants depicted a sense of their constructions evolving over time, and miscarriage was generally connected to a sense of time running out (Carolan & Wright, 2017). This either elicited a sense of acceptance, or exploration of other forms of motherhood. Carolan and Wright (2017) acknowledge the homogeneity of their sample as comprised of middle class, majority race women, and advised caution in generalising to other social groups.

Littlemore and Turner (2020) analysed the use of metaphor in interviews with English women who experienced pregnancy loss (including miscarriage, stillbirth and termination following diagnosis of 'foetal abnormality'). They suggested that metaphors support narrative production by helping to make sense, conceptualise and express life experiences: "when an experience is not widely shared with the rest of society, metaphor is frequently used to bridge gaps in understanding" (Gibbs, 1994 in Littlemore & Turner, 2020, p. 47). Consistent with Rice (2000), Corbet-Owen and Kruger (2001), and McCreight (2008), participants spoke of a loss of agency, feeling separate to their body and blaming their body, which led to some women creating distance between the self and the body (e.g. the body 'hadn't realised', 'hadn't caught on' or had 'failed') (Littlemore & Turner, 2020).

Littlemore and Turner (2020, p. 55) suggested that inhabiting a new 'dislocated' reality following miscarriage can lead to individuals viewing themselves as different people. Whilst

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some participants described an inability to return to who they once were, others spoke of positive changes such as becoming more empathic, resilient and stronger in their faith.

Littlemore and Turner (2020) understood this process of forming a new identity following the loss as a key element of meaning-making and regaining agency over the grief.

Similar to other studies (Corbet-Owen and Kruger, 2001; McCreight, 2008), Littlemore and Turner (2020) did not (consistently) make distinctions between different forms of loss and associated meaning-making. Their discussion about attachment, continuing bonds and parental identity/roles, for example, may be more relevant in the context of stillbirth, though this clarity was lacking in the presentation of results.

(Male) Partner's Perspectives

Three studies explored narratives and sense-making processes from a male partner's perspective (McCreight, 2004; Horstman et al., 2020; Littlemore & Turner, 2020).

McCreight's (2004) study utilised a narrative approach to examine the experience of men whose partner had experienced pregnancy loss. She challenged cultural assumptions that men do not tend to form attachment to the unborn baby, stating that the role of images (e.g. ultrasound) can provide strong visual foci for emotions and play a role in how men construct meanings of birth and loss. Perhaps surprisingly, most men in the study identified feelings of self-blame for the pregnancy loss (e.g. for not interpreting their partner's symptoms correctly or not taking their partner to the hospital in time to prevent the loss). Common reports across narratives included anger, guilt, helplessness, and attributing blame to themselves, God, the GP and family (but not, it seems, to their partners) (McCreight, 2004).

Participants spoke of the importance of remaining strong for the sake of their partners, which resulted in a tendency to put aside their own emotional needs in order to provide support.

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McCreight (2004) hypothesised that differences in men and women's grief responses are likely to relate to more nuanced societal assumptions about gender roles, which legitimise and silence certain forms of expression. On this note, some participants spoke of their identity as a father (which was associated with more intense grief reactions to pregnancy loss), whereas others questioned their 'right' to such terms. McCreight (2004) suggested that this may be due to the uncertainty of whether what was lost can be conceptualised as a baby. McCreight (2004) concluded that the perception that men have only a supportive role is unjustified and neglects the meanings they attach to their loss.

Horstman and colleagues (2020) analysed how male participants 'communicatively constructed' the meaning of their partner's miscarriage through metaphor. The assumption that metaphors serve as 'lay theories' that reflect individual's understandings about the world, and are therefore key to sense-making, underpinned the study. They extend similar studies that examine use of metaphor in narrative production (Littlemore & Turner, 2020) by grounding their study in theoretical models, namely, the Communicated Sense-making Model (Horstman et al., 2020). They also drew on master narratives related to masculinity and pregnancy to support with interpretation.

Horstman et al. (2020) formulated participants' sense-making into two categories: metaphors of miscarriage and metaphors of their role as partner. Firstly, some individuals conceptualised the pregnancy as a gift in various ways, from more literal (i.e. being given something) to more abstract (e.g. the opportunity to become a father). Men identified feelings of helplessness, 'righteous anger' and lack of control associated with the sudden loss, which was also conceptualised in various ways from literal (i.e. a life being taken away) to more abstract (i.e. the loss of hope). Participants narrated a sense of distance from the experience, which was argued to reflect cultural expectations of women as the primary care giver that reinforce

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the assumption of miscarriage as a ‘woman’s issue’ (Horstman et al., 2020). Some participants seemed to draw on these concepts in voicing that they did not know the ‘person’ who had died, positioning their wives as ‘the griever’. Some men noted the ambiguity of the loss due to not having anything ‘tangible’ to grieve, and metaphors of sudden emptiness (e.g. ‘void’, ‘gap’, ‘hole’, ‘empty arms’ or an ‘empty chest’) were utilised to make sense of this (Horstman et al., 2020).

Secondly, Horstman et al. (2020) explored how narratives of relational/social identity were informed by hegemonic master narratives about masculinity and gender roles. Participants constructed themselves as a rock, guard, repair man or ‘secondary character’. The perceived need to be strong, supportive, ‘keep things together’ and prioritise the needs of their partner is consistent with McCreight (2004). This could also be said to reflect the heteronormativity of existing literature on miscarriage (which Horstman et al. (2020) aimed to address, despite their sample’s adherence to heteronormative values). The authors advised against generalising their findings to ‘the male experience’ and acknowledged the need for further research into the experience of individuals who identify as LGBTQ+.

Similarly, Littlemore and Turner (2020) interviewed three male partners (alongside their interviews with women) to understand the use of metaphor in describing experience of miscarriage. The authors did not clearly distinguish between female and male participants when presenting aspects of analysis. However, concepts that seemed to correspond to male participants included feelings of isolation and the acceptance of a new reality, which involved the reconciliation of “...two incompatible realities; one in which he [the father] experiences the future that he would have had, and one in which he cannot” (Littlemore & Turner, 2020, p. 57). The authors referred to acts of symbolism and ‘metaphorical enactment’ that enabled fathers to engage with a parental role as part of accepting and grieving their loss. These

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suggestions are largely consistent with Horstman et al.'s (2020) study, albeit with a smaller sample.

Couples' Perspectives

Some studies previously discussed made reference to couples perspectives of miscarriage (Littlemore & Turner, 2020; Horstman et al., 2020). However, Abboud and Liamputtong (2002) specifically examined couple's experience and meanings related to miscarriage in order to compare perceptions within and between couples. In their study, participants had migrated to Australia from the Middle East or the Philippines, though unlike Rice (2000) this was not presented as an intention to explore the experience of migrant individuals in Western cultural contexts. Similarly to McCreight (2004), Abboud and Liamputtong (2002) argued that existing literature on miscarriage has tended to focus on the experience of women and neglected men's stories of pregnancy loss.

Abboud and Liamputtong (2002) separately described men and women's personal experiences of miscarriage. Women described feelings of devastation, grief, trauma, fear, and guilt. Men reported immediate feelings such as anger, sadness and a grief, but emotions were often de-prioritised in favour of 'remaining strong' and offering support to their partner (as in Horstman et al., 2020). Women tended to differentiate between their own and their partner's responses to miscarriage due to their role of physically carrying the baby (see also Littlemore & Turner, 2020). Consistent with Carolan and Wright (2017), the 'severity' and intensity of men's emotions were suggested to decrease after a shorter amount of time compared to their partners (Abboud & Liamputtong, 2002). Commonalities between couple's narratives suggested a recognition for differences in communication styles and needs over time.

Abboud and Liamputtong (2002) suggested that couples developed causal beliefs to explain miscarriage. A common explanation involved attributing blame; many women blamed

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themselves and/or their body for the loss (or internalised other's suggestions they are at fault), particularly in the absence of medical reasons provided (Abboud & Liamputtong, 2002). Other explanations included physical problems, women's behaviours (e.g. eating habits and physical activity), maternal age, fate or luck, and medical practitioners. Abboud and Liamputtong (2002) posited that couples assume gender roles in response to pregnancy and miscarriage. Women tended to position themselves as a mother (a role that is reinforced by society when a pregnancy is announced), whereas male partners are socially-positioned as emotional and physical support. These observations correspond to previous studies (e.g. Horstman et al., 2020). Whilst Abboud and Liamputtong (2002) facilitate rich insight into the experience of couples following miscarriage, it could be argued that the meaning and constructions of miscarriage are left relatively underexplored. Nevertheless, taken with the other studies included in this review, Abboud and Liamputtong (2002) contribute meaningful layers of understanding.

Littlemore and Turner (2020) highlighted a novel perspective in terms of couple's narratives about miscarriage relating to engaging in behaviours that resembled parenting. They suggested that many parents hoped for something positive to come out of their loss, such as sharing their stories, engaging in organisations, and supporting projects. One couple constructed their work for pregnancy loss charities as "...the only way in which they could 'parent' their lost baby" (p. 58). The authors drew on literature to suggest that 'volunteerism' and 'benefit finding' are important for reconstructing meaning, sense-making, identity change, and recovery (Littlemore & Turner, 2020, p. 59).

Healthcare Professionals' Perspectives

Three studies interviewed medical persons as part of their study (Rice, 2000; McCreight, 2004; Littlemore & Turner, 2020), though other studies offered insight into the role of HCPs

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in constructing meaning in the context of miscarriage, based on interviews with women, men and couples (Abboud & Liamputtong, 2002; McCreight, 2008).

Alongside her interviews with Hmong women, Rice (2000) interviewed traditional healers who, despite their difference in status in Hmong culture compared to HCPs in Western contexts, can offer insight into the influence of health/medical practices on constructions of miscarriage. When initial signs of miscarriage are evident, Hmong women try and prevent it themselves by staying at home and resting. They may consult traditional healers (i.e. medicine women, a masseuse, shaman or magic healer) when severe symptoms of miscarriage develop (e.g. severe bleeding or abdominal pain). Healers may prescribe herbs, seek to reposition the baby, prepare remedies, and negotiate with spirits. Shamanic rituals might also be performed to 'separate' the souls of mother and baby, without which either one might survive at the expense of the other (Rice, 2000).

Similarly, McCreight (2004) interviewed nurses and midwives with the intention of examining attitudes within medical context towards bereaved fathers (though this aspect of her study was perhaps deprioritised in her paper). McCreight (2004, p. 340) suggested that HCPs are often poorly equipped in the context of pregnancy loss and connected this to an 'overpowering institutional context' (as enacted by hospital culture) which can lead to forms of emotion management. This was supported by her male participants who reported that staff often imposed unhelpful or unwelcome constructions of the loss. Most nursing/midwifery participants reported addressing the practical needs of the male partner and acknowledged not 'thinking about' their emotional needs (McCreight, 2004). Those who noted feeling more aware of men's emotional needs stressed the importance of providing sensitive, accessible information, and recognised the tendency for men to 'put on a brave face' for their partners (as noted by Abboud & Liamputtong, 2002; Horstman et al., 2020). Unfortunately,

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McCreight (2004) did not provide demographic information for HCP participants – an oversight, given that gender was likely an important factor in nursing attitudes towards bereaved fathers.

Littlemore and Turner (2020) also conducted interviews with individuals who support people through pregnancy loss at UK-based charities. For the purpose of this review, these participants are conceptualised similarly to HCPs. It should be noted that many of these individuals also had personal experience of pregnancy loss (although specific data were unspecified) and so may offer different perspectives to other studies included in this section. The authors suggested that HCPs (including nurses) play an active role in supporting bereaved families to ‘capture memories’ through the ‘metaphorical enactment’ of hopes and expectations for the child had it lived, that were formed from the moment pregnancy was confirmed. Participants recounted examples, including one father who wanted to read a bedtime story to all of his children together, and another who wanted to have a beer with his son as ‘dad and lad’ (Littlemore & Turner, 2002, p. 57). The inclusion of stillbirth and termination in these conceptualisations invites caution about over-attributing results to the context of miscarriage. Still, the study highlights the role of HCPs in co-constructing narratives of pregnancy loss. This also emphasises the potential harm caused by blunt disclosures, lack of sympathy and compassion, and negative comments during medical encounters as reported in other studies (Abboud & Liamputtong, 2002).

McCreight (2008) argued that HCPs often treat miscarriage as distinct from other forms of pregnancy loss, leading to assumptions about it being less significant. HCPs operate within (and also reinforce) systems that have been argued to medicalise miscarriage – a context where the linguistic worlds of patients and medical professionals are often discordant (McCreight, 2008). As such, HCPs have the power to influence the discourse through which

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bodily experiences are interpreted and, therefore, how knowledge/meaning are created (McCreight, 2008). McCreight (2008) did not interview medical professionals directly; her contributions are drawn from women's narratives of the care received by professionals following pregnancy loss.

Cultural Perspectives

Most of the studies included in the review made reference to the role of societal and cultural narratives on personal constructions of miscarriage. The impact of including cross-cultural research/considerations in the review is discussed in section 1.8.8.

Rice (2000) specifically aimed to address the homogenous nature of existing literature on miscarriage that largely relates to Anglo-Celtic contexts. She drew on Hmong beliefs in reincarnation and the rebirth cycle to explain how miscarriage represents a threat to the survival of Hmong society. The loss of a pregnancy therefore causes significant anxiety in the community, and requires a socially-justifiable explanation for a family's 'failure' to extend their lineage (Rice, 2000). She contemplated the value placed on children and proposed that bearing children provides a form of status to women: "without children, neither Hmong men nor women are perceived complete" (Rice, 2000, p. 101). Perceived status change or social power associated with child-bearing is noted in other studies in Western contexts (Corbett-Owen and Kruger, 2001; Carolan and Wright, 2017).

Several studies discussed burial arrangements, which are embedded within cultural and religious traditions. McCreight (2004) suggested that miscarriage has no legal status and is therefore described as "...an intangible loss with no formal mechanism in Western societies that allows the expression of grief through the formal ritual of burial" (McCreight, 2004, p. 337). This ambiguity can elicit emotions of isolation and distress, which can be exacerbated by social ambivalence to the loss (McCreight, 2004).

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These concepts were extended in her later article, which suggested ambivalence about whether a human life had been formed and lost, lack of legal recognition and (in some cases) ‘foetal remains’ prevent normative death rituals (McCreight, 2008). McCreight (2008) continued to explain that in the Roman Catholic Church, babies who died without baptism were buried in separate areas, usually at night and without ritual. Parallels can be drawn to Hmong society, where a fallen baby is not considered human (as no ceremony was performed) and is buried in the forest without ritual (Rice, 2000).

The lack of social recognition of miscarriage effectively ‘disenfranchises’ the parent’s grief; this goes beyond being unnoticed or forgotten to being socially disallowed, and therefore unsupported (McCreight, 2008). Littlemore and Turner (2020) stated that whilst grief is a normative experience that draws on societal scripts, such norms are not present for pregnancy loss. Because of this, family, friends, co-workers and acquaintances expect less grief and may provide less social support as a result (Carolan & Wright, 2017). Carolan and Wright (2017) suggested that meaning-making (an essential aspect of grieving) becomes more difficult as miscarriage is often invalidated, unrecognised or minimised. They also connected unresolved feelings about miscarriage to mental health difficulties such as depression and complex grief.

McCreight (2008) drew on Foucault (1991) to consider the unquestioned authority of the ‘medical gaze’. She suggested that since the medical profession has not been able to reduce the incidence of miscarriage, the ‘problem’ has been located within women themselves and positioned women as responsible and inadequate. Within this context, the woman’s personhood and identity (and her needs) become invisible – she is objectified through medical and scientific procedures (McCreight, 2008) (see also Van der Zalm & Byrne, 2006 for context).

1.8.6 Summary of Review

This systematic literature review has synthesised findings from eight studies to provide a comprehensive overview of current literature relating to miscarriage narratives. The review was split according to women, men, couples, HCPs and cultural perspectives. Five studies explored the experience of pregnancy loss from multiple perspectives (Rice, 2000, Abboud & Liamputtong, 2002; McCreight, 2004; Horstman et al., 2020; Littlemore & Turner, 2020).

Studies that explored women's narratives of pregnancy loss (Rice, 2000; Corbet-Owen & Kruger, 2001; McCreight, 2008; Carolan & Wright, 2017; Littlemore & Turner, 2020) discussed self-blame, the search for meaning, making sense of the loss, and change in status or identity. A key focus of these studies related to how women conceptualised their loss, and how this impacted on their grief and sense of self.

Studies that examined male partner's narratives of pregnancy loss (McCreight, 2004; Horstman et al., 2020; Littlemore & Turner, 2020) raised similar themes relating to internalised blame, guilt, identity change, gender roles, and grief responses. Arguably, these studies went further to explore *how* and *why* certain narratives were constructed and communicated in comparison to studies with female participants, which seemed more descriptive in nature.

Studies that explored narratives from the couple's perspective (Abboud & Liamputtong, 2002; Littlemore & Turner, 2020; Horstman et al., 2020) were less focused on how partners jointly constructed miscarriage narratives and more centred on gendered differences in grief responses, communication, emotional needs, meaning-making and relational roles. Arguably, identity constructions were left relatively underexplored.

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Several studies investigated HCP's narratives of miscarriage across cultural contexts (Rice, 2000; McCreight, 2004; Littlemore & Turner, 2020). There was consistent recognition of HCP's role in co-constructing narratives – a role that was not always described as welcome or helpful.

Lastly, cultural perspectives were presented from studies that made explicit reference to the wider socio-cultural context, including religious beliefs, burial arrangements, and medical ideologies that influence personal narrative construction.

1.8.7 Quality Evaluation

The studies were assessed according to Tracey's (2010) eight criteria for quality in qualitative research. Each study's adherence to these criteria is represented in Table 5 and can be read in conjunction with the full quality evaluation notes (Appendix F). A high standard of quality was observed across studies, particularly in relation to worthy topic, rich rigor, resonance, ethics and meaningful coherence. The most recent studies included in the review (Carolan & Wright, 2017; Littlemore & Turner, 2020; Horstman et al., 2020) were rated as meeting all of Tracey's (2010) criteria, some to a high standard. This might indicate a shift towards higher quality standards and/or requirements of research dissemination.

Areas of relative weakness across the studies related to sincerity and credibility. Studies that were evaluated as not meeting criteria for sincerity (Abboud & Liamputtong, 2002; McCreight, 2008) and those that were rated as partially met or 'unclear' (Rice, 2000; Corbett-Owen & Kruger, 2001) tended to demonstrate weakness in reflexivity (i.e. the role of the researcher). These studies were also characterised by a lack of transparency, more often related to challenges and limitations than methodological processes. Studies assessed as partially meeting Tracey's (2010) credibility standard (Rice, 2000; Abboud & Liamputtong, 2002; McCreight, 2004) lacked 'thick description' in comparison to other studies, which

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limited the resonance of the research and de-centred participant's voices in favour of the researcher's message. Most studies in the review did not utilise triangulation, multivocality or member reflections. This may be consistent with the qualitative methods and/or epistemological stances employed, though these decision-making processes were not well-documented.

Table 5. Summary of Quality Assessment

Key x = criteria not met ? = criteria partly met / unclear / not stated ✓ = criteria met ✓✓ = criteria met to a high standard	Quality Criteria							
	Worthy topic	Rich rigor	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence
Rice (2000). <i>When the baby falls! : the cultural construction of miscarriage among Hmong women in Australia.</i>	✓✓	✓	?	?	✓✓	✓	✓	✓
Corbet-Owen & Kruger (2001). <i>The Health System and Emotional Care: Validating the Many Meanings of Spontaneous Pregnancy Loss.</i>	✓	✓	?	✓	✓✓	✓	✓	✓✓
Abboud & Liamputtong (2002). <i>Pregnancy loss: What it means to women who miscarry and their partners.</i>	✓✓	?	x	?	✓	?	✓	✓
McCreight (2004). <i>A grief ignored: narratives of pregnancy loss from a male perspective.</i>	✓✓	✓✓	✓	?	✓✓	✓	✓	✓✓
McCreight (2008). <i>Perinatal loss: a qualitative study in Northern Ireland.</i>	✓✓	✓	x	✓	✓✓	✓	✓✓	✓
Carolan & Wright (2017). <i>Miscarriage at advanced maternal age and the search for meaning.</i>	✓✓	✓	✓✓	✓	✓	✓	✓	✓✓
Littlemore & Turner (2020). <i>Metaphors in communication about pregnancy loss.</i>	✓	✓	✓	✓	✓✓	✓	✓	✓
Horstman, Holman & McBride (2020). <i>Men's Use of Metaphors to Make Sense of Their Spouse's Miscarriage: Expanding the Communicated Sense-Making Model.</i>	✓	✓✓	✓	✓✓	✓✓	✓✓	✓	✓✓

1.8.8 Critical Review

This section presents important points for consideration that speak to the strengths and limitations of this review.

The reviewed studies were conducted across various cultural contexts representing European, Western and South-eastern perspectives. Though this may seem incongruent with the current study's location and its social constructionist epistemology, the literature offered rich insight into narrative construction and meaning-making processes of miscarriage. The inclusion of cross-cultural research also highlights the limited nature of existing literature. It is also important to note that the review did not intend to speak to universal narratives. Rather, it posed an opportunity to reflect on existing research in order to inform the current study.

Due to the lack of research in this area, the reviewed studies utilised various qualitative methodologies which are underpinned by different assumptions, aims, samples and methods of analysis. Several studies operationalised 'pregnancy loss' as an umbrella term, which perhaps diluted data relevant to the review question and at times conflated findings related to different forms of pregnancy loss. Furthermore, 'narratives' and 'meaning-making' were defined in various (and often ambiguous) ways, resulting in some studies providing more descriptive, phenomenologically-oriented data. Although subtle, this represents an important distinction that is crucial for situating and informing the current study.

It is sensible to assume that any literature review has been subject to forms of bias. For instance, it is likely that the findings of this review emphasise data that is most pertinent to the current study, which is understandable, yet risks limiting the wider context of findings.

Steps taken to limit bias include the use of search tools, data extraction frameworks, quality assessment criteria and synthesis guidance, supervision with the research team and researcher reflexivity (see section 2.6).

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Further to this, despite drawing on an established quality framework, the quality assessment represents my subjective interpretation of the authors' adherence to the chosen criteria and was not an attempt to present a conclusive or authoritative assessment. Besides, authors could have been working to other frameworks (e.g. Elliott et al., 1999; Madill et al., 2000), which were not incorporated into the evaluation (though there is a certain degree of crossover). However, Tracey's (2010) framework was considered most appropriate in light of the various qualitative paradigms utilised by included studies.

In addition, it is important to consider the relevance of this literature review for clinical practice. Literature reviews synthesise various perspectives and research for clinicians to review, inform guidelines, and utilise in practice. Part of the value of this project is, therefore, the literature review itself. The review has shed light on certain issues for clinicians to consider when working with this population of people who have experienced pregnancy loss and infertility. For instance: the need for appropriate staff training to increase competence in relation to miscarriage and pregnancy loss; sensitivity training and speaking with compassion; the role of language and the need to address over-medicalised systems of knowledge; the importance of individualised care and decision-making; understanding the need for expression, and the various ways that individuals might express their feelings and loss; and improving follow-up care and signposting. The research included in this review also invites curiosity as to whether services currently offer adequate support to individuals (including partners), couples and families. By identifying these clinical implications, the current project can build upon these and further strengthen the need to act on existing knowledge and recommendations.

In summary, the systematic literature review presented a comprehensive appraisal of the most up-to-date, high-quality literature exploring narratives of miscarriage. The review highlighted

the lack of research in this area and also the multidisciplinary nature of this research. Some studies were published in social work or sociological journals, indicating that further research from a psychological perspective might offer a valuable contribution to the research base and clinical practice across disciplines. Potential clinical implications for clinical practice were discussed, as was the role of the current project to strengthen and extend these recommendations.

1.9 Rationale and Aims

Rationale

As highlighted by section 1.7 and the literature review, existing literature is broad in scope and represents high-quality research that enriches current understanding. Despite this, certain gaps are evident. Firstly, studies utilised a range of methodological approaches. Only a small proportion utilised narrative methods of inquiry, thus limiting understanding as to *how* and *why* individuals story experience, and also neglecting temporal aspects (Solomons, 2017). Secondly, studies commonly conflate various forms of pregnancy loss which may be experienced and narrated differently. Thirdly, existing research has explored meaning-making following pregnancy loss from multiple perspectives. Studies focused on female participants have tended to attract more descriptive accounts of experience, which often neglect the complexities and nuances of meaning-making and identity re-construction following pregnancy loss. Lastly, while aspects of narrative and identity construction are present in the literature, their explicit examination is largely neglected or under-explored (particularly in terms of relational co-construction). The current study is in a position to address these gaps and limitations, in order to further enrich understanding, expand narrow discourses on female infertility (Wells & Heinsch, 2020), and offer recommendations for clinical psychology and broader healthcare practices.

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Aims

By utilising a narrative approach, the current study aimed to extend the literature base to offer richer insight into how women who are involuntarily childless story their experience of miscarriage, and how this ‘sense making’ process influences identity construction. This qualitative study also intended to bridge psychological research and political perspectives by adopting a narrative feminist approach to fertility and reproduction. Approaching the study from a social constructionist, culturally-situated perspective was also hoped to offer alternative conceptualisations and facilitate critical engagement with the discursive resources available to women that influence narrative identity constructions.

Therefore, the research question asked:

How do women who are involuntarily childless and have experienced miscarriage story their experience and construct their identity?

This over-arching question invited further areas of inquiry, including relationship to help, helpful and unhelpful support following miscarriage, and how these aspects of experience can inform current NHS practice and service provision.

CHAPTER TWO

Methodology

2.1 Chapter Overview

This chapter outlines the methodological rationale for the study – a qualitative exploration of how women story their experience of miscarriage and identity construction. The study design will be outlined, including the choice of methodology, Expert by Experience Consultation, quality framework and sampling strategy. The study procedure will then be presented, including recruitment and data collection, followed by ethical considerations and steps taken to adhere to ethical practice. The chapter closes by outlining the analytic process, within which researcher reflexivity will be discussed.

2.2 Design

This study comprised a cross-sectional design using retrospective individual interviews to gain understanding as to how women (re)construct their identity following miscarriage through storytelling. This section will outline elements of the research design.

2.2.1 Qualitative Research

Qualitative methodological approaches tend to align with post-positivist/structural positions and aim to examine meaning attributed to lived experience and situate knowledge in context (Ryan, 2006). Though quantitative, qualitative and ‘mixed’ methods approaches all have the potential for valuable contributions to psychosocial fields (Ryan, 2006), qualitative research has been argued to be more useful for examining social phenomena, particularly in relation to under-researched areas (Barker & Pistrang, 2015 in Randall-James, 2018). It was therefore considered appropriate for the study.

2.2.2 A Case for Narrative Inquiry

Narratives are produced, elicited and consumed in various forms such as oral, visual, or written material (Wells, 2011). The current study focused on oral narratives produced within the context of narrative-informed qualitative research interviews.

Narrative inquiry (henceforth NI), denotes a collection of multi-disciplinary methods for interpreting storied language (Riessman, 2008; Adlington, 2012). It is useful when the interest is in *how* and *why* experiences are storied, that is, to whom the story is being told, the reason for telling it, and how the audience shapes what might be told (Riessman, 2008; Wells, 2011; Herman et al., 2012).

Congruent with the epistemological positions outlined in Chapter One, this study adopted a ‘constructionist approach’ to narrative research (Riessman, 1993). Implicit in the assumption that knowledge is co-constructed is the belief that “...narratives are shaped by the local and broader context in which they occur” (Benwell & Stokoe, 2006 in Adlington, 2012). Thus, NI is concerned with the micro-contexts of ‘small stories’ (Georgakopoulou, 2006) as well as the sociocultural contexts in which they reside (Squire, 2008).

Bamberg (2016a, p. 1) stated that the turn to narrative in social sciences suggests a new approach to examining “...questions of lived experience, subjectivity, identity, and sense of self”. Storytelling practices can be understood to re-present subjective experience and sense-making strategies, and therefore should be privileged as a space for identity practices (Bamberg, 2016a). Examining the interactive functions of storytelling can offer insight into the relational identity work carried out by individuals (Bamberg, 2016a). This also invites consideration of the conditions that make stories tellable or untellable based on the perceived entitlement of the narrator to narrate (Solomons, 2017). These aspects distinguish NI from

alternative analytic approaches that, arguably, do not adequately account for the co-construction of meaning in narrative production (e.g. Smith & Osborn, 2008).

Though alternative methodologies could also be considered appropriate in addressing the research question and aims, NI is particularly well-suited to exploring temporal (re)construction of illness/identity or ‘biographical narratives’ (Solomons, 2017). Attending to temporality in experience-centred narratives offers insight into constructions of meaning over time (Squire, 2008). Temporal aspects are incorporated because, unlike other analytic methods that fragment stories into thematic categories, NI examines extended narrative accounts as whole units (Wells, 2011).

NI goes beyond examining the role of language in constructing knowledge, as in other approaches such as discourse analysis (Burck, 2005; Arribas-Ayllon & Walkerdine, 2008), which tend to neglect the purpose of storytelling. Still, how individuals draw on available discourses and how discourse shapes what is possible to know remain important points for consideration (Edley, 2001; Wells, 2011).

2.2.3 Expert by Experience Participation & Consultation

The centring of individual stories was fundamental to this project and methodological approach. Inherent within this stance is an intentional awareness (and, where possible, redistribution) of power between ‘researcher’ and ‘researched’. The phrase ‘*nothing about us without us*’ (Charlton, 1998) was borrowed from disability rights activists to inform the project.

The term ‘Expert by Experience’ (henceforth EbE) is used to acknowledge and privilege the expertise owned by individuals who have experienced pregnancy loss. Value was placed on

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EbE participation and consultation to welcome a critical, informed gaze as well as provide opportunity for involvement in clinical research.

Due to my outsider membership role (see section 2.4.1), no existing connections with EbE individuals/groups had been formed prior to the project's inception. Unfortunately, the pandemic led to decreased service functioning on already limited resources. It was not possible to build connections as originally planned. Despite this, some organisations were able to support the project; their involvement is outlined in subsequent sections. EBE Consultants were recruited alongside interview participants (see section 2.3.1). This also recognised that people drawn to the project may want to participate in a meaningful way without sharing personal stories. Subsequent sections outline the ways in which EbE Consultation informed the study design/implementation in more detail.

2.2.4 Quality Framework

Traditional assumptions about what constitutes quality in research are entwined with a positivist paradigm, which promotes criteria such as validity, reliability, generalisability and objectivity (Ryan, 2006; Tracey, 2010). These constructs tend to be incongruent with qualitative approaches to research, which typically privilege concepts such as transparency and rigor in the production of social knowledge as opposed to providing evidence of validity, et cetera. Values underpinning constructions of quality constitute social knowledge and are therefore situated within fluid local and cultural contexts (Tracey, 2010, p. 837).

The current research has attempted to adhere to Tracey's (2010) quality criteria for qualitative research, as outlined in Chapter One. Despite Tracey's use of language suggesting that it is possible to 'achieve' each of these criteria, the current study has been conducted with the understanding that quality is something that can be strived for but not necessarily 'achieved' in a conclusive sense (see section 1.4). This research will ultimately reflect a state

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of imperfection, though this does not necessarily undermine its close adherence to quality guidelines. Table 6 outlines the quality evaluation of this research according to Tracey's (2010) eight 'big-tent' criteria, and the steps taken throughout the study design/process to align to these.

Table 6. *Self-evaluation of Quality Standards*

Criteria	Steps taken to adhere to criteria
Worthy topic	As suggested by the literature review, this area is relatively under-researched which has repercussions on the individual, community, healthcare and societal levels. The pervasive lack of awareness consistently highlighted by existing research (see section 1.7) is disproportionate to the high prevalence of miscarriage. This study therefore represents a relevant, timely, and important contribution.
Rich rigor	The study utilised appropriate theoretical constructs, epistemological lens, sample and methodological process (including data collection and analysis) according to the research questions and aims.
Sincerity	A reflexive-researcher position was adhered to though the use of the reflective diary, critical discussions with research team, and consultation with EbE, which supported awareness of own biases, assumptions and values (see also section 2.6). A transparent account of decision-making and challenges throughout the research process has been presented.
Credibility	Practices such as triangulation and member reflections were not considered congruent with the epistemological position and so were not included in the research process. In line with quality guidance around credibility, thick description was included, alongside participant quotes, in order to present a transparent and credible account of the narrative interviews.
Resonance	The research details the retelling of lived experience, meaning-making and identity construction following miscarriage in rich detail. Participant’s own words are included alongside analysis and interpretations to increase resonance with the reader. This narrative content is likely to evoke strong emotional connection to the material and are likely to resonate with a range of audiences across various contexts.
Significant contribution	This study corroborates and extends existing literature in terms of understanding the sense-making processes following miscarriage and how such processes play a role in identity construction. It also presents important clinical

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	implications across healthcare settings/disciplines as well as enriching lay person understanding of the topic. The research will be shared in a variety of ways to meet the needs of a range of audiences (see Chapter Four). This approach to dissemination represents its pragmatic use and significant contribution to various contexts.
Ethical	Procedures were considered in terms of specific context (e.g. pandemic), ‘relational ethics’ (e.g. my position as a researcher, interviewing process) and ‘exitting ethics’ (e.g. appropriate debrief and signposting). Ethical considerations/challenges and subsequent decision-making are outlined in a transparent way as part of the research process.
Meaningful coherence	The systematic literature review provided a backdrop and rationale for conducting the current study. Appropriate methodology was utilised according to the research aims. This contributed to a coherent narrative throughout the research (for example, analysis and discussion were embedded within existing literature in a meaningful way).

2.2.5 Sampling Strategy

Wells (2011) suggested that a sample size of five participants is adequate for narrative analysis, in that it facilitates rich data and detailed analysis. The current study aimed to recruit between five and ten participants. The sample was self-selected (Costigan & Cox, 2001; Robinson, 2014), following which purposive sampling (a non-random technique whereby participants are selected based on their characteristics and the objectives of the study) was utilised to select participants for interview (Etikan et al., 2016). This sampling technique was appropriate as the current research does not aim to create generalisations pertaining to the general population. Table 7 outlines the eligibility criteria for interview participants.

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Table 7. *Eligibility criteria for interview participants*

Inclusion criteria	Rationale
Individuals who identify as a woman.	For the purposes of this research, gender was considered a self-assigned identity independent of biological, legal or social conceptions.
Individuals who identify with having experienced miscarriage.	It was considered important for individuals to self-identify with the term miscarriage but also to distinguish from other forms of pregnancy loss which may be associated with different experiences/narratives.
Individuals who are between 25 and 50 years of age.	The life-story model (McAdams et al., 2006) proposed that individuals start to construct ‘self-defining stories’ in the emerging adult years, a process that requires reflective and narrative skill and which continues to develop throughout one’s life. It was hypothesised that younger participants were likely to construct experience and identity narratives in a different way to their older counterparts. Furthermore, research has suggested that the ‘adolescent brain’ continues to develop into at least the mid-twenties, which can have consequences for emotional maturation particularly in high-arousal states (Blakemore & Choudhury, 2006; Arain, et al., 2013). This was considered an important factor in light of conducting sensitive research. Albeit slightly arbitrary in nature, the upper age criteria was chosen in line with the life cycle model and the average age of menopause (NHS, 2018a). It was hypothesised that women over fifty are more likely to encounter medical, biological and social barriers to pregnancy, and therefore construct pregnancy loss in different ways to their younger counterparts.
For individuals not to have had living children either before or after miscarriage	It was hypothesised that women who have had living children are likely to construct narratives, meaning and identities differently compared to women who are ‘involuntarily childless’

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(including through IVF, surrogacy, adoption and fostering routes).	(Letherby, 2002). Whilst further research in this area is clearly needed, this criteria was considered in-line with homogeneity of variance parameters (Robinson, 2014) and the scope of the study.
For the miscarriage(s) to have occurred a minimum of 6 months from first point of contact.	To decrease likelihood of participants being in acute emotional distress at time of interview.
For the miscarriage(s) to have occurred within the last ten years (from first point of contact in research).	Ten years was considered an appropriate upper time parameter to provide a sense of narrative and identity construction over time without compromising richness of data. It also facilitated the inclusion of younger people's stories, albeit presented through the lens of their older selves.
Individuals who are fluent in the English language.	NI focuses on the use, performance and co-construction of meaning through language. Due to my own limitations of only speaking English and my developing skills in narrative methodology, it was considered neither practical nor ethical to invite individuals who speak other languages to participate in the interviews.
Individuals who currently reside in the UK.	NI is concerned with the 'narrative environment' (Squire, 2008) (i.e. the socio- cultural/political context in which narrative co-construction occurs). Extending the scope beyond a UK context was considered incongruent with this methodological approach and the epistemological position.
For individuals to have access to a means of communication by which to participate in interviews and correspondence (e.g. landline, smartphone, tablet or computer).	Necessitated by conducting participant research in a pandemic context; facilitated remote interviews.

2.3 Procedure

2.3.1 Advertising and Recruitment

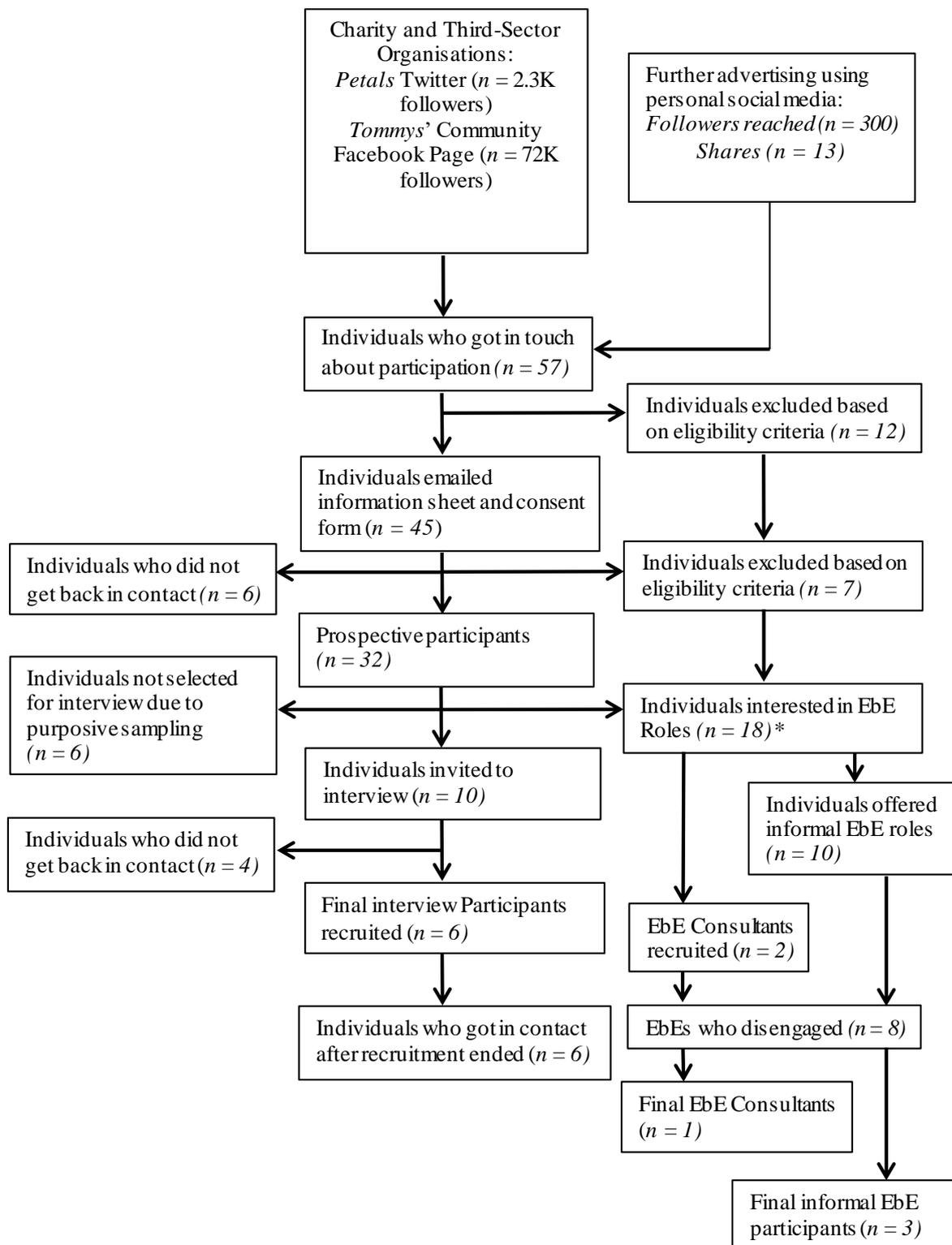
Due to the nature of sensitive research (Dempsey et al., 2016) challenges with recruitment were anticipated. Two recruitment routes were utilised (see Figure 3) through third-sector organisations and the researcher's personal social media. Two adverts were designed accordingly (Appendix G and H), one with minimal information and the other in poster form.

Four pregnancy loss charities were approached. Two agreed to support recruitment. I was permitted to advertise on the *Tommy's* Facebook page and *Petals* posted the advert on their Twitter account, which reached over 2,000 followers at the time of recruitment.

Individuals who were interested in taking part in interviews or as EbE were invited to contact the researcher via email. In total, sixty-three women got in contact expressing their interest in taking part. Fifty-seven of these contacted in the first seven days of recruitment. The recruitment phase lasted two months in total, following which social media posts and the charities who advertised were updated that recruitment was completed.

Prospective participants were emailed the information sheet (Appendix I) and consent form (Appendix J) which detailed the research aims, eligibility criteria, what participating in the project would involve, confidentiality and their rights as a participant. Questions were invited at multiple stages. For those who met criteria for interviews and consented to take part, a date and time was organised via email for the interview. It was highlighted that there would be space before the interview for introductions, to revisit the research aims, explore concerns and/or hopes, and ensure that participants had the information required to make an informed decision about taking part.

Figure 3. Diagram outlining the recruitment and participant selection process



**This represents the number of people in total who were interested in EbE roles across the various stages of recruitment, including those who did not meet criteria for interviews and those who met criteria but were not selected for interview.*

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Demographic data was also collected for interview participants by completion of a form (Appendix K). The rationale provided for this related to the importance of contextualising personal stories. It was emphasised that completion of this form was optional and that involvement in the study would not be impacted based on this decision.

2.3.2 Participants

Ten interview participants were recruited, though four people decided not to go ahead. All participants agreed to have their interviews via Zoom. Demographic data for the six interview participants is presented in Table 8. Pseudonyms³ have been used to protect confidentiality.

Table 8. *Demographic Information for Interview Participants**

Pseudonym	Age	Sexuality	Race/Ethnicity	Religion	Culture
Sami	26	Heterosexual	British-Pakistani	Muslim	Pakistani
Cathy	30	Heterosexual	Caucasian	Christian	-
Laura	44	Heterosexual	White British	C of E ⁴	British European
Jasmine	45	Heterosexual	Chinese	Atheist	-
Beth	35	Heterosexual	White British	None	-
Tabitha	36	Bisexual / Heterosexual	Mixed – White and Black Caribbean	Christian (C of E)	British

*data based on self-report/identification.

Two EBE Consultants were also recruited. Unfortunately, one Consultant made the decision to leave the project for personal reasons. Informal EbE roles were formed for specific aspects

³ Following the completion of the interview, participants were given the option to choose their own pseudonym. Two participants opted to do this; the other five names were selected by the researcher.

⁴ Denotes 'Church of England', a protestant denomination and one of many expressions of Christianity.

of the study due to the high demand for these roles and to increase opportunities for involvement. Ten people were selected as informal EbE and were invited to provide one-off feedback on specific aspects of the project (e.g. the interview guide). Three individuals responded and their feedback was incorporated prior to data collection.

2.3.3 Interview Process: Collecting Stories

Interviews were conducted virtually and all participants attended individually. One person participated from their place of work and five from their homes. Thus, it is important to be mindful of how the 'narrative environment' (Squire, 2008) influenced narrative production. Stories told in a work context may differ substantially to those told in one's home, for example.

Before the interviews took place, key aspects of the information sheet and consent form were emphasised. Space was dedicated for interviewees to raise questions/concerns. Questions about the research aims/hypotheses were welcomed and typically answered as part of the debrief process in order to limit demand characteristics. Explicit questions about my relationship with miscarriage were answered at this stage in order to adhere to values around transparency (Tracey, 2010), whereas implicit curiosities were addressed at debrief. This invites reflection as to the impact this may have had on narrative co-construction.

Following completion of the interview, audio recording was stopped and participants were invited to reflect on their experience. They were also given the opportunity to voice anything they regretted saying and wanted removed from the transcription. This was intended to maintain a sense of ownership for participants over the way they told their stories.

Participants were fully debriefed about the research aims and rationale (see Appendix L). This also involved signposting to appropriate services for information and/or support.

Participants were also given the option to opt-in to research updates and dissemination. The reflective journal (see section 2.10) was utilised before and after interviews to record thoughts, emotional responses and observations that might contextualise audio recordings and aid analysis (e.g. body language, facial expressions, etc.).

2.3.4 Interview Structure: Development of Interview Guide

Interview structure is partly informed by how narratives are conceptualised; understanding narratives as co-constructed lends itself to more interactive, conversational styles of interviewing (Wells, 2011, p. 24). Attending to the influence of power dynamics on narrative co-construction is therefore essential.

Owing to the limited research in this specific area, it was not possible to draw on existing narrative interviews. The interview guide (Appendix M) was therefore informed by the research questions and preliminary literature review. It is important, then, to acknowledge that my hypotheses about what narratives *might* occur may have entitled or silenced narrators to tell particular stories (Wells, 2011). The questions were reviewed by several EBE.

In line with Riessman (1993), several key topics were chosen with follow-up questions. According to Patton (2002 in Wells, 2011), the interview structure was most closely aligned to a ‘standardised, open-ended interview’, whereby the interviewer asks specific questions in a prescribed order. In practice, though, the interviews were lightly structured, flexible and responsive to the information shared by participants. This is in line with advice on conducting sensitive interviews in qualitative research (Dempsey et al., 2016).

Single interviews were conducted that lasted between 50 – 110 minutes in duration.

Interviewees were initially invited to talk about themselves more generally such as life stage, family, skills and hobbies. This was informed by Narrative Therapy principles (unrelated to

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NI) and also aligned to ‘therapeutic interviewing’ (Dempsey et al., 2016). It also gave the opportunity for narrators to construct a holistic, multi-faceted relational identity. My witnessing of these stories supported rapport and relationship-building within a relatively short time-frame (Dempsey et al., 2016).

Participants were invited to tell their story of miscarriage. The list of prompts aimed to encourage conversation about sense-making over time, identity constructions, and relational aspects. Topics such as help-seeking behaviour/experiences and wider social discourse were also explored.

Defining narratives as co-constructed raises questions of ownership (Wells, 2011). To address power imbalances, it was important to create a space in which interviewees felt in control over the stories they tell. Interviewees were provided with as much or little space as they required to answer questions with minimal disruption. Follow-up questions were asked once speakers had re-assumed the ‘recipient position’ (Bamberg, 2016a) and invited narrators to enrich their stories. At the end of interview, participants were also asked if they would like to add anything to the conversation before it concluded.

2.4 Ethical Considerations

Ethical approval was obtained from the University of Hertfordshire (protocol number: LMS/PGT/UH/04189) (Appendix N). The following sections summarise the ethical considerations and decision-making processes in relation to developing and implementing this research.

2.4.1 Outsider Membership Role

There are advantages and disadvantages associated with a position of outsider researcher (Serrant-Green, 2002). Though my membership status (Dwyer & Buckle, 2009) arguably

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awards me certain insider perspectives (i.e. identifying as a woman), I have not experienced the loss of a pregnancy. I therefore use the term outsider research(er) in order to respectfully acknowledge my position in relation to the people who have lived experience of pregnancy loss, and to recognise my inability to fully comprehend this experience (Dwyer & Buckle, 2009). Due to my inexperience within this field, I explored social media, websites, NHS resources and academic/medical literature on miscarriage, which contextualised ethnographic reading. This process represented a steep learning curve and provided valued insight that informed my approach to data collection and also my readiness to witness personal stories.

2.4.2 Consent & Confidentiality

The participant information sheet clearly detailed aspects of consent and confidentiality. Participants had multiple opportunities to ask questions relating to their involvement and rights. Limits to confidentiality and the right to withdraw were emphasised. Informed, written consent was obtained from the women who took part in interviews.

Interviews were recorded on an encrypted audio recording device and later transferred to an encrypted external storage device. Interviews were transcribed by either the researcher or by one of two transcription services. Files were transferred via end-to-end encryption. Both services were required to comply with the University's data protection policy and agreed to the confidentiality agreement (Appendix O). Files were anonymised and password protected.

2.4.3 Communication of Exclusion Criteria

Emotional distress was reported by prospective participants relating to poorly-communicated exclusion criteria, in part due to an impartial advert disseminated by a supporting charity. Individuals reported feeling invalidated by criteria that excluded people who have children. These challenges were navigated thoughtfully by integrating dual positions of researcher and

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clinician, and with support from the supervisory team. All individuals who made contact with the lead researcher were responded to via email. This was intended to 1) validate distress 2) emphasise that the criteria did not represent an assumption that having children minimises the distress associated with pregnancy loss 3) provide an accessible rationale for the eligibility criteria.

2.4.4 Turning People Away

EbE roles were offered to prospective participants who did not meet criteria for interviews or who opted to have a less active role. However, it soon became apparent that these roles attracted more interest than was feasible for the size of the project. Following consult with the research team, it was agreed that a recruiting up to three EbE Consultants was appropriate. People were typically recruited in order of contact. Due to the volume of interest, those who were not recruited for EbE roles were sent a standardised message via email, thanking them for their interest and letting them know recruitment was completed (Appendix P).

2.4.5 Potential Emotional Distress

Considering the sensitive nature of the study and the interview process, it was important to acknowledge the risk of emotional distress in a transparent way with participants in order to highlight the potential disadvantages of participating (whilst also normalising and validating potential distress). The pros and cons of participation were clearly outlined in the Information sheet.

Guidelines for conducting sensitive interviewing were followed which advised drawing on clinical expertise to assess participants for signs of emotional distress during interviews, and co-identifying strategies for managing discomfort (Walker, 2007; Ashton, 2014 in Dempsey

et al., 2016). Participants were reminded to share only what they felt comfortable, and were offered breaks when visibly distressed.

Signposting for further emotional support and crisis intervention was provided on the information and debrief sheets, so that individuals who did not take part in the study were not disadvantaged by not having access to this information.

2.4.6 Conducting Interviews Remotely

This research was conducted within the context of a global pandemic, which in itself raised ethical questions about the timing of the project. However, storytelling has been recognised as a way to sustain people during challenging times (Clandinin et al., 2018).

Offering a degree of flexibility and choice has been argued to facilitate a sense of agency and safety, thereby increasing the quality of interview data for analysis (Heath et al., 2018).

Interviews were conducted at a time/place preferred by participants (Dempsey et al., 2016).

In line with lone working protocols, interviews were conducted during typical working hours to ensure the research team could be contacted/consulted if needed. Participants were also given the option to engage in remote interviews through telephone or video chat, and were screened for sensory, auditory or visual needs in case any adjustments could be made.

Research (Heath et al., 2018) indicates a non-significant difference in data quality between 'face to face' and telephone methods of participation.

Whilst Zoom is considered secure, participants were made aware that this could not be guaranteed. To mitigate security risks, video calls were password protected and 'locked' upon entry. I informed interviewees of my surroundings to assure them of the privacy of the space. Research into use of virtual interviewing tools in qualitative research has suggested that

videoconferencing can have consequences for rapport, non-verbal cues and ethics (Lo Iacono et al., 2016). These considerations have been addressed in sections 2.3.3, 2.3.4 and 2.4.5.

2.5 Analysing Stories

2.5.1 Interview Transcription

As highlighted by Riessman (2008, p. 21), "...transcription and interpretation are often mistakenly viewed as two distinct stages of a project..." (see also Jefferson, 2004a).

Interview transcripts can be understood to play an integral role in the analytic process (Nasheeda et al., 2019). From a social constructionist perspective, they also contribute to the co-construction of narratives between interviewee and researcher, because the researcher plays an active role in interpreting oral material into written text, thereby giving meaning to the personal stories of participants. The role of other transcribers is also important to consider.

The six interviews were transcribed in full verbatim. This included representing pauses; emphasis of speech; intonations; non-audible speech; repetitions of speech; behavioural aspects (e.g. laughter, sighing); interruptions; overlapping speech; 'pronunciational particulars' (Jefferson, 2004a); and 'active voicing' (Wooffitt, 1992).

All interview transcripts were read multiple times whilst listening to the corresponding audio recordings prior to formal analysis; this 'holistic-content reading process' (Nasheeda et al., 2019) facilitated familiarity and immersion in the data. It also supported a thorough representation of oral material using transcription symbols. A summary table and explanation of the transcription symbols used can be found in Appendix Q. An interview transcript extract can be found in Appendix R.

2.5.2 Framework for Guiding Analysis

There are a variety of ways to approach the analysis of narratives, mostly because how a narrative is analysed is intertwined with how it is defined (Wells, 2011). This model of analysis drew on typologies that are particularly suited to oral narratives (Riessman, 2008). These include: thematic/content; structural; interactional; performative; and contextual/discursive. According to Riessman (2005), it is not unusual for these forms of analysis to be combined in contemporary NI practice. This framework is also consistent with literature that promotes a multi-method approach to narrative analysis in order to achieve a rich understanding of complex data (Smith & Sparkes, 2009 in Adlington, 2012; Nasheeda et al., 2019). These aspects of analysis are outlined in Table 9.

These aspects of analysis were conducted for each individual interview to facilitate a thorough exploration of meaning and identity co-constructions in relation to miscarriage. Performative and discursive aspects of analysis seemed particularly important in gaining insight into the identity work and meaning-making taking place (Adlington, 2012).

Table 9. *Aspects of narrative analysis and their analytic focus*

Thematic/content analysis	Primarily concerned with the content of stories told, that is, <i>what</i> is said (Riessman, 1993; 2008).
Structural analysis	Shifts attention to the telling, <i>how</i> a story is told (Riessman, 1993), for example, sequential logic and the organisation of a story (Squire, 2008).
Performative/ interactional analysis	Performative analysis relates to the ‘doing’ as well as the ‘telling’ – the <i>how</i> and <i>why</i> of storytelling (e.g. use of gesture, tone, and body cues). For example, how a teller makes a story

	persuasive by selecting particular narrative devices (Riessman, 2005). Interactional analysis is primarily concerned with the process of co-construction between speaker and listener (Riessman, 2005).
Context/discursive analysis	Contextual or discursive aspects of analysis invite consideration about the micro-contexts of ‘small stories’ (Georgakopoulou, 2006; Squire, 2008) as well broader sociocultural narratives (Wells, 2011).

2.5.3 Analytic Process

Reflective notes were made throughout stages of analysis, intended to notice subjective reactions to the material/process and support reflexivity relating to researcher position. Following a process of holistic-content reading (Nasheeda et al., 2019), interviews were read thoroughly and analysed in turn. Microsoft Word and NVivo qualitative data analysis software (QSR International) were utilised to organise data and assist analysis (see Appendix S and T). Interviews were indexed for content, structure, interactive/performative elements (including identity performance) and context. There was a degree of circularity to this process that allowed for a rich, layered approach to analysis. Table 10 presents questions directly informed by existing narrative literature/studies (White, 2000; Riessman, 2008; Wells, 2011; Cole, 2019) that guided analysis.

The final stage of analysis involved reading across the accounts for points of connection and divergence. Though all forms of analysis were considered, this process was most closely aligned to thematic narrative analysis (Riessman, 2005). Collective analysis offered further context with which to strengthen and/or challenge hypotheses developed from the literature

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review and throughout the analytic stages. Lastly, transcripts were revisited in order to evaluate the perceived ‘fit’ of interpretations made.

Table 10. *Questions informed by existing narrative literature to support with analysis*

Thematic Analysis	<ul style="list-style-type: none"> • <i>What stories are being told?</i> • <i>What kinds of stories/details are missing?</i> • <i>What are the main ‘plots’?</i>
Structural Analysis	<ul style="list-style-type: none"> • <i>How does the person construct their story over time – how does it begin, develop, and end?</i> • <i>In what order are events presented?</i> • <i>Could the story be described as organised, chaotic, chronological, fragmented, etc.? What might this indicate?</i>
Interactional & Performative Analysis	<ul style="list-style-type: none"> • <i>Which stories are present/privileged, and which are silenced/absent?</i> • <i>Who might the story be constructed for, and for what purpose?</i> • <i>Are there gaps, confused parts, or inconsistencies that might indicate preferred, alternative or counter narratives?</i> • <i>How might this person prefer me to see them? How might this influence their storytelling?</i> • <i>How might this story be interpreted differently and by whom?</i> • <i>What counter-narratives may be drawn upon?</i> • <i>How might the presence of the interviewer be contributing to, eliciting, privileging and silencing certain stories?</i> • <i>Could the story be described as organised, chaotic, chronological, fragmented, etc.? What might this indicate?</i> • <i>What relational identities or audiences might be ‘absent but implicit’?</i>
Reading for context	<ul style="list-style-type: none"> • <i>What cultural discourses might the story draw on, take for granted or challenge?</i> • <i>What ‘master narratives’ might the person be drawing on?</i> • <i>Who might be the intended audience?</i>

2.6 Reflexivity

Reflexivity broadly refers to the process of examining one's own beliefs, assumptions and practices. Self-reflexivity in research makes transparent the researcher's values and stance in order for the reader to contextualise the research. Self-reflexivity is important across all aspects of the research process, from its inception to dissemination. It is also congruent with qualitative research such as NI, where the researcher is typically understood to have an active role in narrative co-construction (Riessman, 1993; Wells, 2011). It is equally crucial to reflect on one's relative ability to reflect (i.e. when it is more/less difficult, brings discomfort, avoided, or forgotten).

Detailed process notes and personal reflections were kept throughout the research process and after each of the interviews. In particular, I noted my emotional and relational responses to the storytelling (e.g. shock, sadness, shame, joy, pity, alliance, boredom). I also reflected on my role in the exchanges, the identities I was privileging (in myself and the other), the 'absent but implicit' (i.e. the stories that were silenced, the imagined audiences), the stories I was struck by, and how these factors may have influenced narrative co-construction. This process required me to consider aspects of my identity that were both seen and voiced, and unseen and unvoiced (Burnham, 2012). I was also curious about whether aspects of my identity were more or less present at certain times.

The reflective diary also documented the cumulative effect of the interviews on my learning process. Approaching this work from an outsider perspective led to nuanced and fast-paced development of knowledge/understanding, which needed to be documented in order to maintain a level of transparency and awareness of the (often fluid) interpretations made. Extracts of the reflective diary can be found in Appendix U.

In addition to my personal reflections, the research team provided space for reflection and critical thinking. This facilitated a rich learning and reflective environment that supported the team's commitment to the quality of this project.

2.7 Representing the Narratives

The decision was made to include a summary of each narrative account in the chapter that follows. These aim to offer insight into the conversations by presenting thematic, structural, performative and contextual aspects of storytelling. When thinking about how to present individual stories, a tension arose between the desire to represent a transparent account of the conversations held in the interviews whilst also aligning to the position that the way in which I retell the narratives will inevitably privilege, undervalue or even silence certain stories (Wells, 2011; Randall-James, 2018). To mediate this, direct quotes are included in the account for each narrator, not necessarily to legitimise my interpretations but rather to 're-centre' their voice. Collective narratives are also presented (in a similar fashion) in order to comment on points of connection between the stories and suggest 'commonalities of experience' (Randall-James, 2018; Cole, 2019).

CHAPTER THREE

Analysis and Discussion

3.1 Chapter Overview

This chapter presents a summary of each individual account, in line with the analytic framework outlined in section 2.5 (Riessman, 1993) which takes into account the content, structure, performance and contextual aspects of each story. The ways in which narrators employed or challenged societal discourses will also be discussed (Wells, 2011). Participant's own words are included (*in italics*) amongst my observations in order to contextualise my co-constructions. Following this, collective storylines are presented, whereby points of connection and divergence between individual narratives are outlined. Collective storylines will be embedded and contextualised within relevant literature and theoretical constructs. As previously noted, pseudonyms have been assigned to accounts and all identifiable information omitted or anonymised.

3.2 Individual Stories

3.2.1 Sami's Story

Sami is a British-Pakistani woman in her mid-twenties. She was the only participant to do the interview from her place of work, in a Nursery at the end of the school day. Sami was an engaging narrator who presented a cohesive account of her miscarriage in 2019. Her use of humour established an interactional context and narrative of 'playing down' emotion and vulnerability. She used active voicing (Wooffitt, 1992) throughout the account which facilitated my understanding of who was important to the story and how Sami perceived their role.

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Sami's story began at the time she discovered she was pregnant – an unexpected but “*really happy*” time despite the initial “*upheaval*” at home. Sami brought other people into her story almost immediately which gave the sense that it was important for her to position herself within her family. The story took an instant turn when Sami described her realisation that something was wrong (“*as we come around to accepting it...I started um:: getting really bad back pains↑*”).

Sami initially constructed the miscarriage as a physical experience and described a number of encounters with hospital staff, who were positioned as ambivalent and dismissive throughout the account: “*there was kind of the sensation that something was wrong, but they were just like “no, it’s fine...you’re fine, go home”*”. Her use of pronouns (‘we’/‘them’) indicated a sense of distance and power imbalance between her and staff (“*we went to hospital and they said (1) “yeah everything is fi::ne” *um, you know, “don’t worry::”*”). Sami’s narrative presented her as determined to “*just keep going*”; she ignored her family’s advice to return to hospital and minimised physical symptoms. This positioned her as a ‘good patient’ (Solomons, 2017) who complied with hospital advice, which seemed to counter staff’s perceived insinuation that she was being neurotic.

Sami miscarried while at work. Her use of intensifiers (“*gushing blood*” and “*excruciating pain*”) gave the sense that she was drawing on authorised medical discourse to validate her physical pain. This also invited me into an allyship position, which possibly served to counter her experience of being dismissed by medical professionals.

Sami appeared to orient to wider narratives of miscarriage as reflecting poor decisions/behaviour (“*Obviously, it was my fault*”), immediately juxtaposing this talk with “*God knows best*”. The way Sami ordered these stories gave the impression that she was attempting to resist narratives of self-blame by understanding the miscarriage as God’s plan.

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She then began to construct the emotional aspects of miscarriage, including her experience of depression. Her introduction of emotional experience later in the story, only after she'd storied significant physical changes and invalidation by others, indicated that this sequence had created a sense of safety from which to present alternative constructions/identities.

She spoke of the role of her partner in supporting her ("*he feels like he needs to be the one that's the strong one*"), which aligned with social expectations about gender roles. She seemed to make claim to a 'parent status', a possible preferred identity ("**it doesn't mean for one second that we weren't parents so you know, e-even if it was for two weeks*"). Her partner felt visible in the narratives presented to me.

Sami talked about lack of information/support as to how she could "*honour our baby*", explaining that "*you're just left with...the loss*". The story turned to her involvement with charities and online communities, a "*big part of the recovery*", where she learned about ways to remember the loss ("*memorabilia*"), accessed counselling, and joined support groups. In contrast to earlier talk focused on self-blame and guilt, Sami described a transformative moment when "*they...told me that you know it wasn't my fault and I think that was a really big thing that I needed to hear at the time...because it just felt like it was*".

Sami brought her story to a close by resisting shame/guilt ("*I'm not ashamed of what happened*"). A possible 'quest narrative' (Frank, 1995) surfaced: "*I've accepted it, that it is part of who I am*". Her following talk ("*you think about that child everyday*") left me with a reminder of her pain, and a sense of her resilience.

3.2.2 Cathy's Story

Cathy is a 30-year-old White British woman who works as a teacher and lives with her husband of several years. She presented a concise yet vivid account of her experience of two

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miscarriages in 2019. Her storytelling was clear and mostly chronological. She occasionally used active voicing, typically when describing interactions with hospital staff.

Cathy's story began with her marriage and plans to start a family. She clearly remembered the excitement of the first pregnancy, though recalled feeling that "*something wasn't quite right*". Three days before her 12 week scan, she started bleeding and was in and out of hospital. The scheduled scan confirmed that the baby had stopped growing some weeks prior. Following this, Cathy described "*gushing*" blood which prompted her to return to hospital. Staff were positioned as unfazed: "*they sent us away, saying "oh::, it would be like a heavy period"*". Her tone became disparaging whilst describing hospital support as "*minimal*" and "*very sort of medical*". Cathy explained that a later scan confirmed "*it had all gone*". Her tone was brisk and unemotional, adding to a sense of detachment (also denoted by her switchable use between 'baby' and 'it').

The story swiftly moved on to Cathy's second pregnancy. This story built "*confidence*" but was interrupted by a growing sense of "*dread*" that "*it might happen again*". I felt that I was sharing to some extent in this process of uncertainty, hope and heartbreak as Cathy told her story. Whilst the first miscarriage was constructed as a physical experience, possibly understood within broader medical frameworks, the second miscarriage felt relatively unstoried with a marked absence of narrative detail ("*there were no physical signs*"). Cathy skipped to her decision to have a D&C ("*I didn't want to wait for the natural stuff*"). Her pace increased as she recounted that "*the first miscarriage sort of stay[ed] inside of me for, what, four or five weeks*", indicating some distress at this idea.

In contrast to earlier, more mechanical talk, Cathy introduced a more nuanced relationship between physical and emotional aspects. She contrasted her first miscarriage as "*natural and there's absolutely no denying that it was happening*" with her second ("*[it] didn't feel real at*

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the time”). Cathy reflected that the interview was the first time she had spoken about the miscarriages in depth, and recognised that “*it’s been a lot*”. Though Cathy’s words alluded to significant emotional pain, I noted that a sense of distance remained on both our parts.

Cathy’s narrative turned towards finding a cause (“*we started questioning why this was happening*”). Her determination that “*something else was going on*” led to a referral to a Recurrent Miscarriage Clinic and she joined a research programme which offered a diagnosis (“*I had these elevated ‘killer cells’*”). Cathy’s talk leaned towards narratives of self-blame, though her split between self and body (“*finding out that, you know, it’s something in my body, these cells, that have caused it...has meant that I blamed, may-maybe not myself but like my body for it*”) seemed to remove her from control (and responsibility).

Cathy spoke to support available following miscarriage and drew in other characters more explicitly at this point. Her talk about her marriage and wanting to be “*strong for each other*” countered dominant narratives that tend to assume the male gender role as unilaterally strong/supportive. Cathy spoke about finding it difficult to open up to family members (particularly her mum), which contributed to her decision to access counselling to “*unpack things*”. Her church community was positioned as supportive, especially older members of the congregation (“*a larger proportion that you might expect have been through it*”). Cathy’s talk indicated that miscarriage is more “*taboo*” when experienced at a younger age.

Cathy’s talk of change, such as becoming more communicative about her feelings (“*being able to talk about stuff like, more deeply*”) was balanced with a recognition that “*there’s a lot of emotion still there*” and “*talking about emotions is probably getting harder*” as time moves on. This closing narrative seemed to present Cathy’s new-found drive to talk and process emotions as incongruent with the social support on offer.

3.2.3 Laura's Story

Laura is a 44-year-old, White British woman who has experienced 4 miscarriages since 2016. She was a reflective, generous storyteller and spoke as though she was well-versed in the story. Her vivid use of metaphor and narrative detail facilitated rich insight into her experience. Laura fluidly time-travelled between past, present and future (a possible tool to separate narrative events – Schiffrin, 1981). At times, this gave the impression of a 'chaos narrative' (Frank, 1995), with numerous, intricate sub-stories. Laura named this early on by situating her story in a constant state of flux (*"it's been quite difficult, uncertain...transient...sort of time in my life anyway"*), a clause that encapsulated the essence of the story (Labov, 1972).

Laura's use of pronouns gave a strong sense that this narrative construction of her journey and identity development did not emerge in isolation but in collaboration with others. She named her age early on, as if it was of central importance (*"both of us were, you know, nearing 40"*). For each of her pregnancies, she described *"falling pregnant very quickly"*, which seemed to express elements of 'ironic narratives' (Kelly, 1994).

As her story of recurrent miscarriage unfolded, Laura described an increasing indecision about whether to *"keep trying"*. There was a sense of urgency (*"we didn't really have a lot of time to waste"*) alongside defeatism (*"we were just like "well it's not gonna happen"*). Laura's act of constructing this latter mind-set as *"self-protection"* created a sense of trepidation about the story to come.

Unlike other accounts, Laura constructed her miscarriages as primarily emotional experiences. Her brief nod to physical symptoms hinted at more severe difficulties (*"obviously mine were still relatively early but even at 8 or 9 weeks it's just...I never would have imagined the pain, the physical experience of it"*). Laura attempted to story the

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miscarriages in order (though the first and second felt rather enmeshed) and this gave a sense of progression in terms of emotional intensity/significance.

Laura constructed her relationship (“*we’ve been amazing to each other*”) and her experience of counselling (“*it made me uncover so much emotion and feelings that...I just didn’t even let myself think about*”) as helpful in making sense of miscarriage. Despite this, she drew on limited sense-making narratives based on “*common messages*” about miscarriage as being either “*just one of those things that...can’t be helped*” or “*caused by something the WOrman has done*”. As her story progressed, Laura negotiated between constructions of responsibility and blame. She presented herself as “*cautious about overdoing it*” and wanting to “*do everything right*”. Her pace slowed, eye contact was lost, and she became visibly emotional as she concluded that “*...all my eggs are crap*”.

Laura reflected on her initial pragmatism to the first miscarriage (“*it was kind of like “oh well, you know, it’s just one of those things...loads of people lose them”*”) and second miscarriage (“*we picked ourselves up and went “move on”...put on a brave face*”). She acknowledged focusing on “*the medical elements*” and “*pushing the emotion aside*”. Laura frequently used metaphor and symbolism (e.g. “*it’s like a treadmill, like I fell off and then went “right, hop back on”*”) which could be conceptualised as devices to make sense of the chaos (Horstman et al., 2020).

The construction of a lost or damaged identity was one of the strongest threads running through Laura’s narrative (“*I’ve felt like a shadow of my former self*”). Counselling supported her to recognise that the miscarriages had “*massively affected my feeling of who I was*”. She also named feeling “*anger and resentment*” towards the miscarriages (“*I’d put my life on hold*”).

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Towards the end of her story, Laura's talk turned to forms of coping (e.g. running and raising awareness). This story resembled a quest narrative (Frank, 1995) and gave a sense of resolution to the story (Labov, 1972). Laura's drive and determination were also characterised by her retort to "*traditional social expectations*" and assumptions made about "*a 44-year-old woman clearly having kids*" – "*actually I do have a family, I don't have children but I do have a family*". This skilful 'coda' (Labov, 1972) signalled the end of the narrative, and brought Laura's story to a defiant close.

3.2.4 Jasmine's story

Jasmine is a 45-year-old Chinese woman who narrated her experience of two miscarriages. Her story began with a long, fluid stretch of talk, which gave the sense that it was a familiar story to tell. For most of the story I was positioned as a passive audience, though I found myself engaged by her emotional storytelling and 'comic/ironic' narratives (Kelly, 1994), which may have served to create distance through humour.

Similarly to Laura, it seemed important to Jasmine to name her age (particularly in reference to me as her immediate audience: "*this is going to be wa:y before your time*") and age represented a key thread throughout her account. Her story began by introducing her relationship and the decision to "*start trying*".

Jasmine recounted two very different experiences of miscarriage. Due to being "*foolishly*" unaware that she was pregnant, the first miscarriage came as an understandable shock ("*it just didn't occur to me that I was, like, Miscarrying*"). Jasmine brought narratives of "*guilt and shame*" into her story early on ("*I automatically started to blame myself... "oh it must have been the sushi, o:h:: I was drinking*"). Brief descriptions of symptoms were embedded in her talk, their unspoken impact made visible through embodied communication such as slow, soft voice and frequent wiping away of tears. Jasmine reflected that the first miscarriage was

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“physically the most painful and traumatic”. This comparative talk bridged her story of the second miscarriage, which *“hit me harder because I knew about [the pregnancy]”*.

Jasmine’s second miscarriage started whilst she was shopping. Her talk hinted at denial as she remembered debating finishing her shopping before tending to the bleeding. She attended hospital and miscarried in the bathroom. I noted extreme sadness as I listened to her story of trying to rescue the *“perfectly formed sac”* with the toilet brush as she *“tried to find a sign of a baby”*. Jasmine’s talk became fragmented as she described her regret about *“handing it over to the nurse... ’cos they would’ve just discarded it”*. She tearfully finished her first stretch of talk by drawing on narratives of fate (*“it wasn’t meant to be”*).

Beyond the first part of her account, Jasmine’s story lost its sense of chronology as she became more reflective and centred on meaning-making. She spoke of a conflict between wanting to *“forget about it and kinda get on with life”* and her desire to *“process it”* (*“it’s just really overwhelming”*). Jasmine accessed counselling – a mixed experience (*“you go round in circles and nothing really changes”*). Support groups and online communities were constructed as helpful (*“knowing that I wasn’t alone, erm, because...you feel like you’re the only person”*) but Jasmine also recognised that *“it can only, like, do so much”*.

Jasmine reflected on cross-cultural constructions of miscarriage: *“there’s a lot of shame and guilt attached to miscarriage...in some cultures you just don’t talk about that stuff”*. She referenced British clichés/metaphors (*“stiff upper lip”*, *“brushing under the carpet”* and *“not airing your dirty laundry”*) (Horstman et al., 2020) and drew parallels to her family culture (*“we don’t talk about, you know, our feelings or emotions, LEt alOne something like miscarriage”*). She also appeared to equate her family’s support with hospital care in terms of focusing on the physical recovery (*“[mum] was good at...making broths and Chinese soups”*). Jasmine used metaphor to describe her husband’s role of support (*“my rock”*) and

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their previous disconnect (“*bumpy road*”). A restitution narrative (Frank, 1995) briefly surfaced as Jasmine concluded they were in “*a better place*”.

Jasmine reflected on “*this taboo in society*” which makes miscarriage “*too uncomfortable to talk about*”. She spoke in detail about the problematic silence surrounding miscarriage (“*like the 12 week thing...when it does happen it’s even more isolating because nobody ever knew*”). Jasmine’s talk took a philosophical turn as she described an intergenerational lack of education/understanding about the female body, which was linked to “*deep-rooted misogyny*” and attributed to Jasmine’s “*naivety*” about fertility. I was positioned as a potential ally (“*hopefully you’ll be one of those people who can help make those necessary changes*”).

Jasmine ended her story by reflecting an unwillingness to return to ‘normal’. She positioned herself as “*a different person entirely than I was before*”, constructing a sense of personal growth through adversity (Frank, 1995).

3.2.5 Beth’s story

Beth, a 35-year-old White British woman, storied her experience of three miscarriages since 2018. Overall, Beth narrated her story chronologically by anchoring events to dates of personal significance.

Beth was in her study for the interview and presented an academic/career-driven identity before storying her “*journey with infertility*”. She dedicated time to set the scene (Labov, 1972), starting with the decision to “*try for a baby*” after a duration of irregular periods (“*we already knew something wasn’t quite right*”). This was entwined with talk about her father becoming seriously ill, which implied a ‘bad omen’ for the events that followed.

After some initial confusion (“*they all blur into one*”) Beth pinpointed the exact day she noticed unwanted signs during the first pregnancy, a specificity that conveyed a sense that it

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was not easily forgotten. Her instant regression to the previous conversation was interpreted as avoidance (*“I started bleeding before that-so you asked about hobbies, um, and one of the things that I'm really into is running”*). Though, her following talk seemed to draw on widely-accepted narratives about the causative nature of vigorous activity (*“after runs I was bleeding and I thought, “hmm, maybe...I’m overdoing it a bit”, you know(?)”*).

Beth’s narrative of her second miscarriage gave a sense of unwanted familiarity (*“I absolutely knew what was happening”*), whereas the third was presented as a complete shock at a routine scan (*“we were just astounded because we-everything was going right, th-there was no bleeding”*). The absence of physical symptoms seemed to contribute to a sense of meaninglessness (*we’ve been through all the tests...there’s no reason they should keep happening”*).

Like others, Beth’s constructions were initially physical (*“I remember that feeling, the physical feeling of not being pregnant anymore”*), characterised by ‘markers’ of fertility/pregnancy (*“my boobs immediately deflated”*). Beth acknowledged this as she explained that *“I see miscarriage as...it’s almost kind of more the physical side of it”*. She continued, almost in an educative role: *“but it's not just a physical...it is not just one thing that happens, you know(?)”*. This bridged her talk of psychosocial constructions (*“I talk about miscarriage and I talk about grief...the grief is the social process...and I see them, I, I talk about them differently”*).

By introducing grief, Beth brought her husband into the story (*“I was dealing with my grief but not our grief”*). This created a sense of separation, which seemed symbolic at times; she described being *“split”* at the hospital (*“he was on the other side of the curtain...I was crying and he wasn't there with me”*). Similar constructions surfaced at a later point as Beth spoke of losing her friendship group at church (*“they all had kids and they went into their sort of*

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crèche and sat in a different part of the church”). Beth described the importance of processing grief together with her husband (“*we never made sense of what happened*”) and her use of pronouns suggested the presence of her husband in the narratives presented. The time spent “*remembering and crying together*” seemed restorative.

Beth storied her decision to “*leave the church*” due her friendship group “*withdrawing*”, leaving her feeling “*invisible*”. She positioned herself as “*a constant reminder of what can go wrong*”. Beth resisted being “*cast as this bitter, vengeful*” person or a “*glass doll in need of protection*” in favour of a possible preferred identity (“*I’m strong – you have to be*”).

Beth spoke about receiving a teddy from hospital; while her deservedness of this gift was minimised (“*it was meant for stillborn babies and we were only 7 weeks*”), the bear seemed to bring “*so much comfort from holding him that day*”. His significance was apparent (“*we couldn’t deal with the bear being locked away with all that grief...so we’ve kept it out...and [he’s] always, always sat on our bookshelves with us*”). Similarly, Beth spoke of her dog and the “*peace*” that “*being able to nurture her has brought me*” (though she adamantly resisted the ideas of ‘pet parents’ or “*baby replacement*”).

Beth described a sense of transformation (“*I’m a completely different person now*”), which was interjected as she turned to the future (“*we are about to embark on IVF*”), reminding us both that her fertility journey is not yet over. This presented a cocktail of hope and inevitable failure (“*we are waiting for the miscarriage to happen...the next one will be our last*”).

Beth presented an identity that continued to resist “*standards of motherhood*”. She countered cultural stereotypes of “*women juggling career or kids*” by asking “*hang on a minute...why can’t women do other things with their lives?*”. Her closing narrative created a sense that she was constructing a new identity and future (“*that’s what I’m currently in a position to*

explore”), reminding me that “*I am more than my miscarriage*” and that her story is far from over...

3.2.6 Zadie’s story

Zadie is a 36-year-old British woman of mixed White and Black Caribbean descent who storied her experience of nine miscarriages. Her storytelling was charismatic yet vulnerable. Zadie tended to focus her story around relational and identity change narratives rather than taking me through each miscarriage chronologically.

Zadie oriented me to her story by introducing her partner and “*small but intimate*” family, immediately constructing her relational identity. This brief moment of ‘normality’ was infringed by her talk of being “*outwardly bubbly*” and knowing how to “*put on a smile*”, which hinted at a private pain behind this mask worn for the “*outside world*”.

Zadie storied three of her miscarriages in some detail, referring to these babies by name. As she moved through the story, she tended to refer to the miscarriages as a collective experience. Zadie constructed miscarriage within broader medical frameworks: “*it’s almost like living with a disease...it’s something that I can’t escape, it will never go away...it’s an invisible illness*” (see Lampman & Dowling-Guyer, 1995).

Zadie presented two distinct identities: the ‘self before miscarriage’ and the ‘self after miscarriage’. She would often juxtapose these selves, which served as a continuous reminder of this unwanted change marked by a loss of self-worth and self-respect. Like Cathy, Zadie also seemed to construct distance between her body and her sense of self; her body was personified (“*even my own body’s playing tricks with me*”) and sometimes addressed directly in her talk. This seemed particularly potent as she spoke of a missed miscarriage where there

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were no physical symptoms: *“even now, you’re kicking me when I’m at my absolute lowest...it felt cruel, like...why would you try and give me that false hope(?)”*.

Zadie commented on her (previous) partner’s change in identity (*“it just affects your relationship and the dynamic and the person that I married just wasn’t that person anymore”*). She was the only participant to talk about the impact of miscarriage on romantic intimacy. She described the break-down of her first marriage following miscarriage, after which she entered into an abusive relationship. She appeared to position this as a form of self-punishment (*“I don’t think I deserved anything better”*), which reinforced her strong sense of unimportance. Her next relationship also ended following multiple miscarriages and an extra-marital affair. Zadie continued to centre on self-blame narratives as she spoke of her *“failure”* and *“incompetence”* (Dyer et al., 2002):

“I had broken him because I couldn’t give him a child and he married me and we thought we’d have this family and so (.) how can I be angry with him when all he wants is a family and I can’t give him that, as his wife”.

Reflecting on her current relationship (which was positioned as secure and supportive), Zadie seemed to question social assumptions about gender roles (*“sometimes men can...internalise more and feel like they have to be sort of the stronger one”*), commenting that these stereotypes were reinforced by others (*“his parents messaged me but didn’t message him”*).

Zadie’s talk turned to her experience of counselling:

“I had so many emotions and hurt and questions that I wanted a place where I could like put that out there (2) but with the NHS that isn’t the place for it and they’re more focused on like CBT...so it can help me with different breathing techniques or (.)

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thinking about triggers, um, so that side of it, yeah, but for actually dealing with the actual reasons why...”.

Zadie negotiated her position within dominant narratives about age and fertility. Her purposeful description of her pregnancies as planned (“*I wanted to be a young mum*”) possibly worked to counter “*disrespectful*” associations between younger maternal age and carelessness or ‘mistakes’. Zadie spoke of a shift in external perception as she aged, marked by unhelpful comments (“*rather than saying “oh, you’re young, you’ve got loads of time” now it’s “oh, the clock’s ticking”*”). This seemed intrinsically connected to the “*trauma of turning 30*” which appeared to draw on normative cultural values about a woman’s life stage and family status.

3.3 Collective Storylines

The preceding section re-presented each participant’s narrative account. This section considers points of connection and divergence between accounts by examining patterns in the data. Whilst collective analysis drew more heavily on thematic NI (Riessman, 1993), aspects of structure, performance and context remain important and are still considered. Table 11 summarises the main storylines and sub-stories identified during collective analysis. Each story will be presented in turn below. Unsurprisingly, many narratives discussed here align with the interview questions. It is therefore important to remain reflexive about the methodological process and my role as researcher in terms of stories that are advanced or silenced. In addition, this commentary on patterns in the data are presented from my lens/position as outlined in Chapter One. As a caveat to this section, I draw on the words of Beth: “*everyone experiences this differently...I think it's really easy to generalise and I think that's partly what society does...[but] they're very individual, they are unique.*”

Table 11. *Main storylines and sub-stories*

Story	Sub-story
Stories of change	<p><i>‘You don't expect it's going to happen to you’</i>: A life disrupted</p> <p><i>‘That person that I was before just went’</i>: Disrupted identities</p>
Stories of challenges	<p><i>‘These babies were real and they were loved’</i>: Validating ambiguous loss</p> <p><i>‘It just felt like it was my fault’</i>: Making sense of internalised blame</p> <p><i>‘You're expected to just get on with it as if nothing happened’</i>: Accessing NHS support</p>
Stories of growth	<p><i>‘I want to make a difference’</i>: Regaining agency (through meaningful acts of resistance)</p> <p><i>‘I'm a completely different person and that's not all bad’</i>: Reconstructing identity, creating a new future</p>

3.3.1 Stories of Change

Participants' accounts can be conceptualised as 'narrative of experience' (Squire, 2008), which tend to follow chronological structure based on components of storytelling: orienting the listener, introducing the event that breaks stasis (initiates the plot of the story), evaluation (the narrative's meaning) and resolution (closure and/or a return to stasis) (Labov, 1972).

Participants storied miscarriage as breaking a sense of stasis in various ways. These 'regressive narratives' (Robinson, 1990) describe a move away from a valued goal and give expression to tragic storylines (Bury, 2001).

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'You don't expect it's going to happen to you': A life disrupted

Miscarriage has been described as a disturbance of social norms, expectations and (pronatalist) master narratives (Cabell et al., 2015; Wells & Heinsch, 2020; Horstman et al., 2020). Women whose pregnancies do not adhere to culturally-expected, normative transitions to motherhood (Cabell et al., 2015; Wells & Heinsch, 2020) must create stories that account for their violations. Participants narrated the sudden and unexpected nature of miscarriage. For some, this seemed to relate to a sense that miscarriage happened 'out there' but not close to home:

Beth: *"it's something abstract...you know there's a word called miscarriage and you know that women lose their babies but that happens to someone else, right?"*

Cathy: *"you definitely don't...expect it's going to happen to you"*.

Sami: *"you understood it but you didn't have a connection towards the word, you know-unless you suffered it...obviously I've seen it in storylines you know, like in EastEnders and, that type of thing, um, but yeah, it wasn't until recently where it became (.) different (.) so the impact it became a bit more (1) real"*.

The unexpected nature of miscarriage was often connected to an initial sense of denial (McCreight, 2008). For example, Jasmine stated: *"at first I thought...well, a lot of women bleed during pregnancy, it's really common"*. Jefferson (2004b) suggested that instances of 'first thoughts' provide a way for speakers to explain and normalise extraordinary events. Because this talk occurred in a context where both speaker and listener knew what happened next, it heightened a sense of tragedy about the story to come (Bury, 2001).

Consistent with literature (Carolan & Wright, 2017) participants' narratives created a sense of disruption to an otherwise 'normal' life trajectory. This could be conceptualised as a

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‘contamination sequence’ (McAdams et al., 2001), which involves a ‘good life scene’ being spoiled, ruined or undermined by what follows. Constructing stories in a temporal, logical order is fundamental to the way humans attempt to understand events and establish coherence across past, present and unrealised experience (Ochs & Capps, 2001 in Solomons, 2017). When invited to tell the story of their miscarriage, most participants started by telling me about their relationship and events that led up to the pregnancy. This seemed to draw on normative values and assumptions about what a typical fertility journey *should* look like (Corbet-Owen & Kruger, 2001; Cabell et al., 2015; Wells & Heinsch, 2020). Structuring the narratives in this way perhaps mirrored the lived experience of the narrators as their expectations were thwarted (Trepal et al., 2005). This is also consistent with research (Horstman et al., 2020) that positioned miscarriage as a ‘chaotic force’ that disrupts the expected forward progression of life. The nature of ‘moving backwards’ also corresponds to ‘regressive narratives’ (Robinson, 1990).

According to Jefferson (1984; 1985), how people order ‘troubles-oriented talk’ often represents a tension between attending to the ‘trouble’ and the ‘business as usual’. This could signify a discomfort with ‘restitution narratives’ as participants negotiated with the idea of a return to a life similar to the one before (Frank, 1995). Some interviewees drew on broader understandings of recovery as beginning with acceptance, such as Laura: “*coming to terms with the decision to stop trying...and realising that we’re not, (.) I’m never gonna be a mum*”. Acceptance is often conceptualised as a gradual process of adjustment involving constructing and integrating a new identity (Åsbring, 2001). Though, some narratives gave the impression that a return to ‘normal’ was not possible or even desired (Thomas-MacLeod, 2004):

Laura: “*I feel like I’ve come to terms with some of it, I’ll never, I’ll never completely get over it*”.

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Jasmine: “*when something like that happens to you...you can't just go, “OK (.) well, you know, this happened to me, I lost a baby, let's just get back to normal, how things were before”*”.

Participants tended to move between ‘progressive’ and ‘regressive’ narratives throughout accounts (Robinson, 1990), possibly representing a difficulty in reconciling the ‘dislocation’ between the world that *is* and the world that *should be* (Littlemore & Turner, 2020).

Constructing restitution/acceptance as heroism in the face of adversity is prevalent in Western cultural contexts, particularly in relation to physical health (Adler et al., 2015). Restitution narratives can be inspiring but also alienating (Frank, 1995). Participants alluded to this alienation in talk about the ‘relentless hope’ of the pregnancy loss community. Gaining hope from subsequent pregnancy success stories was reported as a reason for some people accessing online support (Gold et al., 2012). Zadi described how the “*focus always goes back to rainbow babies instead of the miscarriage*”, which seemed to reinforce the idea that you’re “*not supposed to talk about it*”. This sense of secrecy (“*I know that w-we are out there, I'm sure*”) (Miall, 1986) seemed congruent with Zadi’s narrated discomfort with restitution, hence maintaining a sense of disruption and leaving her in a state of limbo (“*it's hard to find your place in society*”).

‘That person that I was before just went’: Disrupted identities

Littlemore and Turner (2020) suggested that inhabiting a ‘new reality’ can lead to individuals viewing themselves as different people, or as split from their ‘main identity’. All participants storied a sense of change, loss and/or damage in relation to their sense of self:

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Zadie: *“I remember getting home, um, and just, I just wasn't the same person... that moment was the single most biggest changing point in my life”*.

Beth: *“I am a fundamentally...completely different person now”*

Jasmine: *“[I'm] a different person entirely than I was before...it changes you”*.

Laura: *“they've had ju-a massive impact on my confidence, my self-belief...my self-esteem...erm, who I am and my purpose and meaning and identity”*.

Some participants presented confused and tentative identity narratives, often due to the uncertainty of what was lost (McCreight, 2004). Cathy questioned whether she 'qualified' as a parent, naming a *“sort of half way point”*. She spoke of a connection with *“something growing inside me”* but noted instances where *“it didn't feel right”* to consider herself a parent. Through this talk, Cathy constructed an identity that was changed (*“I think all your experiences affect who you are”*) but undefined.

Some constructions aligned to a 'spoiled identity' (Goffman, 1963). Laura spoke about *“feeling like each time I'd lost a big part of me”*. Her use of metaphor conceptualised her experience: *“it's like I'm...trying to find my path and I can't...I feel pretty lost and empty”*.

This also aligns with Franks' (1995) 'chaos narrative', which tend to refer to *“...unpredictable symptoms, unsympathetic responses and lack of control, which impede on a 'clear path ahead”* (Solomons, 2017, p. 57). Zadie storied similar feelings of chaos (*“it changes you, who you are and you become a stranger to yourself...I don't even know who I am anymore”*) and spoiled identity (*“who the hell is going to want me?”*), talk that appeared to be reinforced by Christian narratives about the duty of a wife and purpose of marriage (Barrett, 2010).

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Ideas borrowed from physical health literature may contextualise participants' constructions. The disruption caused by illness risks a 'major assault' on identities, which can create 'biographical disruption' (Carricaburu & Pierret, 1995) or a 'violated self' (Solomons, 2017). This can lead to the development of a 'new self' (Åsbring, 2001) through a process of identity reconstruction, whereby an individual develops a new sense of normality and their place in the world (Solomons, 2017). This can be seen in Sami's talk about her hopes for the future: *"I think I've definitely changed (.) since having::: errr*, a miscarriage...the wanting to be a mother...now more than ever since I've lost one"*.

In their study focused on identity and adjustment following illness, Dickson et al. (2008) describe that perceived loss of agency following change can elicit a crisis of identity. Identity crises can lead to a comparison between the current (ill) self and the old (desired) self, as narrated by Zadie:

Zadie: "I'm just not the same person and I'm fighting because I want, I want to get that back so I feel like it's a constant battle with my mind and with my body...I've come through a lot and I'm still fighting".

According to Adler et al. (2015), the construction of 'the fighter' represents a person's agency over their health difficulties. Themes of agency were narrated across accounts:

Laura: "I think for ages I was just living in this limbo of uncertainty and emotional rollercoaster of feeling completely out of control with it".

Zadie: "with miscarriages you've got no control...being able to take that control was really important because...I was powerless".

Carolan and Wright (2017) suggested that the process of making sense of the loss can in itself offer an increased sense of control over the 'chaos'. Bell (2013) suggested that after the initial

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disruption and confusion of falling ill subsides, individuals often seek to develop a secure, ‘realigned self’ (or ‘identity continuity’ – Wolfenden & Grace, 2012). She argued that illness can shape people’s narratives of the self through disrupting relationship with their body as well as their social position (Bell, 2013). This is also consistent with literature (Carolan & Wright, 2017), which suggests that miscarriage can be perceived to disrupt a sense of motherhood and thus represents a shift in status characterised by a loss of belonging (Rice, 2000; Corbet-Owen & Kruger, 2001). This can be experienced as a sudden ‘outsider status’ to normative ‘mum culture’ (Carolan & Wright, 2017). Beth spoke to this in her talk of motherhood as a “*closed community that I’ve been excluded from for a very long time*”. Whilst she narrated being “*more accepting of [miscarriage] as part of my identity*”, this was balanced with “*equally, it’s not something I’m going to be defined by*”. Through this talk, Beth seemed to counter wider social discourse that reduce women to their fertility (“*it feels like this is all you are, all you are is your fertility and...people see you as a failure because you haven’t had a baby*”).

3.3.2 Stories of Challenge

Stories relating to the challenges associated with miscarriage represented an area of significant commonality across the accounts. Whilst it is not possible to comment on all collective storylines, the more prevalent stories are discussed.

‘These babies were real and they were loved’: Validating ambiguous loss

A key thread between accounts related to how participants sought to understand (and validate) their distress in the context of ambiguous loss. This phenomenon is well-

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documented in the literature (Trepal et al., 2005; Carolan & Wright, 2017; Horstman et al., 2020) and aptly summarised by Laura: “*Losing a pregnancy or a baby is-because they’re not physical and no one’s seen them...people can’t see the tangible thing...people don’t think you should be upset about it*”. In attempting to conceptualise what was lost, individuals made reference to ‘loss of imagined future’ (Carolan & Wright, 2017) or ‘what might have been’ (Littlemore & Turner, 2020):

Jasmine: “*they may have not lost a baby...but it’s still a loss to them...it’s everything that you’d hoped and dreamed for*”.

Zadie: “*it’s almost like overnight everything I thought my life would be was just pulled away*”.

Sami: “*Once you find out you’re pregnant you start having these, erm (.) kind of dreams for your child...what you’d name them...(laugh) things like if we’re going to make them like into Lord of the Rings fanatics or you know make them really well-read, and erm have like piano lessons, or something, you know(?)*”.

Beth: “*we had visions of the puppy and the baby growing at the same time and how lovely that was*”.

Participant’s use of pronouns often gave the impression that this future had been imagined in collaboration with their partner/family (e.g. Jasmine: “*we made plans as soon as we found out [we were pregnant]*”).

The process of making sense of ambiguous loss did not always seem to translate to identity constructions (e.g. Jasmine referred to “*the babies that I lost*” but unlike others made no claim to a parent identity/role). Some interviewees spoke of ambiguity related to the length of the pregnancy and how this influenced the meaning of the loss (Cosgrove, 2004):

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Laura: *“I never thought of them as babies or, you know, we never named them, because they were so early”*.

Jasmine: *“[thinking about] the early miscarriage versus the later ones, and, you know, where you just don’t feel...as important, you know, because it’s so common and because it happens (.) so early that I don’t think they realise that we still experien-go through the same emotions as those who had a later loss”*.

Jasmine’s use of pronouns (‘they don’t realise’) was vague but hinted at wider societal/community perceptions. This seemingly influenced her felt need to minimise the significance of her loss (*“I felt that...shouldn’t have made such a fuss over it”*). Jasmine worked to challenge a “grief hierarchy” (*“a loss is a loss...grief is grief”*) based on assumptions about ‘lesser losses’ (Lovell, 1983). Jasmine appeared to question her deservedness for support, yet contrasted this with the lack of (and desire for) recognition:

“[early miscarriage] is worse in a way, because you have that added guilt and shame, erm, and you don’t get the same, you know, validation...you don’t get the support from, you know, the bereavement mid-midwives or anything like that...not even-I wasn’t even given a leaflet...I walked away with nothing”.

Zadie storied similar challenges associated with recognising her loss in social arenas:

“people will say “oh, have you not (.) have you got kids?” And then, I hate saying No because it’s like, well, I saw two-I say my two sons (I) I saw them (.) they might not have been like full term but one’s buried and one’s cremated, and they’ve got names. They existed”.

This talk began by navigating difficulties associated with an unresolved social status and societal value placed on motherhood (Carolan & Wright, 2017). Zadie’s narrative then turned

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to disenfranchised grief (McCreight, 2008) and mourning rituals, which gave the impression that this had been an important part of validating the existence and loss of her babies, as well as the significance of her pain. The search for meaning after miscarriage strongly relates to beliefs about death, which are rooted within cultural, religious and familial values (Carolan & Wright, 2017). Social and legal barriers to death rituals/ceremonies shape the parent's ability to grieve a miscarriage (McCreight, 2004) and represent multiple losses associated with ambiguous loss.

Other participants storied the importance of 'saying goodbye' in validating their loss:

Beth: *"we wrote letters to all our babies...lit a candle...kind of in place of a funeral"*.

Laura: *"I know I wanna do something now so I think I'm going to get a tattoo .hheh (.)*

I've never got a tattoo, but just a little one so I've got something with me all the time".

Beth spoke of her commitment to *"honour these three babies"* through sharing her story (*"if I don't talk about them...nobody's going to know they existed and they did...they were wonderful and they were loved so much"*). These narratives are in line with research that identified validation of physical and emotional experience, the need for mourning, creating memories, and re-membering (Becker, 1995; Carr, 1998) as common needs following miscarriage (Abboud & Liamputtong, 2002).

'It just felt like it was my fault': Making sense of internalised blame

McCreight (2008) argued that the search for meaning following miscarriage typically involves a search for causality. This process operates within 'contingent narratives' about the beliefs, origins and causes of an illness (Bury, 2001). 'Core narratives' (i.e. cultural levels of

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meaning attached to suffering and illness) (Bury, 2001) also inform and perpetuate myths about the causes of miscarriage that are still highly prevalent today (Madden, 1988).

The absence of a medical explanation or ‘clear answers’ can exacerbate internalised guilt and blame (Nikcevic et al., 1999; Åsbring & Närvänen, 2004), as narrated by participants:

Jasmine: *“what did I do? Did I do something wrong? Did I eat something? Did I, you know, cause it?”*

Beth: *“I spent a lot of time after the first one thinking it was the running that did it”.*

Sami: *“it felt like I, you know, I’d let everyone down”.*

Laura: *“I did probably question whether I’d done anything myself or whether there was something I shouldn’t have done”.*

This talk aligns with cross-cultural narratives about the role of women’s bodies and behaviours in causing miscarriage (Rice, 2000; Abboud & Liamputtong, 2002). This sometimes manifested as specific actions or constructions of embodied identity. For example, Sami referred to herself as a *“curvy, big girl”* and questioned whether she had eaten the *“wrong foods”*.

Certain participants constructed a sense of explanation linked with maternal age (Abboud & Liamputtong, 2002) and for older interviewees this was connected to ‘time running out’ (Carolan & Wright, 2017). Jasmine spoke of being unable to *“turn back the clock”*, appearing to draw on ‘taken-for-granted knowledge’ (Solomons, 2017) related to a woman’s ‘biological clock’. Her presentation of ‘evidence’ that age doesn’t necessarily determine fertility (*“there’s still women out there who are far younger than me who are struggling”*) possibly reflected her attempts to source alternative explanations to self-blame such as fate or luck

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(Abboud & Liamputtong, 2002). Narratives that draw on religious/spiritual notions of a ‘higher plan’ or fate can be said to increase ambiguity or confusion about the loss (Carolan & Wright, 2017). Jasmine spoke to this later as she voiced her hatred of the mantra ‘things happen for a reason’ (“*no they eff’i:ng doN’T! .hhh (laugh) sometimes really crappy things happen for no reason at all, it’s just the way it is*”). Zadie also hinted at confusion when drawing on religious narratives, which led her to question her deservedness for punishment: “*why would I be made so that it looks like everything’s okay...it makes you question, what I’ve ever done(?)...I don’t think I’m a bad person*”.

Assuming responsibility for miscarriage may serve to restore a sense of agency, particularly over future pregnancies (Littlemore & Turner, 2020). Beth storied an increased sense of responsibility for her second pregnancy (“*cutting out caffeine straight away, you know, do everything I’m supposed to*”). However, constructing personal agency in this way also posed difficulties for participants (Abboud & Liamputtong, 2002) and led to ‘moral claims’ (Bury, 2001; McCreight, 2008). These are often reinforced by others, as Laura described with her mum: “*she basically said to me(.) “you’ve got to slow down...start looking after yourself”*”.

Some participants created distance between the self and body, which enabled them to ‘personify’ and attribute a ‘separate agency’ to their bodies (Littlemore & Turner, 2020, p. 54). For some, this seemed to provide a way to distance the moral self from blame (Bury, 2001; Miller, 2015):

Beth: “*I punished [my body] by doing the marathon...I thought it deserved it, and I was proud of that*”.

Zadie: “*it’s hard to look at and to like a body that you feel has let you down*”.

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Cathy: “[I was] *blaming my body for it a bit...I’ve ne-never really blamed it on anything I did, you know, anything I can control, but, you know, it’s made me probably think a bit less of, of my body*”.

This is consistent with Littlemore and Turner (2020) who argued that the embodied nature of pregnancy loss has consequences for the relationship people have with their bodies. Laura suggested that the reason she is “*fitter than I’ve ever been*” was an attempt “*to compensate for the fact that [my body] is rubbish in other ways*”. Zadi spoke of her anger about needing to lose weight to access IVF “*because I’m not good enough as I am*”. Sami described her plans to eat healthily and exercise (“*so when I do...try for another baby my body’s physically ready for it and we limit the chances of whatever went wrong the first time*”).

Foucauldian (1991) ideas of the body as representative of identity constructs and adherence to ‘normality’ seem relevant here. McCreight (2008) drew on these ideas and argued that powerful medical constructions of miscarriage locate the ‘problem’ of miscarriage within women themselves, therefore positioning them as responsible and inadequate. Medical discourses and practices impose narrative structure on embodied lives, and are consequently internalised (Hardy & Kukla, 2015). This connects with participant’s narratives of blame which tended to be internalised from the wider environment in times of crisis/chaos (Dickson et al., 2008).

‘You’re expected to just get on with it as if nothing happened’: Accessing NHS support

Participants constructed failures in understanding and invalidation of physical/emotional needs as the most significant barriers to accessing support. Whilst participants spoke about similar difficulties associated with family/friends, this section will primarily focus on NHS

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primary and secondary care as this represented one of the most prevalent storylines across accounts.

All women storied the experience of seeking medical consultation in response to early signs of miscarriage, which were typically perceived to be met with unhelpful attitudes:

Beth: *“I definitely don't feel that they, um, show, have shown me any kindness, support, respect, um, and I think that my trauma was definitely made worse by the hospital and hospital staff”*.

Jasmine: *“I'm really proud that we have the NHS in this country...but, yeah, there's a-a hell of a lot of work, I think, that needs to be done, erm, when it comes to medical, you know, professionals and the, the language they use”*.

All participants utilised active voicing (Wooffitt, 1992) to characterise dialogue and interactions with medical staff (for some, this was the only time it was used). This form of storytelling invited me ‘onside’ and narrative co-construction felt more explicit at these points (Jefferson, 1974). Medical staff were presented as ‘powerful but removed’, and participants as ‘powerless but credible’. This sense of ‘bio-power’ (Foucault, 1991; McCreight, 2008) supports a small body of literature that suggests women and minority identities are disproportionately disbelieved in healthcare settings, particularly in relation to ‘invisible’ illness/difficulties (see Chrisler et al., 2016; Samulowitz et al., 2018; Meads et al., 2019; St Clair, 2020).

Physical health literature suggests that the invalidation of an ‘illness’ (particularly in the acute phase) can exacerbate identity crisis (Åsbring's, 2001 in Solomons, 2017). This may offer insight as to the relationship between participants’ multiple experiences of invalidation and constructions of ‘disrupted self’ (Bell, 2013) or ‘spoiled identity’ (Goffman, 1963).

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Participants worked to repair (Lindemann & Nelson, 2001) these experiences of social ‘discreditation’ (Solomons, 2017) by drawing on wider medical discourse to authorise their position as the informed patient and legitimise their concerns. Talk such as ‘I knew something wasn’t right’ was common across accounts and was often introduced directly before interactions with HCPs, who were often storied as incompetent, dismissive or simply unbothered:

Laura: *“they basically said that I would probably miscarry but “you just need to go home””*.

Jasmine: *“she said “you’re not actively miscarrying...I’m sure it’s fine” and...sent me on my way”*.

Zadie: *“they don’t even give you a follow-up...it’s not like other illnesses where what’s needed isn’t seen as a necessity”*.

Reissman (1993) advised that the way in which speakers structure a story provides insight into how a teller might make a story persuasive. Use of intensifiers also seemed to represent an attempt to validate symptoms and concerns (Corbet-Owen & Kruger, 2001) and can be used by speakers to index social identities (Jones, 2017). Thus, interviewees’ (counter)narratives may be seen as working to reject identification with stereotyped/stigmatised identities (Goffman, 1963) (e.g. as neurotic, ‘time-waster’ or hypochondriac) by poisoning themselves as socially credible (Solomons, 2017).

Individuals are more likely to internalise narratives from the wider social environment during an identity crisis (Dickson et al., 2008; Solomons, 2017). Consequently, it is important to consider the role of HCPs in co-constructing narrative identity following miscarriage (Corbet-Owen & Kruger, 2001). McCreight (2004) proposed that HCPs are most likely to

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'set the tone' after a death, though are often poorly equipped to do so. This was highlighted by Beth: *"counselling with somebody who is trained in infertility is really, really important"*.

It has also been suggested that professionals often treat miscarriage as distinct from other forms of pregnancy loss, leading to invalidating assumptions about it being less significant (Lovell, 1983; McCreight, 2008). These dynamics were apparent as participants storied unhelpful comments (most received from professionals, including Psychologists), some of which appeared to reinforce narratives of self-blame:

Sami: *"there were...jibes and comments... "it wasn't the right time"..."you can always have another one"..."you should try to move on"*.

Zadie: *"the line that will never ever leave me, um, she said, "oh, it's alright, you're only young, you got plenty of time" ...if I could go back and see her now, and tell her that the crap that I would go to endure, like don't ever tell anyone that."*

Jasmine: *"she just turned round and said to me, "oh, why did you leave it so late?" and I was stunned (I) you kind of walk away that you start getting really, you know, angry and upset"*.

Zadie: *"it was just like, "well, you're a bit young anyway like, surely it wasn't planned" and it felt like that judgement on me"*.

Participants appeared to construct a sense of personal agency by the extent to which they accepted (or rejected) 'expert' opinions (Solomons, 2017). This is consistent with literature (Åsbring & Närvänen, 2004) that suggests knowledge is a way to gain control over uncertain illness trajectories. In line with McCreight (2008), alternative spaces such as support groups were constructed as offering 'solace' and 'permeable discourses' from which women could construct (and contribute) their own understandings, reconstruct their identity, and re-

conceptualise experiences that had been named in ways that disempowered them (see also Lotay, 2018).

3.3.3 Stories of Growth

Western narratives about ‘post-traumatic growth’ (Tedeschi et al., 1998) and ‘triumph over adversity’ (Leith, 2009) are preferred by society (Frank, 1995) and tend to promote a ‘happy ending’ filled with hope (Adler et al., 2015). Consequently, speakers may feel compelled to privilege these stories, particularly in an interview context (Miczo, 2013). Telling stories is highlight ritualised (Goffman, 1967) and there are known consequences for not doing “...what ought to be done” (Jefferson, 1988). Messier stories that do not conform to this framework often remain unvoiced (Leith, 2009).

Robinson (1990) also argued that ‘progressive narratives’, which offer a positive construction of negative events/experiences (Bury, 2001), offer a more engaging form of storytelling and present the individual in a more positive light. Speakers can therefore influence the ‘relational distance’ of recipients to the story as they create varying degrees of intimacy (Jefferson, 1985).

‘I want to make a difference’: Regaining agency (through meaningful acts of resistance)

Consistent with chaos narratives (Frank, 1995) and narratives of regression (Robinson, 1990), participants generally narrated a perceived loss of agency following miscarriage (Horstman et al., 2020). Woven throughout the fabric of each account were hints of participant’s attempts to regain some form of influence over their lives and selves (Adler et al., 2015).

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Lichtenthal et al. (2010) suggested that bereaved parent's meaning making after the loss of a child can involve 'benefit finding' (i.e. the desire to help and increased compassion for others' suffering). Similarly, Littlemore and Turner (2020) proposed that many parents hope for something positive to come from their loss such as sharing their stories, engaging in organisations, and supporting projects. These 'narrative values' (Herman et al., 2012) were strong threads throughout accounts:

Jasmine: *"I want to make a difference. I wanna help, you know(?)"*.

Beth: *"...help other people, you know, because there isn't that support out there, so, you know, anything that we can do that helps some woman going through this for the first time who's utterly terrified, um, that's worthwhile"*.

Sami: *"we all agreed that you know if it's more of an open subject and spoken about then you know more people wouldn't be afraid to talk about it"*.

Some interviewee's use of pronouns shifted ('I' to 'we') which gave the impression that they positioned themselves in allegiance with, or as representative of, the pregnancy loss community (de Fina et al., 2006 in Davies 2012), and perhaps also with me.

Interviewees appeared to position their speaking openly about their experience as an act of resistance against the 'social silencing' of miscarriage (Carolan & Wright, 2017). This is consistent with McCreight (2008) who suggested that 'narratives of resistance' can sometimes be the only available form of expression. Some of the older participants' narratives seemed particularly politically-situated. Laura explained: *"miscarriage is a silent thing, it's just not spoken about...it's about women, so people don't want to talk about it, it's about blood, it's...private, you know(?)"*. Zadie's assertion that *"I'm finding my voice a bit more"* appeared to directly/proudly challenge this powerful culture of silence. Jasmine also

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drew parallels between the “*stigma*” associated with miscarriage and the “*taboo*” associated with mental health difficulties, which seemed to speak to additional barriers in accessing psychological support.

Drawing on physical health literature, concepts of ‘survivor identity’ (Kaiser, 2008) and ‘heroic identities’ (Thomas-MacLean, 2004) are perhaps relevant to discuss. Some participants seemed to express elements of heroic narratives (Kelly, 1994 in Bury, 2001) in their reconstruction of relational identity. For instance, Beth spoke about the role of campaigning as a way to process/cope with grief and anger. She positioned herself as relatively privileged which gave the impression that she felt morally obliged to “*speaking out about this, even though I’m told not to*”. This talk positioned Beth in an advocacy role, which seemed consistent with the leadership and educative identities presented throughout her account. Constructing these roles seemed to be “*a way of turning something good out of something shit, basically*”.

Similarly, Jasmine’s talk hinted at a possible quest narrative (Frank, 1995) as she narrated “*feeling I need to do something*” to make a difference for other women and wider society (this involved co-facilitating a support group, starting an Instagram account, and contributing to a book). Littlemore and Turner (2020) suggest that ‘volunteerism’ and ‘benefit-finding’ are important for reconstructing meaning, sense-making, identity change, and recovery. Individuals may therefore seek to engage in these ‘metaphorical parenting’ behaviours following a loss as a way to enact these roles (Littlemore & Turner, 2020).

‘Agentic growth’ following life transitions or challenging experiences has been suggested to correlate with positive mental health and increased ‘transition satisfaction’ (Bauer & McAdams, 2004; Adler et al., 2015). However, it is also worth considering how the quest narrative could exacerbate feelings of loss as the empowering nature of the quest is dissolved

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by the ‘chaos’, disruption and betrayal of recurrence (Thomas-MacLeod, 2004). Thomas-MacLeod (2004) and Frank (1995) also highlight that quest narratives and/or ‘heroic identities’ might feel too uncomfortable, and narrators can often revert back to the pain. For example, following her talk of marathons, fundraising, reconnecting with her spirituality, and commitment to making a positive difference for others, Laura reflected: *“I feel like I’ve come to terms with some of it, I’ll never, I’ll never completely get over it”*. The pregnancy loss seemed to be conceptualised as part of the self, something that ‘lives alongside you’ (Littlemore & Turner, 2020, p. 60).

‘I’m a completely different person and that’s not all bad’: Reconstructing identity, creating a new future

Participants drew upon quest narratives (Frank, 1995) at various points in their accounts, in which “...the ‘journey’ of illness – including painful experience – is presented as having provided opportunity for transformative learning about the self and the world” (Solomons, 2017, p. 203). This is consistent with previous research (Littlemore & Turner, 2020) where some participants reported positive changes such as becoming more empathic, resilient and stronger in their faith (see also Lichtenthal et al., 2010).

Similar evaluations were noted by interviewees, including relational/identity changes and existential gains (e.g. insight into life priorities and increased compassion for others’ hardships) (Solomons, 2017), as they contemplated what had been learned and/or gained from their experience:

Cathy: *“I think it has also sort of made me think more or a little bit differently about my faith, um, and my own strength”*.

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Jasmine: *“my husband and I are a lot closer. We can talk more openly about, you know, our emotions...since these miscarriages, I’ve found I’m, you know, even more empathetic (.) it’s kind of made me want to be a better person and be less judgemental”.*

Laura: *“I think it’s really made me reassess, erm, me (.) and (.) who I am... I’m not quite sure who that is yet-.hheh...and wha-uh-where I wanna be...I’m really into mindfulness now, which has really calmed me down and I think I’ve become more erm...I don’t know whether spiritual is the right word(?)”.*

Sami: *“I me::an, I can’t say there’s many [positives] but it’s definitely made us stronger together”.*

Beth: *“this is with the caveat of ‘I’m not saying that I’m glad the miscarriages happened because they made me into a better person’, that’s a horrible narrative, but I think as a result I’ve become a lot kinder (.) uh...this is going to sound weird but the happy parts of my life are much happier...I’m much kinder, I’m much less focused on work”.*

Kelly (1994) argued that the reconstruction of identity is expressed more or less within one particular narrative form or ‘genre’ (i.e. epic/heroic, comic/ironic, disembodied/romantic and didactic). Stories of growth seem to have given particular expression to elements of tragedy and heroism.

Zadie was the only participant who seemed to counter ‘benefit-finding’ narratives (Littlemore & Turner, 2020). She alluded to her waning ability to “*stay positive*” throughout the miscarriages rather than ending on stories of hope. The extent to which Zadie repeated her determination to “*keep positive*” is unusual in storytelling and served to intensify this talk (Kleres, 2011). Norrick (2000) suggested that repetition functions as evaluation because it embeds the speaker’s feelings within descriptive elements of the narrative. Because Zadie’s

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positivity seemed to dissolve as her story progressed, I felt a strong sense that this coping strategy had ultimately betrayed her (particularly as she storied her unrewarded hope of a rainbow baby). It may also connect with earlier discussion relating to the betrayal of recurrence as disruptive to 'quest narratives' (Thomas-MacLeod, 2004). One positive outcome for Zadie included finding her best friend (who shared a similar journey with infertility) through this process: "*she understands me as a woman...when I'm with her, I think we feel (.) this is normal, we're normal*". Through this talk, Zadie constructed a strong narrative of normality which perhaps countered all the other situations she had felt alienated as a childless woman in society (Miall, 1986; Letherby, 2002).

It was noted that participants' language tended to become more tentative and stilted when reflecting on aspects of miscarriage that seemed to be more distressing or not usually spoken about. This was signified by the frequent 'prepositioned epistemic hedges' (Weatherall, 2011) (i.e. the '*I don't know*'s), which indicate that the speaker is not totally sure or committed to what follows in their turn of talk. Additionally, interviewees would regularly 'error correct' (Jefferson, 1974), denoted by the frequent occurrence of the interjection '*uh*'. Jefferson (1974) argued that this could either relate to 'production errors' (i.e. difficulty in producing coherent speech) or 'interactional errors', which relate to the "...mistakes someone might make as they attempt to speak appropriately depending on audience and situation" (p.181). Jefferson suggested that interactional errors can serve as a resource for negotiating and reformulating a current set of identities (of self and other). This also contextualises the act of speakers gauging my reaction as they (re)formulated their narratives and identity co-constructions during the interview (Goffman, 1967).

Matthews and Matthews (1986) described how the 'transition to non-parenthood' requires reality reconstructions, identity transformations, and role readjustments. Consistent with this,

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participants seemed to work towards re-authoring their identity narratives by constructing a rich, multifaceted self. This ‘narrative repair’ (Lindemann & Nelson, 2001) can be conceptualised as a response to damaged identity (Goffman, 1963; 2009) and suggests a narrative of personal growth through adversity (Frank, 1995).

Laura constructed changing relationships with herself, others, and hobbies, which have come to hold different meanings (“*exercise has become a huge part of my identity...and provides release, purpose...and sense of achievement*” and “*I haven’t read books in years...I started reading...a lot of really interesting books*). Other participants narrated similar stories of existential gains. Jasmine spoke of “*re-evaluating my life, my job, my why*”, resembling a quest narrative and the reformulation of her identity/future in line with her values (Herman et al., 2012).

Accepting a new reality and regaining agency over grief are important processes in forming a new identity following pregnancy loss (Littlemore & Turner, 2020). For some participants, reconstructing their identity and future embraced other forms of motherhood, whereas others indicated an acceptance that their fertility journey was coming to an end (Carolan & Wright, 2017).

CHAPTER FOUR

Critical Review, Implications and Conclusions

4.1 Chapter Overview

This chapter presents a summary of the analysis and discussion, with reference to the research aims and surrounding literature. A critical review of the study is presented, including adherence to quality criteria and relative strengths and limitations. Clinical relevance and implications will be discussed, together with avenues for dissemination and directions for future research. The chapter closes with final conclusions.

4.2 Overview of Analysis and Discussion

This study aimed to address the research question: *how do women story their experience of miscarriage and construct their identity?* The preceding chapter was comprised of two parts: 1) summaries of individual accounts 2) collective storylines embedded in surrounding narrative and miscarriage literature. Individual stories were analysed according to content, structure, performative, interactive and discursive aspects (Riessman, 1993; Wells, 2011) to gain insight into both narrative and identity (co-)construction. Collective narratives related to stories of change, challenge, and growth. These are summarised in turn below.

The stories of shock and surprise are consistent with wider literature about the typically unexpected nature of miscarriage (McCreight, 2008; Carolan & Wright, 2017). Participants constructed a sense of disruption to the normative process of becoming a mother created by miscarriage, resulting in normative expectations about pregnancy being interrupted (Corbett-Owen & Kruger, 2001; Trepal et al., 2005; Wells & Heinsch, 2020). Narratives of miscarriage as a chaotic force that disrupts the ‘natural progression of life’ (Horstman et al.,

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2020) fit with Frank's (1995) chaos narrative and Robinson's (1990) regression narrative.

Participants also discussed the difficulties associated with acceptance and reconciliation (of loss and childlessness). This strongly relates to literature that described the dislocation between 'the world that is' and 'the world that should be' (Littlemore & Turner, 2020). These narratives were positioned as incongruent with social expectations of restitution (Frank, 1995), which were often resisted or unwelcome (Adler et al., 2015).

Akin to these stories of disruption, participants constructed miscarriage as a force of change that caused disruption to their sense of self and to the expected identity change process of entering into motherhood. This 'biographical disruption' (Carricaburu & Pierret, 1995) commonly incorporated a perceived loss of agency and control over the miscarriages, which can lead to a crisis of identity (Dickson et al., 2008). The impact of adverse experiences on identity construction has been explored in physical health literature, which suggests that illness can lead to a 'violated self' (Solomons, 2017). Similar concepts have been explored in relation to miscarriage, whereby individuals can view themselves as different or 'split' from their main identity (Littlemore & Turner, 2020). The way in which participants constructed their narrative identity drew on concepts of lost, damaged or 'spoiled identities' (Goffman, 1963). These are linked to experiences of social stigma and loss of status or belonging through disruption of the normative development to motherhood through pregnancy and childbirth (Rice, 2000; Corbet-Owen & Kruger, 2001; Cabell et al., 2015; Carolan & Wright, 2017). This can result in a sense of confusion (McCreight, 2008) and chaos (Frank, 1995) as individuals attempt to reconstruct or 'realign' (Bell, 2013) their identity and develop a new sense of self, normality, and their place in the world (Åsbring, 2001) following their transition to non-motherhood and acceptance of childlessness (Matthews & Matthews, 1986; Letherby, 2002).

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A key story of challenge related to understanding and validating miscarriage in the context of ambiguous loss. This is well documented in the literature-base (Trepal, Semivan & Caley-Bruce, 2005; Horstman et al., 2020). Research suggests that attempts to conceptualise what was lost often draw on 'loss of imagined future' (Carolan & Wright, 2017; Littlemore & Turner, 2020). Participants' uncertainty about what was lost fit with literature on disenfranchised grief (McCreight, 2004; 2008), which relates to the lack of legal/social recognition and access to death rituals following miscarriage. Participants' identified needs were associated with mourning, creating memories, and remembering, which is consistent with research (Abboud & Liamputtong, 2002).

Participants narrated the need to navigate social and medical discourses of self-blame (Foucault, 1991; Hardy & Kukla, 2015). McCreight (2008) argued that the search for meaning following miscarriage typically involves a search for causality to explain the loss. The lack of 'clear answers' (Åsbring & Närvänen, 2004) can lead to 'moral claims' that exacerbate guilt and blame (McCreight, 2008). Participants' self-blame narratives, particularly as related to body and behaviour, are consistent with existing research (Abboud & Liamputtong, 2002; Carolan & Wright, 2017) and can be observed across cultural contexts (Rice, 2000). Some participants found comfort in conceptualising a sense of distance between body and self, which has been argued to make it easier to attribute blame (Littlemore & Turner, 2020) whilst maintaining moral status (Bury, 2001; Miller, 2015). On the other hand, claiming responsibility may serve to construct a sense of personal agency in the face of chaos (Littlemore & Turner, 2020).

One of the most prevalent collective storylines related to accessing NHS support. Consistent with wider literature (McCreight, 2008), participants constructed failures in understanding, invalidation and power imbalance as significant barriers to accessing support. HCPs are

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believed to play an important role in narrative and identity construction (Corbet-Owen & Kruger, 2001). However, participants narrated a sense of ‘social discreditation’ and, in response, seemingly sought to legitimise their accounts by constructing credible identities, for example as the ‘informed patient’ (Reissman, 1993; Solomons, 2017). In doing so, participants appeared to resist stigmatised identities (Goffman, 1963). Participants appeared to create a sense of agency by the extent to which ‘expert’ advice/support was accepted (Åsbring & Närvänen, 2004; Solomons, 2017). Online pregnancy loss communities were positioned as a helpful alternative space to get needs met and regain control over narrative identity.

Participants constructed a sense of regaining personal agency following miscarriage, which was generally associated with feelings of powerlessness, chaos and crises of identity (Horstman et al., 2020; Frank, 1995; Dickson, Knussen & Flowers, 2008). Agentic growth following adversity has been linked with positive mental wellbeing (Bauer & McAdams, 2004; Adler et al., 2015). Participants narrated small acts of resistance as important in regaining a sense of agency. This is consistent with McCreight (2008) who proposed that ‘narratives of resistance’ are often the only available form of expression. These acts included sharing their stories, finding their voice, countering the silence, volunteering, fundraising and supporting projects. Littlemore and Turner (2020) suggested that ‘volunteerism’ and ‘benefit-finding’ are important for reconstructing meaning, identity change and recovery. However, the empowering nature of the quest narrative (Frank, 1995) can be dissolved or disrupted by the betrayal of recurrence (Thomas-MacLeod, 2004). Combined with the discomfort of a ‘survivor identity’ (Kaiser, 2008) or ‘heroic identities’ (Thomas-MacLean, 2004), speakers often reverted back to the pain of miscarriage and acceptance of childlessness.

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Narratives of reconstructing identity after miscarriage tended to involve positive changes such as increased empathy and resilience, stronger relationships, and existential gains (Solomons, 2017). This is consistent with existing literature (Littlemore & Turner, 2020). However, participant's talk seemed tentative as they evaluated identity changes and negotiated their comfort in constructing them as positive. This was denoted by uncertain speech (Weatherall, 2011) and interactional error correction (Jefferson, 1974). Some participants seemed to construct a new identity and create a future in line with their new-realised values (Herman et al., 2012). For some, this involved embracing other forms of motherhood, whereas others indicated an acceptance that their journey with fertility had come to an end (Carolan & Wright, 2017).

4.3 Quality Assessment

As outlined in chapter two, Tracey's (2010) 'big tent' quality criteria for qualitative research informed the research design (see section 2.2.4). This section presents a critical review of the extent to which aspects of quality were adhered to within broader reflections of relative strengths and limitations of the study.

4.3.1 Strengths of the Research

This research addressed gaps in the literature and extended previous research that explored narrative construction following miscarriage (Rice, 2000; Corbet-Owen & Kruger, 2001; McCreight, 2008; Carolan & Wright, 2017; Littlemore & Turner, 2020). In light of recently-published research highlighting the lack of progress in healthcare in response to miscarriage (Lancett, 2021), the study has offered a timely perspective in relation to an under-explored area of research and clinical practice. It is hoped that understanding of miscarriage in both lay and healthcare contexts can be enriched.

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Narrative methods can be said to represent efforts to "...include life experiences of those at the margins of society..." (Wells, 2011, p. 10). This study offered women an opportunity to share their unique lived experience, including how they made sense of miscarriage and how this may have impacted on their sense of self. Participants spoke to their reasons for taking part, which included: challenging stigma, increasing awareness, helping other people, and addressing healthcare inequalities. Thus, the study was politically and socially positioned as an opportunity to incite pragmatic change. The study offers important considerations for clinical practice, which are further outlined in section 4.4.

This study attracted interest from a number of countries around the world, including Europe, America and Australia. This level of engagement implied a high degree of relevance and is consistent with criteria for a 'worthy topic' (Tracey, 2010). Unfortunately, it was not possible to cater to this high demand for participation, in part due to the epistemology and scope of the project. Future research exploring similar lines of enquiry might consider epistemological positions that are more congruent with cross-cultural samples.

The social constructionist (Burr, 2015) and feminist narrative (Herman et al., 2012) lenses invited a reflexive, critical approach to the research process. Within this, it was important to own my perspective and remain reflexive about how my positionality/context influenced the research narrative. Inherent in these deliberations is the recognition that the data could be interpreted in various, equally valid ways (Riessman, 2008 in Randall-James, 2018).

Contemplations about reflexivity rely upon one's concept of self (May, 2002); this required me to remain aware of the role I played in co-constructing individual/collective narratives (and the wider research story). Grosz (1995 in Leith, 2009, p. 13) claimed that "the author's intentions, emotions, psyche, and interiority are not only inaccessible to readers, they are likely to be inaccessible to the author herself". In response to these challenges, I have strived

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towards transparency, sincerity and reflexivity throughout the presentation of this research to increase its credibility and rigour (Tracey, 2010). For instance, I have outlined ethical challenges and the steps taken to address them, shared excerpts from my reflective journal and, where possible, have shared my reflections with the reader. It was hoped that these steps have contributed to a sense of coherence and sincerity to the story (Tracey, 2010).

Extending reflections of my positionality to the project and its participants, the advantages of my outsider researcher role (Serrant-Green, 2002) were two-fold. Firstly, it supported my emotional investment in the project without risking burnout or compromising personal boundaries (Taylor, 2011). Secondly, this sustained my resilience in completing participant research within the context of a global pandemic. Whilst my outsider status was associated with both advantages and limitations, certain aspects of my identity (e.g. gender) afforded me insider membership (Dwyer & Buckle, 2009). This allowed some degree of shared knowledge between me and interviewees (Solomons, 2017) without compromising the centrality of participant's stories.

Overall, this study has met the research aims in terms of: gaining insight into the processes through which women make sense of their experience of miscarriage; increasing understanding as to the discursive resources available to women from which to construct personal narratives; and how women's constructions of miscarriage influence their identity narratives. The study was consistent with, but also extended, existing psychological research in this area. Furthermore, aspects of the analysis were contextualised within broader physical health and illness literature, which indicated novel areas of inquiry relating to women's narratives of miscarriage.

4.3.2 Limitations of the Research

Conducting participant research in the context of a global pandemic created complex challenges. Certainly, some of Tracey's (2010) quality criteria were more challenging to adhere to. Examples of ethical considerations are outlined below. These were navigated by integrating dual positions of researcher and clinician, and with support from the supervisory team.

The relatively high attrition rate observed during recruitment is consistent with the sensitive nature of the research (Dempsey et al., 2016) but deserves further consideration. Potential barriers to engagement could have involved informational insufficiency (Snow, 1980) (though this is unlikely due to the information sheet and numerous opportunities to ask questions) or failure to sufficiently develop relationships before the point of involvement (Walker, 2007). Aspects of the methodology that observed to good ethical practice (Tracey, 2010; BPS, 2014; 2018) included: a defined interview schedule; the risk assessment/management protocol; drawing on clinical expertise to assess participants for signs of emotional distress during interviews; and co-identifying strategies for managing discomfort (Walker, 2007; Ashton, 2014 in Dempsey et al., 2016). Nonetheless, it is important not to neglect the disengagement process, which can be 'glossed over' in methodological reflections (Snow, 1980). This is especially important if future research in this area is to adequately support the needs of this population to safely and ethically participate in sensitive research.

The eligibility criteria for interview participants were selected in line with assumptions about homogeneity of variance in qualitative research (Robinson, 2014), though this can be less problematic in NI as it does not seek generalisations (Wells, 2011). Despite this, aspects of the sample's heterogeneity (e.g. number of miscarriages, cultural identity and religion) invites

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contemplation as to how this may have impacted the inquiry. On the other hand, aspects of homogeneity deserve the same deliberation (i.e. all participants had accessed counselling via NHS, pregnancy loss charities, or both) as to the relational influence on narrative/identity co-constructions. Recruitment routes utilised online communities/charities, which may have skewed the sample towards individuals who are more active members of third-sector support. Examining the role that counselling and online communities played in participants' narrative constructions was beyond the scope of the study, though this would undoubtedly benefit from further research.

Though relatively small, the sample size was appropriate for NI which seeks to gain rich insight into subjective experience (Wells, 2011). NI does not seek generalisations or claims to truth (Randall-James, 2018). It is entirely probable that the narratives presented do not resonate with other people's experiences, neither were they intended to. It might be worthwhile for future research to extend the current study with a larger sample size congruent with an alternative methodological approach. Thematic analysis, for instance, would offer a systematic approach to analysing patterns of meaning in data with a larger sample size (Joffe, 2012).

Furthermore, this research focused on a sample of women who are involuntarily childless. This facilitated a rich exploration into the participants' narratives of experience. It also responded to the need to deconstruct and expand narrow discourses on female (in)fertility (Wells & Heinsch, 2020). However, this focus creates additional difficulties in terms of generalising the research to different experiences and cohorts of women, particularly those who have children. Future research could respond to this need, and also play an important role in dismantling harmful assumptions that the significance of miscarriage is lessened when individuals have children before and/or after miscarriage.

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Ambivalent or positive associations with miscarriage are scarcely represented in the literature-base, which has been argued to represent cultural assumptions about the meaning of pregnancy/loss (Corbet-Owen & Kruger, 2001; Lotay, 2018). The current study has done little to address this gap. One explanation for this could be that samples that are self-selected are more likely to recruit individuals for whom pregnancy/miscarriage has been a powerful or meaningful experience (DeFrein, et al., 1996; Corbet-Owen & Kruger, 2001). By reinforcing certain assumptions about pregnancy loss, the experiences of individuals who do not align may be further subjugated. This supports the necessity to privilege individual constructions and adhere to a person-centred approach to meeting medical and psychosocial needs following miscarriage (McCreight, 2008).

The ‘journeys of learning’ (Palaganas et al., 2017) demonstrated throughout the research process can be conceptualised as both a strength and limitation of this research. Gaps in researcher knowledge that posed a threat to quality criteria such as rigor and meaningful coherence (Tracey, 2010) will be outlined here. Firstly, aspects of the interview guide (e.g. structure/length/language) could be considered tenuous both in terms of NI and social constructionist assumptions. And yet, it offered me a sense of containment when conducting the interviews, and upheld the boundary between roles of researcher and clinician (which may have invited a more therapeutically-driven relational stance) (Ashton, 2014). This enabled a more focused conversation relevant to the research aims and questions.

Secondly, the collective storylines were, inevitably, closer aligned to thematic narrative analysis – the emphasis of which is on the ‘what’ more than the ‘how’, the ‘told’ rather than the ‘telling’ (Riessman, 1993, p. 3). An assumption that language is a direct and unambiguous route to meaning underpins this approach, which mimics objectivist modes of inquiry (Riessman, 1993). When multiple narratives are grouped into similar thematic categories,

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readers must assume that everyone means the same thing by what they say (Riessman, 1993). The stories that are ambiguous, deviant or that don't fit are typically omitted and therefore go unspoken. However, the adoption of narrative frameworks (e.g. Frank, 1995; Robinson, 1990) has been argued to safeguard against over-interpreting the range of meanings conveyed by participants (Bury, 2001).

Thirdly, aspects of interactional analysis are arguably under-reported in the preceding chapter. According to Riessman (1993), narratives of experience are "...occasioned in particular settings..." such as medical and social situations, where storyteller and recipient jointly participate in conversation (p. 4). Narrator and listener are understood to create meaning collaboratively through 'question and answer exchanges' (Riessman, 1993).

Analysis is strengthened by including all contributors to a conversation. As only participant quotes were presented during Chapter Three, a significant part of the analysis was underrepresented. This means that reflections about my role in co-constructing meaning, narratives and identity was only partially presented to the reader. Despite this, aspects of performative analysis arguably compensated by providing insight into how participants sought to persuade and move their audience (through language and gesture, for example).

Although it was more difficult to comment on gestures and body language (partly due to the nature of remote interviews), the 'doing' of storytelling was considered and provided insight that further contextualised narratives (Riessman, 1993).

Finally, it could be argued that the analysis process neglected the significance of silences during participants' talk. Attending to the use (and meaning) of silence during the interviews is argued to correct an over reliance on participants' stories, bring the body into analytic preview, and address the researcher's stance/actions (Charmaz, 2009). It begs the question as to what was present in the spaces of the stories that were told. Silences are also thought to

offer insight into participants' constructions of self (Charmaz, 2009) and would therefore have added a valuable dimension to analysis.

4.4 Clinical Relevance and Implications

In April 2021, new research into miscarriage suggested that worldwide reform of care is needed (Lancet, 2021). The authors called for a "...complete rethink of the narrative around miscarriage and a comprehensive overhaul of medical care and advice offered to women who have miscarriages" (Lancet, 2021, p. 1597). The report highlights the relevance of the current study, and invites consideration of its applicability to clinical contexts. The interventions suggested by the current research can be positioned at multiple locations including clinical, community, research and policy. These will be spoken to below.

This study responds to the need for re-conceptualisations in the field of miscarriage (Lancet, 2021) by exploring the ways that women who are involuntarily childless construct identity and make sense of miscarriage. The lack of available discourse, coupled with prevailing assumptions that link pregnancy and motherhood to female identity, have been argued to maintain the stigma and marginalisation surrounding miscarriage (Rogers, 2021). Analysis suggested that individuals can both draw on and resist essentialist narratives and dominant medical/illness discourse in their constructions of miscarriage and self. This seemed to give rise to stories of disempowerment, loss of agency, internalised blame/shame, subjugated experience, invalidation, and lack of support. Participants described the significant marginalisation and stigmatisation that women who have experienced miscarriage, pregnancy loss and infertility still face today (Cabell et al., 2015; Feldstein, 2018; Wells & Heinsch, 2020). The collective narratives also speak to the difficulties that can arise when losses have not been recognised and appropriately mourned for in social arenas. This study, alongside existing and future research, has the potential to play an important role in normalising

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experiences of pregnancy loss and involuntary childlessness. It is hoped that this may support individuals to speak about their experiences and needs without fear of social stigma or disenfranchisement, and increase availability of appropriate support from families, communities and healthcare services.

The diversity of the interview participants and narrative identity constructions revealed the substantial variation in experiences, and sense-making processes, of miscarriage. An individual's culture, ethnicity, religious/spiritual beliefs, family values, romantic relationships, and age (amongst many other factors) are likely to shape their constructions of self following miscarriage. The need to recognise – and validate – the many meanings of pregnancy, miscarriage, infertility, childlessness and femininity is consistent with calls to expand narrow social (and medical) discourses on motherhood and female fertility (Wells & Heinsch, 2020). This may also help to address the stigma associated with miscarriage and facilitate greater control for women over their reproductive identity.

This research has highlighted the importance of recognising and privileging individual constructions of miscarriage in clinical contexts. Narratives can be understood as an expression of values (Herman et al., 2012). It is therefore vital for HCPs to identify narrative identity processes and take account of the meanings constructed in order to provide sensitive, person-centred care that does not perpetuate potentially harmful and restrictive discourses (McCreight, 2008). In clinical contexts, this may suggest the importance of a co-produced formulation between the individual and HCP about meanings associated with pregnancy, miscarriage and motherhood. HCPs should not underappreciate their role in co-constructing narratives of miscarriage and identity, as outlined in Chapters One and Three.

Unfortunately, the narrative accounts presented are consistent with previous research (e.g. Kong et al., 2010) that suggests professionals generally lack awareness and sensitivity in

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relation to psychological aspects of miscarriage (such as grief and identity transitions). This is consistent with the Lancet report (2021) which indicates a significant lack of improvement in miscarriage-related healthcare in recent years. As emphasised by Mills et al. (2014):

“professionals should be mindful that women may delay accessing care in an attempt to self-protect through emotional disengagement” (p. 949). By addressing gaps in clinicians’ knowledge, competence and sensitivity, and increasing the tools available to staff providing care, perhaps it is possible to repair the valid mistrust and disengagement from the pregnancy loss community, as voiced by a number of participants.

Improving and investing in consistent, high-quality staff competence frameworks is offered as a helpful starting point. Whilst training needs are context/service dependent, four broad ideas are outlined here. Firstly, increasing understanding of pregnancy loss (and its physical, medical and psychosocial aspects) is likely to naturally improve staff sensitivity and communication skills. This could encourage staff to identify individual needs, which is hoped to empower both people accessing services and those delivering care (see Abboud & Liamputtong, 2002). Secondly, providing training about the role and impact of language may also support staff to adopt a critical stance towards outdated/insensitive terminology and concepts. This is hoped to increase competence (and confidence) for staff to support individuals as they make sense of their experience and express their needs, thereby improving the experience of people accessing care.

Thirdly, incorporating models of grief and loss – and their relationship with life transitions and identity constructions – into medical contexts could inform and improve clinical practice. The desire for medical staff to validate miscarriage as a loss has been unanimously named by participants. This is also visible in existing research (see Section 1.8). Recent research (Erato et al., 2021) has indicated that some women who experience pregnancy loss are likely to

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report an increase in the importance of motherhood compared to women who have not experienced a loss. The research emphasised the importance of validating maternal identity (where appropriate/desired) following a pregnancy loss, as many women in the study seemed to strongly associate with this role (Erato et al., 2021). This aligns with recommendations from the current study that stress the need to value personal meanings and identity constructions following miscarriage. Providing staff with the necessary tools to conceptualise miscarriage within grief and bereavement models is therefore advised (see Frost et al., 2007; Brier, 2008; Malacrida, 2016). Understanding the process of grief and loss in the context of miscarriage may also increase appreciation for immediate needs (including burial arrangements and ‘saying goodbye’), follow-up care (e.g. signposting), and psychosocial needs (e.g. identity work, transitions and acceptance) going forward. Suggestions as to how to incorporate models of grief into clinical practice are well-documented and supported by existing literature (e.g. McCreight, 2008; Littlemore & Turner, 2020) and briefly explored below.

Lastly, addressing cultural awareness and competence of staff is suggested to support the delivery of appropriate, person-centred care during and following miscarriage by, for example, encouraging curiosity about personal constructs such as pregnancy, miscarriage, motherhood and infertility (Chalmers, & Meyer, 1992; Wells & Heinsch, 2020). Increasing understanding for how cultural frameworks impact meaning making, narratives and identity is central to this competency. Culturally-specific pregnancy loss training could also interrelate with training on grief and loss to further contextualise (and expand) understanding of clinical and psychological needs. Incorporation of models of grief and bereavement with socio-cultural competence might include, for instance, the availability of psychoeducation and resources focused on normalising various experiences and meanings of miscarriage, and

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appropriate and thoughtful signposting to services that can support with individual, relational and family support.

This research has highlighted the need to centre both pregnancy loss and identity practices in therapeutic work. Identity constructions following miscarriage are significantly under-researched from a Psychological perspective (see Chapter One). This may have contributed to a lack of knowledge and awareness for the need for psychological support following miscarriage in mainstream Mental Health Services. Applying established concepts of transition, identity change, and acceptance alongside conceptual frameworks such as spoiled identity (Goffman, 1963), disrupted identity (Bell, 2013) and identity transitions (Matthews & Matthews, 1986; Letherby, 2002) when working with this population may support clinicians in co-constructing holistic formulations and intervention plans. Psychologists may also benefit from further training in relation to the role of dominant socio-cultural discourse in shaping personal meaning-making and identity constructions.

In therapeutic contexts, narrative-informed approaches are suggested to be helpful in supporting individuals to construct and communicate their experience of miscarriage. The narrative methodology that informed this research responded to ethical considerations relating to the sensitive nature of pregnancy loss and ownership of narratives, which can be especially important in relation to stigmatised or subjugated stories. For this reason, narrative approaches can be particularly helpful in times of distress or transition. Compassion-Focussed Therapy (CFT), Acceptance and Commitment Therapy (ACT), and (where appropriate) trauma-informed approaches are also indicated to be helpful psychological models when working with this population. In addition, recent research (Rogers, 2021) has suggested that working with the body in therapy might be useful to counter mind/body dualism, as reported by some participants.

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Furthermore, Rogers (2021) advocated for a social justice approach in clinical practice in order to reduce the silence and taboo associated with miscarriage. By extension of this approach, the decolonisation⁵ of psychological knowledge, theory, research and practice could support the deconstruction of cultural concepts that have been argued to uphold patriarchal and racist institutions (Fineman, 1991; Roberts, 1993; Feldstein, 2018; Wells & Heinsch, 2020). Psychology could therefore participate in expanding narrow cultural discourses of female in/fertility, inviting alternative constructions of motherhood roles and identities, and challenging essentialist and naturalistic notions of the female identity (Roberts, 1993; O'Reilly, 2014; Cabell et al., 2015).

The individual narrative accounts also highlighted the role of third-sector and charity organisations in supplementing NHS services for the pregnancy loss community. Participants spoke of reasons for accessing non-NHS organisations, which included seeking support for: psychoeducation, resources, individual counselling, social/community support, and couples/family support. In some cases, participants suggested that charity organisations facilitated reparative spaces where they could construct and contribute their own understandings, reconstruct their identity, and reconceptualise experiences that had been imposed by medical persons/systems in ways that disempowered them (McCreight, 2008; Lotay, 2018). With this in mind, developing closer ties between NHS and third-sector organisations might be beneficial in terms of improving opportunities for shared learning and bi-directional organisational support (see Baines et al., 2010; Goodwin et al., 2012) and, ultimately, improving support available to people who have experienced pregnancy loss.

⁵ Decolonising approaches in Psychology can be defined, broadly, as processes or practices that: acknowledge the colonial social contexts in which individuals and institutions exist; critically interrogate all hierarchies of power that maintain inequality; advocate for social change; and amplify marginalised voices, perspectives and forms of knowledge. Examples of decolonising approaches might include working to: understand structural inequality, address historical disregard for indigenous knowledges, and decentre individual psychopathology. The reader is directed to Cullen et al. (2020) for further context and relevant literature.

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Anecdotally, it is also worth noting that a high proportion of staff and volunteers affiliated with national and local organisations have lived experience of pregnancy loss. Creating more opportunities for EbE Consultation and participation in NHS service development and improvement projects would be encouraged.

Qualitative research has been argued to bridge the divide between research and practice/policy communities (Birnbaum, 2000; Sallee & Flood, 2012). High quality qualitative research seeks to resonate with audiences across contexts (Tracey, 2010) and therefore stands in a potentially powerful position of inspiring recognition of the need for systemic change. In line with the Lancet (2021) and recent campaigning by Tommy's, service managers and policy makers are encouraged to review accessibility of healthcare following miscarriage. Removing barriers to access might include: offering psychosocial support more readily, not requiring a trauma diagnosis to receive counselling from NHS services after pregnancy loss, and not needing to experience recurrent miscarriage to access medical and psychological support. These suggestions could be considered as part of the NHS Long Term Plan's (Alderwick & Dixon, 2019) expansion in relation to access to high quality psychological therapies, which has specifically highlighted Perinatal Mental Health, Adult Common and Severe Mental Health Problems, Digital Delivery, and Community Mental Health as priorities for growth. This may also offer an opportunity to reconceptualise mental health support following miscarriage in terms of how/when different support options are offered (i.e. immediate, short-term, longer-term) and to whom (e.g. individuals, couples, families and communities).

In conclusion, this section has outlined clinical implications and potential levels of intervention of the current research. Recommendations have been offered relating to clinical, community, research and policy, which support and extend existing suggestions for clinical

practice (see Chapter One). Although it is important not to negate the role of research in highlighting healthcare inequalities and knowledge gaps, its role in actively creating systemic change is often underappreciated or underexplored. With this in mind, the following sections outline plans as to how the study can directly inform clinical practice on the service-level.

4.5 Dissemination

This research is due to be presented at the Life of Medical Science's 2021 research conference at the University of Hertfordshire. The study is also intended to support an NHSE⁶ service development project of a new maternity service in the Bedfordshire region, and there are plans to incorporate the research into the staff induction programme. It is also possible that the project will be presented to the service's People Participation group (comprised of EbE) who play an important role in shaping service implementation, to inform and evaluate the service going forward (Heron & Reason, 2006). Furthermore, there are opportunities to present the research to a wider community of Clinical Psychologists, a group that represents almost all pilot sites for maternal mental health services across England. It is hoped that the research can support service planning and clinical practice. Other avenues for dissemination include publication in a peer-reviewed journal and producing accessible research summaries to share with the participants of this study, third-sector organisations, and the wider pregnancy loss community to whom this project serves (Tracey, 2010; Sallee & Flood, 2012). Therefore, the current study has, at least to some extent, fulfilled its aim to raise awareness, amplify voices, inspire action, and contribute to real-world, pragmatic change on the service, community and individual level.

⁶ NHS England (NHSE) is the NHS Commissioning Board, an executive non-departmental public body of the Department of Health and Social Care. It oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.

4.6 Directions for Future Research

Sallee and Flood (2012) argued that qualitative research can be used to bridge the gap between research, policy and practice. Though, researchers often engage in inquiry that is inaccessible to the practitioner and policy communities who could most benefit from it (p. 137). Consequently, it is important to go beyond research for research's sake, and commit to inquiry that can be translated to multiple contexts so as to inform policy and practice (see Birnbaum, 2000). Therefore, future research could play an important role in continuing to inform and evaluate service implementation in relation to clinical psychology and healthcare more broadly. It is also important to understand how different forms of research, from different methodological/epistemological paradigms, might work together to further improve clinical practice (Pope & Mays, 1995; Brydon-Miller, 1997; Todd et al., 2004; Willig, 2012; Bhati et al., 2014). For example, service improvement projects might involve quantitative measures of staff's perception of competence and confidence in supporting people following miscarriage. Alternatively, the use of service audits and service evaluation could be explored to gain insight into the impact of applied research on service development. These avenues for future research are in discussion as part of the service development project outlined in section 4.6. It is therefore possible that this research could inform an impact case study and longer-term service evaluation projects. This study has also highlighted broader areas of research that would benefit from further exploration, including similar lines of inquiry into partners' and couples' experiences of miscarriage. Such research could also inform future service development, as initiated by this study.

4.7 Conclusion

This project set out to explore how women story their experience of miscarriage and construct their identities. This thesis has provided a critical review of the current knowledge

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regarding how women make sense of miscarriage. Informed by social constructionist and narrative feminist approaches, narrative inquiry was utilised to examine storytelling practices, narrative co-construction and relational identity as women storied their experience of miscarriage. Collective storylines related to stories of change, challenge and growth. This original research has produced new knowledge, not only about women's experiences but also about the strengths and limitations of this method of enquiry. This work has demonstrated an ability to conceptualise, design and implement a project for the generation of new knowledge that has the potential to influence developments in NHS maternal mental health services across England, as well as to raise awareness and inspire action at the community and individual level.

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Appendices

Appendix A. Glossary of terms

Term / phrase	Meaning
Miscarriage	The loss of a pregnancy during the first 20 weeks gestation. Synonyms include: spontaneous abortion, non-viable pregnancy, foetal demise. May be synonymously referred to as ‘pregnancy loss’, though this term also encompasses other forms of loss such as ectopic pregnancy, stillbirth and neonatal death.
Embryo	An unborn or unhatched offspring in the process of development, in particular a human offspring during the period from approximately the second to the eighth week after fertilization (after which it is usually termed a foetus).
Foetus	An unborn or unhatched offspring of a mammal, in particular an unborn human more than eight weeks after conception.
Stillbirth	The birth of an infant that has died in the womb (strictly, after having survived through at least the first 28 weeks of pregnancy, earlier instances being regarded as abortion or miscarriage).
Complete miscarriage	All of the pregnancy tissue has been passed. Typically, the cervix is closed and there is no sign of a pregnancy sac in the uterus. An ultrasound examination may be performed to confirm the diagnosis.
Incomplete miscarriage	Much of the pregnancy tissue has passed, but some remains in the uterus. Typically, the foetus has been passed, but parts of the placenta remain. The cervix remains open, and bleeding may be heavy.
Trimester	A period of three months, especially as a division of the duration of pregnancy. Pregnancy is divided into three trimesters: the first trimester refers to the first 12 weeks after conception.
Expectant management	Usually defined as ‘watchful waiting’ or close monitoring by a physician instead of immediate treatment following a miscarriage.

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Missed miscarriage	A type of early pregnancy loss in which the deceased embryo or foetus is retained in the womb for a period of time, during which the usual symptoms of miscarriage may not occur. Sometimes referred to as a 'silent miscarriage'.
Induced labour	The process or treatment that stimulates birth/labour/delivery. Inducing labour can be accomplished with pharmaceutical or non-pharmaceutical methods and may be used as a treatment option for miscarriage.
Infertile	Defined as the inability to reproduce. Synonyms include: sterile, barren, non-fertile.
Incomplete resolved spontaneously	An incomplete miscarriage that resolves without the need for medical intervention.
Recurrent miscarriage/ pregnancy loss	The occurrence of two or more pregnancy losses (ASRM, 2008). Other sources define recurrent pregnancy loss as three or more consecutive losses. Can be referred to as 'habitual' or 'recurrent abortion'.
Sub-clinical miscarriage	The loss of an embryo at or before 5 weeks gestational age.
Gestation	The process or period of developing inside the womb between conception and birth. Gestational age refers to the number of weeks since conception.
Inevitable miscarriage	Refers to a miscarriage that cannot be avoided. The cervix is open, bleeding is heavy or increasing, and abdominal cramping is present.
Threatened miscarriage	The occurrence of vaginal bleeding early in pregnancy but with no other signs of problems. In some instances, the bleeding subsides and the pregnancy continues to term. In others, the bleeding becomes heavier and miscarriage occurs.
Cervix	Opening to the uterus.
Uterus or womb	The organ in the lower body of a woman where offspring are conceived and in which they gestate before birth.

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'Unannouncing'	The process whereby parents inform people about the loss of their pregnancy.
Dilation and curettage or 'D&C'	Dilation and curettage is a brief surgical procedure to remove tissue from inside your uterus, usually after a miscarriage or abortion. It refers to the dilation of the cervix and the removal of lining or contents of the uterus by scraping or scooping.

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Appendix B. SPIDER Search Tool

Sample	Wom?n OR female*
Phenomenon of Interest	Miscarriage* OR “pregnancy loss*” OR “natural abortion” OR “spontaneous abortion” NOT abortion
Design	Interview OR narrative*
Evaluation	Narrative* OR Stor* OR meaning* OR sense* OR understanding OR belief OR accounts OR experience OR descriptions AND “sense of self” OR self-perception OR identit*
Research Type	Qualitative OR “qualitative research” OR narrative OR “narrative analysis” OR “narrative inquiry”

Appendix C. *Initial search strategy*

(Wom?n OR female*) AND (Miscarriage* OR “pregnancy loss*” OR “natural abortion” OR “spontaneous abortion” NOT abortion) AND (Interview OR narrative* AND Narrative* OR Stor* OR meaning* OR sense* OR understanding OR belief OR accounts OR experience OR descriptions) AND (“sense of self” OR self-perception OR identit*) AND (Qualitative OR “qualitative research” OR narrative OR “narrative analysis” OR “narrative inquiry”)

Appendix D. Data extraction tool (based on Noyes et al., 2019)

Data extraction field	Information extracted
Context and participants	Important elements of study context, relevant to addressing the review question and locating the context of the primary study; for example, the study setting, participants and participant characteristics, the intervention delivered, etc. Retaining detailed information about study context may support interpretation and synthesis at later stages.
Study design and methods	Methodological design and approach; methods for recruitment; the specific data collection and analysis methods utilized; and any theoretical models used to interpret or contextualize the findings.
Findings	Key themes and concepts presented in the primary studies.
Quality	Primary studies are assessed for quality against specific criteria. They are assigned quality ratings based on their adherence to these specified criteria.

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Appendix E. Tracey's (2010) Eight "Big Tent" Criteria for excellent quality in qualitative research.

Criteria	Definition
Worthy topic	The research topic is relevant, timely, significant and interesting.
Rich rigor	The research uses sufficient and appropriate theoretical constructs, sample, data collection, context and analytic process.
Sincerity	The study is characterised by self-reflexivity (of the researcher's values, biases and assumptions) and transparency (about methods, procedure and challenges).
Credibility	The research uses thick description (including rich detail and explanation of implicit/tacit knowledge), triangulation, multivocality, and member reflections.
Resonance	The research influences or moves readers/audiences through evocative representation, authentic generalisations and transferable findings.
Significant contribution	The research provides a significant contribution across different areas including: theoretically/conceptually, morally, heuristically and practically/methodologically.
Ethical	The research considers and aligns with procedural, relational, culturally-specific and exiting ethics (including sharing the research).
Meaningful coherence	The research abides by what it claims to be about, uses methods that align with stated aims, and meaningfully connects literature, findings and interpretations.

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Appendix F. *Quality evaluation notes for papers included in systematic literature review*

<p>Rice (2000). When the baby falls!: the cultural construction of miscarriage among Hmong women in Australia.</p>	<p>Demographic info lacking (e.g. age categories – oldest category defined as ‘over 51’; number of children ‘10 and over’). Important contextual information missing.</p> <p>Including traditional healers in interviews – good context but too ambitious for aims? Perhaps takes away from women’s explanations.</p> <p>Interviews conducted in own language = good for accessibility of research and accuracy, however recruitment and interviews and transcription all done with assistance of bi-cultural research assistant. Could represent a negative especially as no member checking conducted. Some transcripts were cross-checked by interpreter for accuracy. Themes discussed with bi-cultural research assistant for validation.</p> <p>Ethical practice – informed consent was obtained. Interviews conducted in own homes, prioritised comfort of participants. Ethical challenges discussed (e.g. potential discomfort for participants talking to a stranger) but not appropriately addressed in the text.</p> <p>Verbatim quotations used to illustrate women – resonance, meaningful coherence, transparency.</p> <p>The women interviewed had not experienced miscarriage. Nor had their immediate households. However, not specifically focused on women who had miscarriages. Rationale provided = women may not feel comfortable discussing experience with strangers. A good way to gain insight but represents significant limitation.</p> <p>Used thick description and interview quotes to evidence interpretations and information – also increased resonance with reader and connection with material.</p>
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NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

	<p>Transparent about methods but not about self-reflexivity? No evidence of own position, epistemological position (except possibly feminist?). However, does reflect on impact of outsider research (e.g. ppt comfort in talking to her).</p>
<p>Corbet-Owen & Kruger (2001). The Health System and Emotional Care: Validating the Many Meanings of Spontaneous Pregnancy Loss</p>	<p>Define pregnancy loss as inclusive of miscarriage and still births.</p> <p>Conceptualise pregnancy as a socially constructed experience – gives insight into epistemological position but not stated in-text. Illness experiences – pregnancy loss is a social experience that goes far beyond physiology.</p> <p>Included 3 women who described losing pregnancies that were ‘unwanted’. Acknowledges range of feelings about pregnancy loss from positive, to unwanted, to ambivalence = addresses the homogenous nature of literature/societal expectations that lead to expectations about it being negative.</p> <p>How women negotiate the meaning of their loss in various social systems in which they are functioning.</p> <p>Psychosocial contexts in which individuals experience preg loss have been neglected in research and medical care.</p> <p>Some very important groups of women were not represented, as only participants who spoke the first language (English) or second language (Afrikaans) of the interviewer were included. This meant that no African women participated. Problems with accessibility, but author’s acknowledged this = transparency about limitations and positionality.</p> <p>Ethical practice - Anonymity, informed consent, consent form. Ppts told that the interviews might illicit painful or difficult memories and that referrals would be made if necessary. One participant was referred for psychological counselling after the interview.</p>

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	<p>Methods – use of translation for Afrikaans-speaking participants. Translated into English then back into Afrikaans to ensure accuracy – however, possible to have mis-translated words/meaning in the process?</p> <p>Language, narratives, stories, metaphors etc. all represent subtle but important cultural meaning. This could have been lost.</p> <p>Results – divided women into those wanted pregnancy and those who didn't want pregnancy – crude categorisation, not accounting for complexity and nuance?</p> <p>Said it was concerned with co-construction of meaning between ppts and health professionals however in methodology it is clear that HCPs responses were only analysed in relation to perceived ability to meet the emotional needs (short and long term) of the women.</p> <p>Limitations – not possible to discuss in detail how dominant discourses of gender, class, religion, and culture impacted on the way in which women (and health professionals) construct the meanings of pregnancy and pregnancy loss. But acknowledged this was important.</p> <p>Feminist literature reflects on the essentialist ways in which being a woman is tied to being a mother. Considered natural, inevitable, right thing to do. Women's identity and power are derived from their ability to mother. Social status, achievement, special, powerful, dutiful. So pregnancy loss = marginalisation, feeling defective, abnormal, weak, inadequate. Blaming self, body (finding fault e.g. anemia, weight) – body failed. Reproductive failures. Guilt and shame, sometimes exacerbated by male partners. Disconnected, guilty, empty and alone.</p> <p>Flushing something down the toilet – what does this symbolise?</p>
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	<p>For those who didn't want pregnancy, it represented abusive/unhappy relationship, loss of freedom.</p> <p>Pregnancy loss viewed positively – thought also shame and regret. Less comfortable talking about meanings of pregnancy loss – could be related to less meaningful, or taboo about being relieved when loss occurs.</p> <p>Sample not representative of any group</p>
<p>Abboud & Liamputtong (2002).</p> <p>Pregnancy loss: What it means to women who miscarry and their partners.</p>	<p>Similar age range to my study = comparison.</p> <p>IPA epistemology but TA method – incongruence here? Slightly confused as reader, not clearly communicated.</p> <p>Snowball sampling – heterogeneous group. Assumptions about 'hidden community' being hard to reach. Not the case in my study. Implicit assumptions.</p> <p>No ages included for male partners – important context for sense-making?</p> <p>TA = 'emerging themes' – not accounting for co-construction and influence of researcher position/interpretation. Insinuates discovery of themes that are 'there'.</p> <p>The women generally responded with shock and surprise when they discovered they were pregnant and when the pregnancy ended in a miscarriage. Two v different experiences, conflating them is reductionist/simplistic?</p> <p>No info about whether participants have living children or not.</p> <p>Several women commented that they had only heard of miscarriages but did not know anything about it until they themselves had miscarried. Consistent with my findings. Resonance – more emotional? Feminist – lack of education/awareness.</p> <p>Comparing men and women experiences – direct comparison. Rationale for this not clearly explained?</p>

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	<p>Some couples had children and some did not. One couple's child was born a few months before the interview (the twin was the miscarriage). This is going to majorly affect the meaning making and experience. Inclusion criteria too broad to draw meaningful themes? Homogeneity of variance possibly more important for TA?</p> <p>BLAME – important. Not eating right foods/enough food, or too much physical activity e.g. dancing. Heterosexual couples. Contributes to heteronormativity in society/literature = exacerbates assumptions. Split into 2: women/men personal experiences (themes produced). And then men/women perceptions of their partner's experience (no themes produced). No comment on co-construction within couples, more of a comparison.</p> <p>Other couples were able to 'put it out of their minds' due to becoming pregnant – reductionist, simplistic and minimising the pain?</p> <p>States not generalisable to all Muslim women – but the sample is comprised of all Christian women? Also was it intending to be generalisable?</p> <p>Reaction about forgetting about the miscarriage observed in other studies.</p> <p>Findings – go between narratives and themes. Not presented consistently. Limits resonance, coherence, and transparency of method/research process.</p> <p>Stated women blame themselves (their body) however there was no mention of this in the findings or quotes included.</p> <p>The women knew what the man was experiencing at a time of loss more than the man knew of their wife/partner's experience – how would they know this? How can the authors make this claim?</p> <p>Interpretations/conclusions not always adequately explained or backed up with data.</p>
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NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

	<p>Women, therefore, need immediate support and counselling to facilitate recovery – inconsistent with previous message about grief reduces over time, as expected.</p> <p>Of particular importance is the need to convince the women against self-blame, as this may jeopardise their self-esteem and lead to emotional ill health later on – problematic language (‘convince them’)?!</p> <p>Male counsellor as men feel more comfortable – not backed up by data. Gendered assumptions.</p> <p>Lacking in reflexivity about assumptions – laden with assumptions throughout (which are positioned as being ‘proved’ in conclusion) with no reference to participant data.</p>
<p>McCreight (2004).</p> <p>A grief ignored: narratives of pregnancy loss from a male perspective.</p>	<p>Identifies assumptions made in literature based due to lack of data from fathers.</p> <p>Draws upon existing literature – meaningful coherence, theoretical underpinnings.</p> <p>Operationalised pregnancy loss as inclusive of miscarriage and stillbirth. Three men had had experience of miscarriage, six had experienced a stillbirth and five had experienced both miscarriage and stillbirth.</p> <p>2 men in the study had no living children but the rest did – implications for narrative construction and identity?</p> <p>Often asserts something is ‘worse for men’ without explanation, rationale or evidence/data.</p> <p>Credibility – some use of long quotes but not consistently used to back up interpretations made from interviews.</p> <p>Appropriate sample, data collection, analysis. Decision-making clear and justified.</p> <p>Transparent in terms of methodology and process but lacking self-reflexivity. No mention of epistemology – could this be a more positivist-informed approach as some of the language suggests?</p>
<p>McCreight (2008).</p>	<p>Includes miscarriage and stillbirth.</p> <p>Includes literature review (but not systematic?).</p>

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

<p>Perinatal loss: a qualitative study in Northern Ireland.</p>	<p>Attended groups over 3 years to recruit to build trust.</p> <p>Triangulation used – question the appropriateness/relevance for NI? But haven’t stated epistemological position that informed the research/methods, so it might fit depending on this.</p> <p>Ethical adherence – considered ethics of vulnerable group and notion of causing no harm in relation to sampling methods. Gained ethical approval, considered anonymity and consent.</p> <p>Limitation – interviews conducted several years after loss, may have impacted memories? (Time since pregnancy loss 2 months – 34 years).</p> <p>Not claiming to generalise findings which is consistent with narrative approach (but still not linked to epistemology).</p> <p>States it’s narrative analysis but the process reads more like thematic analysis?</p> <p>Did not meet sincerity – whilst reflective, congruent, coherent etc., researcher did not state epistemological position, address their assumptions/biases, and this came through in conclusions drawn from the study.</p>
<p>Carolan & Wright (2017). Miscarriage at advanced maternal age and the search for meaning.</p>	<p>Reflexivity/sincerity criteria – before beginning the interviews, Carolan engaged in epoche (Creswell, 2007), a preparatory examination of researcher biases and assumptions.</p> <p>Recruitment methods unknown/not stated.</p> <p>Ambiguous loss and Feminist ecological frameworks. Grounded in theoretical underpinnings, increased coherence (however, not explicitly/consistently drawn on throughout?). Contributed to meaningful coherence and credibility.</p> <p>Ethics: informed consent, no mention of debrief? But obviously considered and adhered to appropriate recruitment etc.</p>

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

	<p>USA context = healthcare inequalities, access to IVF/fertility treatment – impact on meaning made to some extent? Reflection on power dynamics and social GRACES – influence on meaning- making.</p> <p>Could have gone further with conclusions e.g. real-world implications, healthcare context, pragmatic use?</p>
<p>Littlemore & Turner (2020). Metaphors in communication about pregnancy loss.</p>	<p>Ethics – participants all over 18. Written, informed consent.</p> <p>Operationalisation of terms – included termination (due to medical diagnosis) and stillbirth. Only study to include this? How might termination for medical reasons (TFMR) impact narrative construction?</p> <p>Self-selected sampling = unbalanced in terms of gender and experience.</p> <p>Recruitment through 3 charities who were partners in study – transparent re conflict of interest.</p> <p>Recognise sample is skewed in terms of those who needed help/support from charities. (Could link to my study/sample). Recognised this – “our project is designed to improve care for those who are finding it difficult to come to terms with their pregnancy loss, so we wanted to hear from people who needed this care most”.</p> <p>Of the 35 participants, 31 were women who had experienced a loss, three were male partners of the female participants, and one was a friend of the bereaved. Focus on interviews with women. Didn’t always distinguish between different participants in communicating findings.</p> <p>Transparent about methodology but lack of reflexivity?</p>
<p>Horstman Horstman, Holmanb & McBrideb (2020). Men’s Use of Metaphors to Make Sense of Their Spouse’s</p>	<p>Triangulation after analysis and member checking.</p> <p>Meaningful coherence and real-world impact – the current study’s findings provide a common language to use with patients and families suffering from miscarriage.</p> <p>However, the article has been critiquing unhelpful cultural meanings/narratives e.g. heteronormative, reinforce gender roles etc. Now it wants to use these same terms as a common language?</p>

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

<p>Miscarriage: Expanding the Communicated Sense-Making Model.</p>	<p>Sample was large but homogenous – composed of predominantly white, cis-gender, heterosexual, married, educated men. But not necessarily aiming to generalise?</p> <p>Interview – open-ended questions. Phone, skype or f2f. Offered participants choice = flexibility, accessibility. Audio-recorded and transcribed verbatim.</p> <p>Ethics – over 18 years old. Use of social media. No rationale for decision-making relating to ethical considerations/challenges. However, have provided a transparent account of methods/procedure.</p> <p>Recruited any male-identified individual who was older than 18 years old and had experienced a miscarriage with a spouse.</p> <p>Acknowledged that LGBTQ+ men also experience miscarriage, but only heterosexual, cis-gender men volunteered for the study. No reflections as to why this might be?</p> <p>Recognised that the results represent the experiences of a particular group of men, and not the entirety of the ‘male experience’.</p>
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Appendix G. Recruitment advert created for social media

Miscarriage

ARE YOU A WOMAN AGED 25 TO 50 WHO HAS
EXPERIENCED A MISCARRIAGE BETWEEN
6 MONTHS AND 10 YEARS AGO?

WOULD YOU LIKE TO SHARE YOUR STORY?

WE ARE INVITING WOMEN TO SHARE HOW THEY MADE
SENSE OF THEIR MISCARRIAGE.

WE ARE DOING THIS TO BETTER UNDERSTAND HOW
MISCARRIAGE MAY IMPACT ON WOMEN'S IDENTITY.

if you are interested and would like more
information about how to get involved, please
contact Emma on
ew18abd@herts.ac.uk

University of
Hertfordshire **UH**

Ethics
Committee

This study has received ethics approval from the University of
Hertfordshire Health, Science, Engineering and Technology Ethic
Committee. Protocol number: LMS/PGT/UH/04189.

Appendix H. Recruitment poster

 Trigger Warning

Participants Needed

Psychology Research into Miscarriage

Women's Narratives of Pregnancy Loss and their Effect on Identity

What is the study about?

The study aims to explore how women make meaning of their experience of miscarriage and whether this process has an impact on their identity. This research is interested in the dominant messages within society that are available to women as they form their own narratives and meaning from their experience of miscarriage. It is hoped that this research will contribute to research surrounding miscarriage, amplify the voices of those who have had this experience, increase the awareness of professionals and services, and encourage conversations about current support provisions.

What would it look like if I took part?

- You would be invited to take part in an informal interview with the main researcher called Emma.
- You would be asked some questions about your experience of miscarriage.
- Interviews will be audio recorded so they can be analysed.
- You can withdraw from the interview at **any point**.

If you are interested in taking part, please contact Emma for more information about what to expect.

What are the criteria for taking part?

- ✓ Are you a woman?
- ✓ Have you experienced one or more miscarriages in the last 6 months - 10 years?
- ✓ Are you between the ages of 25 - 50?
- ✓ Are you willing to participate in an interview using a video chat such as Zoom?
- ✓ Are you a fluent English speaker?

If you had children before or after your miscarriage(s) you do not meet criteria for this study. If you have any questions, please get in touch.

Want to get in contact or ask a question?
Email Emma at:
ew18abd@herts.ac.uk

You don't have to be interviewed to get involved... If you have thoughts about this type of research or any of the themes highlighted here, we'd love to hear from you!

University of Hertfordshire UH Ethics Committee
This study has received ethics approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee. Protocol number: LMS/PGT/UH/04189.

Appendix I. Participant Information sheet



UNIVERSITY OF HERTFORDSHIRE

**ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
(‘ETHICS COMMITTEE’)**

FORM EC6: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Title of study:

Exploring women’s narratives of pregnancy loss and their relationship to sense of self.

Introduction:

Thank you for taking an interest in this research. You have been invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time when making this decision.

The University’s regulation, UPR RE01, ‘Studies Involving the Use of Human Participants’ can be accessed via this link:

<https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs>

(after accessing this website, scroll down to Letter S where you will find the regulation)

What is the purpose of the study?

Miscarriage is a relatively under-researched area. Little has been done to understand how women make sense of this experience, and what resources are available to them in order to do this (e.g. dominant beliefs/values in society). This study aims to address this gap in the literature by exploring how people talk about their pregnancy loss, what meaning they made from it, what factors impacted this process, and whether it affected their sense of self (i.e. identity).

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You can withdraw from the interview at any point without having to give a reason. Your data can be withdrawn up to two weeks after the interview by contacting the researcher (see below for details). You do not need to give a reason. Beyond two weeks your data cannot be withdrawn as it will have been analysed. A decision to withdraw at any time, or a decision not to take part at all, will not affect any treatment or care that you may receive (should this be relevant).

Are there age or other restrictions that may prevent me from participating?

Yes. To take part, you must be between the ages of 25 – 50, have experienced one or more miscarriages between 6 months and 10 years ago, be fluent in the English language, be living in the UK and be willing to participate in a telephone or video interview (e.g. over Zoom, Skype, Webex). It does not matter if you are currently trying to conceive, or if you are not. If you have children (via natural conception, IVF or adoption) from either before or after your miscarriage(s) then you are not eligible for this particular study. There are no exclusions based on culture, ethnicity, religion, relationship or socio-economic factors.

What will happen if I decide to take part?

The first thing to happen is that you will be asked to read and sign a consent form. You will then be contacted by the lead researcher Emma to talk about how you want to be involved and arrange the next steps. There are two ways you can be involved in the study:

- 1) We will arrange to have a conversation together on a video chat or by telephone and you will be invited to talk about your miscarriage. There will only be one interview and it will last between 60 - 90 minutes.
- 2) If you want to participate or contribute to this research without taking part in an interview, you can provide feedback about the study. We can discuss the options together if this is something you are interested in.

What do I have to do?

In the interview, you will be invited to talk about your experience of miscarriage. You are welcome to bring someone with you for support, but they will not be asked questions in the interview. The questions will relate to themes such as how you made sense of the

loss, what helped you to do this, whether/how this process impacted on your sense of identity, and the support you accessed or would have liked to access.

Are there possible disadvantages, risks or side effects of taking part?

Taking part in the study may cause uncomfortable or distressing feelings and/or memories to resurface. No matter how long it has been since a loss, it can always be painful to revisit. Only you can know if talking about this experience will be right for you. Please take time to consider whether this is something you feel able to do at this time, and think about how you can take care of yourself afterwards.

If you think that you might want to access support, whether or not you take part in the study, then please consider the following options:

- Access your GP who will be able to discuss psychological services such as your local Wellbeing Service or Community Mental Health Service;
- If you are feeling depressed, or experiencing thoughts of self-harm or suicide, you can call the Samaritans for free on 116 123. They are available 24/7, every day of the year;
- Access a local charity that provides support and counselling, such as The Grove (Bedfordshire), Petals (Cambridgeshire), or Alternatives (Hertfordshire);
- Visit online charities and organisations for miscarriage and pregnancy loss, such as The Miscarriage Association, Tommy's, Kicks Count and Saying Goodbye;
- Visit <https://www.miscarriageassociation.org.uk/> for more information and support.

What are the possible benefits of taking part?

The personal benefits of you taking part in this research might be low. Whilst some people might find it comforting to talk about, the interview questions follow certain themes relevant to the research, which may limit the conversations you would choose to have. However, there are potential wider benefits of taking part; it is hoped that this study will increase awareness and understanding of how women make sense of miscarriage within a cultural and societal context, and begin conversations about current support pathways available. By doing so, it is hoped that this research can be beneficial to individuals who experience pregnancy loss in the future, by improving understanding and support available (if these are identified as areas for improvement).

Audio Material

The interviews will be audiotaped using a secure encrypted audio recorder, and stored securely on an encrypted memory device. File names will be anonymised and identified by a code or pseudonym (assigned name). You can choose your own pseudonym if you like (this will also be used in the write up). Recordings will then be transcribed and anonymised (i.e. all names and identifying information removed) before the analysis.

What will happen to my information?

All data collected will be confidential and stored electronically on an encrypted mass memory/storage device. Consent forms will be password protected and stored separately from interview data. Audio recordings will be anonymised prior to storage and password protected. Audio recordings will be transcribed for analysis; external transcription services may be utilised for this. Such services will be required to sign confidentiality agreements and all data will be transferred securely. Anonymised data (e.g. transcripts) will be kept for 5 years and may be utilised for secondary analysis. Identifying information (such as consent forms and audio recordings) will be deleted on completion of the study. Your personal data will not be passed on to any third party or organisation. The write up may include direct quotes from the interviews.

What will happen to the results of the research project?

The results of this study will aim to be published within two years. Findings might also be presented at conferences. Any information you share will be kept anonymous throughout this process. If you are interested in keeping up to date with the progress of this research, such as when it is published and how you can access any publications, please indicate this at the end of the consent form and you will be added to a mailing list. This will only share information about this particular study and your details will never be shared. It does not matter whether you choose to participate or not.

Who is organising and funding the research?

The research is associated with the University of Hertfordshire Doctorate in Clinical Psychology. The research is a requirement of the programme prior to qualifying as a Clinical Psychologist working within the NHS.

Ethical review of the study

The project has been reviewed and approved by The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is: [LMS/PGT/UH/04189](#)

Who can I contact if I have any questions?

If you feel that you require further information about this study or any of the details provided here, please do not hesitate to get in contact via email (*see below*). Emails will be responded to within 2 working days.

Name of Principal Researcher: Emma Wallis
Title/Job Role: Trainee Clinical Psychologist
 **Email Address:** ew18abd@herts.ac.uk

What next?

If you are interested in taking part in this study, please read and sign the consent form (attached) and send to Emma on the above email address. If you would like more information, please get in touch with Emma via email. If you do not want to take part in this study, then you do not need to do anything further.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

**Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB**

Thank you

Thank you for taking time to read this information sheet and giving consideration to taking part in the study.

Appendix J. Participant Consent form



**UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
(‘ETHICS COMMITTEE’)**

**FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS**

Participant Consent Form

Title of study: Exploring women’s narratives of pregnancy loss and their relationship to sense of self.

I, the undersigned [*please give your name here in BLOCK CAPITALS*]

.....
...

hereby freely agree to take part in the above titled study.

UH Protocol Number: LMS/PGT/UH/04189

Please give contact details, sufficient to enable the investigator to get in touch with you:

☎ *Phone Number:*

📧 *Email:*
.....

I am interested in [*please mark as appropriate*]:

- Taking part in the interviews.
- Offering my thoughts, feedback and advice about the research.
- Becoming a consultant to the research.

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the interview at any time without disadvantage or having to give a reason, and that I can withdraw my audio recordings up to two weeks post interview without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the potential risks of my suffering harm or adverse effects and I have been informed about options for aftercare and support available to me in the event of this happening. I am aware that all suggested options are available at no cost to myself.

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

7 I understand that I will not be contacted again in the future in connection with this or another study, unless I specifically request to be kept up to date with the progress of this research (including any publication that may result).

Please mark the following statements as appropriate:

- I confirm that I have read and understand the Participant Information Sheet.
- I agree to the above statements in this consent form.
- I have had the opportunity to ask questions and had them answered.
- I am between the ages of 25 – 50.
- I agree to take part in this study.

Signature of participant.....Date.....

Signature of (principal) investigator.....Date.....

Name of (principal) investigator *[in BLOCK CAPITALS]:*

...EMMA WALLIS.....

Thank you

Please return this form to the researcher via the email provided.

Appendix K. Participant demographics form

Participant Demographic Information

If you feel comfortable, please fill out the following information*:

How did you hear about the project?

.....

Age:

Gender:

Sexuality:

Race/Ethnicity:

Religion:

Culture:

Geographic location/region:

Socioeconomic status:

**Why am I being asked this information?*

This is called demographic information and is collected for each participant who decides to take part in the research project. This is to provide more context for the research in terms of who has taken part. This is particularly important when discussing the findings, which may be specific to certain individuals or more generalisable, depending on the sample of people who have taken part.

What will be done with this information?

For information about how your information will be stored and used in the study, please refer to the information sheet provided.

You do not have to provide this information if you do not wish to. It is entirely voluntary and your participation in the study does not depend on you providing this information. You can also answer some and leave some blank, if that is your preference.

If you have any questions please do not hesitate to contact the Primary Researcher Emma.

Thank you

Please return this form to the researcher via the email provided.

Appendix L. Participant debrief form

Participant Debrief Form

The interview is now complete. Thank you for taking part.

Thank you for taking part in this research. It is greatly appreciated. It is hoped that this research can continue the conversation surrounding miscarriage and pregnancy loss to further improve awareness, understanding and support available to those who experience it.

It is natural for emotions to resurface or intensify when we talk about painful and distressing experiences. Be kind to yourself and try to dedicate some time to self-care, whether that's giving yourself some time and space to reflect, having a warm bath, talking to your family or partner, phoning a friend, listening to music or watching a film.

If you feel that you need additional support following your interview, please consider the following options:

- Talk with a trusted partner, family member or friend about how you're feeling and what you might need at this time;
- Your GP will be able to advise you on accessing psychological support in relation to your experience of miscarriage and/or mental health difficulties, such as a referral to your local Wellbeing Service or Community Mental Health Service;
- If you are feeling depressed or experiencing thoughts of self-harm or suicide, please access emergency crisis support by calling 999 or presenting to A&E. You can also contact the NHS helpline 111 for non-emergency advice.
- You can call the Samaritans for free on 116 123. They are available 24/7 every day of the year.
- There are local charity organisations that provide information, support and counselling services. Some examples are:

The Grove (Bedford)

Petals (Cambridgeshire)

Alternatives Pregnancy Crisis & Support Centre (Herts)

- You can visit online charities and services for more information, advice and support, such as:

The Miscarriage Association

Tommy's National Centre for Miscarriage Research

Kicks Count

Saying Goodbye

Once again, thank you so much for your time, effort and energy.

Please let Emma know if you would like to be kept up to date with the progress of this research and any publications that result.

Appendix M. Interview guide

Proposed interview schedule

- Zoom troubleshooting
- Demographic form
- Distress/upset
- Participant rights
- Ok to audio record and record on zoom?
- Debrief form to follow
- Questions may overlap

I am interested in hearing about your life and relationship with miscarriage, and how you would describe your journey to me. I will be interested to listen to the stories about what has happened to you and so will want to give you the time and space to tell me about this as fully as you want to. I will try to sit back and listen to your answers as much as I can, without interrupting. Is that okay?

Before we talk about miscarriage, it would be good to hear a bit about you as a person, more generally. Things about you, your life stage, your family, what you like doing, that sort of thing.

Before we talk about miscarriage, I'd like to ask you what language you prefer me to use. Do you tend to say 'miscarriage', or 'pregnancy loss', or something else...?

- 1) Tell me about you and your life.
Life stage? Who is in the family? What brought them here today?
What terminology do they prefer (to refer to their own experience)?
- 2) What does miscarriage mean to you?
When did you first hear the term?
Who used the term and where?
- 3) Starting from the beginning, can you tell me the story of your miscarriage(s)?
When did it happen?
What happened?
How did you feel/react?
Was anyone else involved?
What were/are your expectations (about pregnancy/motherhood)?
What do you think shaped your expectations?
- 4) How did you make sense of your miscarriage at the time?
How did you understand what happened?
What was the response of others e.g. partner/family members?

- 5) What helped you to understand this experience?
For example, things that family and friends might have said, doctors, social media, films, and societal, cultural or religious beliefs, etc.
- 6) How was your understanding affected by common messages about miscarriage?
How do you think miscarriage is viewed in society?
Where do you think these ideas come from?
- 7) Has your relationship with miscarriage, or your understanding of it, changed over time? Can you tell me about this?
Do you feel differently about it now compared to when it happened?
What have been the challenges and high points?
Are there any positive things that have happened or you have learned as a result of your experience of miscarriage?
- 8) How has your experience of miscarriage shaped/changed you as a person?
How did you change personally because of the miscarriage?
Do you consider it a part of your identity / what makes you who you are today?
Has it impacted how you relate to your body (e.g. body image or self-esteem)?
How has your relationship with motherhood/parenthood changed as a result?
- 9) Who did you turn to for help?
Did you seek help? In what way/form?
Was this helpful or unhelpful?
What support was available to you [friends/family/community/healthcare]?
What were your expectations of seeking help? What was your experience?
- 10) Can you tell me about what *helped* and *hindered* you in talking to others (such as your partner, family, friends, colleagues or services) about your miscarriage?
How did people respond? What was that like?
Do you think it is easy to talk about miscarriage?
Has this become more or less difficult over time?
- 11) Is there anything else that you feel is important for you to voice? Is there anything you would like to add to our discussions before we end?

Ending

- How has it been, talking to me today?
- Is there anything else that you feel is important for me or other people to know about you, and your experiences with miscarriage? Is there anything you would like to add to our discussions before we end?
- Are there any things that you're feeling uncomfortable about having said? (Any things that you don't want to be included in your account?)

Appendix N. Ethical approval confirmation letter



HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA
ETHICS APPROVAL NOTIFICATION

TO Emma Wallis
CC Jennifer Heath
FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE 30/06/2020

Protocol number: LMS/PGT/UH/04189
Title of study: Exploring women's narratives of pregnancy loss and their relationship to sense of self.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 01/07/2020

To: 01/04/2021

Please note:

Appendix O. *University of Hertfordshire's confidentiality agreement for transcription services*

20.08.2020 | Version 0.1 | IRAS NO. 284812



Non-Disclosure Agreement with Transcription Company

This non-disclosure agreement is in reference to the following parties:

Emma Wallis (discloser)

and

_____ (transcriber)

- The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.
- If the recipient is able to identify and knows the participant in the recording, the recipient agrees to cease transcription, inform the disclosure and destroy any copies of the recording.
- The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.
- The recipient agrees to return and/or destroy any copies of the recordings they were able to access provided by the discloser.

TRANSCRIBER TO COMPLETE:

SIGNED:

NAME:

DATE:

Appendix P. *End of recruitment email sent to prospective participants*

Dear [NAME],

Thank you for your interest in the research project exploring women's narratives of miscarriage and their impact on identity. I am so sorry for your loss.

I am overwhelmed by the support for the project, and the generosity demonstrated by women such as yourself for wanting to share your experience.

The project has received an overwhelming response. Whilst this is positive for the project, it unfortunately means that we reached capacity for the interviews, and so are no longer recruiting for this.

If you have any questions or comments, then please get in contact with me. Once again, thank you for getting in touch and for your support for this project. I wish you all the best.

Best wishes,

Emma

Emma Wallis

Primary Researcher

Trainee Clinical Psychologist

 ew18abd@herts.ac.uk

Appendix Q. *Transcription symbols (Jefferson, 2004a)*

Symbol	Meaning	Example
[square brackets]	Represents overlapping speech	I: um, [thank you] P: [yeah]
= (equals sign)	Represents ‘latching’ i.e. no perceptible gap between the end of one person’s speech and the beginning of another’s	I: um, thank you= P: =yeah, no problem
Hyph- <u>Underline</u>	Indicates a broken off word, utterance or stutter Indicates where emphasis or stress has been placed on a word or part of a word via pitch and/or amplitude.	P: I ju-, I just don’t know I: I <u>just</u> couldn’t <u>believe</u> it
(.)	Represents a brief pause that is between >0.1 seconds and <1 second.	I: please, (.) take your time
(1)(2)	Numbers in brackets represent pauses in seconds	P: I just (1) really couldn’t believe it
CAPITALS	Indicates especially loud words or sounds relative to the surrounding talk.	P: I was like “NO”!
◦Degree signs◦	Used to bracket a word or utterance that is softer relative to surrounding talk.	P: I ◦just can’t◦- I: that’s ◦okay◦
“speech marks”	Indicate the speaker imitating another person a.k.a. ‘active talk’.	P: she said “yeah, OK”
(xxx)	Represents inaudible speech. The number of ‘x’s’ represent approximate number of words missed.	P: I- (xxx) (.) sorry
.,?!	Punctuation markers indicate intonation rather than grammar	P: I was like “NO”!
.hhh or hhh	A dot-prefixed row of ‘h’s’ indicates in-breath. A row of ‘h’s’ can also be used within a word to indicate breathiness.	
hheh	Indicates outbreath and/or short laugh sound.	
(brackets)	Text that it in single brackets and italicised represents a non-speech element such as laughter or another descriptor	P: hahaha! (<i>laughs</i>)
: (colon)	One or more colons indicates an extension of the immediately preceding sound; the longer the colon row, the longer the prolongation.	P: I was so:::: tired afterwards
[square brackets]	Square brackets surrounding italicised text indicate deliberately-omitted text such as names for confidentiality purposes	P: I spoke to [<i>Name</i>] about it
↑↓	Arrows indicate shifts into especially high or low pitch.	P: That’s a good ↑ques↓tion I: ↑Thank ↓you.
*	Indicates ‘creaky voice’.	

Appendix R. *Interview transcript exert (Sami)*

I: You're ok. Take your time.

P: (4) (*sniff*) phew. Sorry, I didn't realise it was gonna be this- (*sniff, audibly crying*)

I: it's really hard, I can imagine to-to go back over the memory.

P: (4) um yeah, yeah so (.) um (.) my colleague sorted, most of them had come down. (2)

They knew I was pregnant as well so obviously they could kind of guess what was happening. Um, my:: manager, er*-um, er had called er my partner .hhh, one of my colleagues took me to the hospital, um, as well (*sniff*). Um, I was at the hospital for four hours, nobone had seen me. I was gushing through my-my pants, my clothing (.) just, .hhh you know, again in a lot of pain um (.) (*tut*) and I was really frustrated with the hospital anyway. Um, my partner [*name*], couldn't come as well, because he had come from work. .hhh (*sniff*) erm (3) (*tut*) and um, they said "sorry , we can't do anything, erm we don't know what's going on, you have to go to another hospital" erm* and that was just kind of gut-wrenching because it was like, "if you had told me, like, four hours ago I could have gone to another hospital .hhh (*sniff*) and found out what had happened" erm. So then we had to go to another hospital again wait another four hours um cos the miscarriage had happened kind of around er, 12/1 o'clock-ish so it was kind of like a full-day thing. (*sniff*) err, went to the hospital um, and it jus- again just prolonging kind=you know it was just taking so long .hhh um (.) apparently because it wasn't deemed kind of uh im↑portant enough compared to other patients, um so we finally had blood test and things like that and I was just getting really irritated and antsy and I was like "I wanna go home" erm, and then:=finally after blood tests they said, that, all, you know "you're having a miscarriage" and I was like, they said (.) no, sorry, they said er "you could

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possibly be having a miscarriage, we don't know for sure, we can't refer you to anything because everything's closed?" .hhh "and the early pregnancy unit clinic is closed for the day so you'll have to come back tomorrow" (.) (*sniff*) so:: we had to come back the next day and we had to go through all the internal vaginal examinations again. Erm (.) (*tut*) and obviously they said you know there was no, there was no, um, no foetus in the womb (1) um so yeah obviously uh* didn't go back to work for about a mo- err a good couple weeks after that as well. So, yeah, that was a-uh (*sniff*) uh-a bit- (*sniff*) I'm sorry (xxx) (*audibly crying*)

I: [it's ok]

P: [I'm so sorry]

I: No, please don't apologise. It sounds truly traumatic, erm, I can't imagine what it's like to tell that story(.) in what I assume is the same building, possibly?

P: No, lucki- this is actually another setting, I did[n't]

I: [okay]

P: [last] very long in my last job, as you can imagine (*laughs/crying*) (*sniff*)

I: yeah, sure (.) okay.

P: Mm, yeah

I: Do you want to take a couple minutes just have a breather, or (.)?

P: (*sniff, laugh*) hheh, yeah, maybe because I probably=I'm just sat here crying to my phone↑=

I: =That's absolutely fine!

P: (*Chuckles awkwardly*) yeah, sorry!

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I: Take a-take a break, take a breath, and (.) do you have a glass of water or anything?

P: Ye::a:h, I just, think it's probably just a little bit (.) more-more emotional just because I should have been due around this tim[e (.) as] well, so it's a bit... phew... you know? Yeah.

I: [yeah]

I: Yeah, 'course.

P: sorry

I: No, [course]

P: [actually, bear] with me I'm just going to get a drink (*laughs*) (10) (*sniffing and crying*).
(3) hheh (.) thank you:!

I: No, please! (2) Please don't apologise ever=

P: =[hheh]

I: [You're in]credibly brave fo-for telling this and for telling your story (.)

P: (.) Thank you (*sniff*)

I: Just [let me know]

P: [I'm okay]=

I: =let me [know] when you're ready

P: [yeah]

P: Yea::h, no, I'm ok, it's just, you know. It's just a* (*stutters*) big thing to (.) kinda, talk
(*awkward laugh*) .hheh=

I: =absolutely.

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P: Yeah I'm ok, I'm just (2) yeah its just the last couple of weeks have been really emotional about it as well, erm (2) yeah we kind of expected that July I would be a bit all over the place (xx) so yeah, I'm ok, you can ask me wh-what you need to ask.

I: do you think that erm that's part of the reason that you got in touch about the project, erm, with it being around this time? (14:00)

P: Ye::ah, so erm (.) there's a group on kind of Facebook and other social media platforms erm and it's the erm (.) Tommy's um association .hhh a-er lady put out that you were doing research erm (.) behind it and I think we kind of all agreed that it was interesting (.) erm to see that someone had taken an interest in kind of .hhh an area that's not really spoken[↑] about as much, erm is very taboo:: still, erm, and you think at this day and age it wouldn't be something that people wouldn't shy away to talk from, erm (.) so yeah, I kind of thought it would be (.) good to t-talk about it with someone who –I didn't know if you'd experienced it yourself, or erm (1) you were just researching- but we, you know we all kind of agreed that you know if it's more of an open subject and spoken about then you know more people wouldn't be afraid to talk about it. Erm, so yeah, it kind of appealed in that way for us.

I: thank you. That's really nice to hear (2) erm-

P: hheh (*laughs*).

I: okay (2) .hhh can I ask, erm (.) what were your, erm, kind of, initial expectations about pregnancy and-or motherhood, or ...?

P: erm, mm-hmm (.) erm:: (2). I don't-I don't know if I had kind of any expectancies, I er- I obviously expected er, you know, a healthy baby and and (1) kind of (.) we were planning on making sure we all learned to drive so that we could go to appointments and things more easily .hhh and obviously I have a very small room so it's (*laughs*) just about converting my room, you know, into the kind of the baby room. Erm (.) yeah it was very much kind of (3) I

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think it was just more of, of, of the baby we had started coming up with names, erm (.) you know, err* kind of (.) once you find out you're pregnant you kind of start having these erm (.) kind of dreams for your child, you know, what you want to do::, erm (.) yeah, what you'd name them, erm (1) you know, erm, we kind of spoke about (*laugh*) things like, umm (4) if they're, if we're going to make them like into Lord of the Rings fanatics or you know (*laugh, sniff*) make them like really well-read, and erm (.) have (.) like piano lessons, or-or-or something, you know. Erm, me and my partner are very big gamers as whhhell so we were like, you know, that type of thing um. Kind of motherhood didn't scare me because where I work in education it was kind of like, you know (.) I'm gonna be the one who knows all about early years and he's gonna know all about the kind of teenage years, so w- erm- so because my partner works with teenagers, he's a TA as well, er::m* (.) so it was kind of that type of thing, erm, so yeah (*laugh*)

I: mm::, okay (2). Thank you hheh. Um (.) how did you make sense of your miscarriage at the time?

P: (1) erm:: (2) to be honest fo-for a-hheh, er-a good while I didn't make sense of it, erm:: (.) it was very much I-I* couldn't sleep, I couldn't eat, err::*, I was very much depressed, err, in bed all the time (.) erm and it was kind of felt (.) like (.) hard. I felt very much um, obviously, it was my fault, I was blaming myself a lot, umm, (*sniff, voice wobbles*) (1) I felt really bad because obviously my partner was grieving as well, erm↑, and God (xxx) (*sniff*)=

I: =it's okay, take your [time].

P: [erm], yeah, so, erm (.) it (.) again I-I threw my hands up to God and I was like, you know what, God knows be::st and you know, but you know half of me was like "why did it happen to me?" erm↑ (*voice wobbles, cry*) (*whispers*) °sorry° (.) erm, yeah so (*wobbles*) °oh god°(.) so:: (*tut*) and then I happened to (.) it was, erm, yeah it took me a long

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while, erm, I-erm (.) I think then I started kind of looking at*, *erm, sort of support groups like Tommy's um (.) as well, which you know other mothers who had experienced the same thing, erm, and it was kind of a, a-err, a situation where people would talk without feeling judged umm (.) so they were a really good, erm, comfort to me as well, erm, obviously there's my partner as well, he really helped me through it .hhh erm (3) erm, yeah so I ended up staying with him more than .hhh being at home with my own family↑ just because they=I suppose I couldn't really (.) go home because if felt like I, you know, I'd let everyone down, everyone was expecting (*sniff*), you know a baby in the family so, you know, it was just one of those things. Erm, I don't have a great relationship with my mum, erm but when she tried to:* I suppose comfort↑ She didn't rea::lly? Erm, she made a lot of jibes and comments which kind of didn't help the situation either (*sniff*) erm, but yeah then my partner and Tommy's were a-err really, really big support network for me .hhh erm, yeah=so it kind of started (.) slowly coming to acceptance erm you know, maybe a couple of months after everything happened, erm so yeah (*hheh*).

I: mm, thank you I can, I can really feel that s-some aspects are so difficult to talk about, so (.)

P: [mmm]

I: [thank you] hheh.

P: no, that's alrighhht.

I: Are you doing okay – can I just check in with you hheh?

P: yeah, yeah! (*Laugh*) I just feel really bad that I'm crying on the phone, erm, to you and you hheh don't know me from Adam and you've just got to sit here listening! (*Sniff*)

I: it's okay to cry. (1) It's absolutely, [erm], absolutely understandable and ... yeah.

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P: [(*laugh*) thank] you.

I: okay (1). Erm (.) I think you've touched upon this already (.) (*clicks tongue*) but what helped you to understand the experience, for example, things that family and friends might have said, doctors, social media, films, and [societal], cultural or religious beliefs.

P: [mmhmm]

P: erm, yeah like I said, um (.) in terms of kind of throwing my hands up to god er-umm, like I said I-er follow Islam .hhh so I was praying and kind of making sense of it and (.) that helped me towards it .hhh erm (.) to be honest a lot of (.) kind of people's comments are a lot of (.) oh, you know, it's not the right time, a-or:: erm, you know, you can always have another one and i-er*, they-they don't help when people make that type of a comment .hhh Er::m (2) yeah but I-I (*hheh*) every time someone said that to me just wanted to scream because it's like, I've just, I've lost a child I don't need to hear that I'm going to have another one or I can have another one la'er-on (.) erm, and I think some of the comments can be quite (.) and not helpful to people who have (*stutter*) a-er had pregnancy losses .hhh um::, but yeah again just kind of the-er* support groups like Tommy's and miscarriage association are all kind of big ones that helped kind of process and (.) that journey a little bit easier.

I: yeah (.) yeah (2) that's great, thank you *hheh* .hhh err, mm, ↑how was your understanding affected by common messages about miscarriage?

P: erm (2) ooh, erm:: (1) sorry can you repeat that? I-I (*flustered*) (.) j-just to let you know also erm I'm very dyslexic so sometimes I don't understand things (*laugh*), erm so if you (.) don't mind repeating that for me?=
I: =absolutely fine! So, (.) erm, I'm basically asking how you think miscarriage is viewed in society, and where these ideas may have come from, and .hhh whether any of those messages impacted your understanding?

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P: I thi::nk with (.) miscarriage it's not (.) like, again, in: kind of, storylines ther-they show it and (1) it's very much, (.) they don't show the kind of th*-the darker side behind it where (1) you kind of feeling so low that (.) you, you contemplate different things and darker routes, .hhh erm, you know (1) I was really, really low:: at one point, erm (.) you know and kind of wanted to do things that would obviously harm myself↑, erm, you know, ending life, that type of thing (*voice wobbles*) erm (.) kind of media is portrayed as, erm (1) (*tut*) it's kind of, they-they suffer it and the-they kind of get over it very quickly (.) when you don't, (.) erm. You know, you think about hat child every day, erm↑, ooh .hhh (*takes breath*), and so I-I don't think it's an outwardly positive approach to it, erm (.) you're so kind of, (.) you see the lack of (*tut*) (2) it's kind of the care and the respect that you kind of want, you know, when I was at the hospital (1) I-I kind of thought people would be you know making sure you're okay, that, you know, they would try and support you in a certain way .hhh erm, and I never got that support and you're kind of just told the information and you're kind of left alone with it (.) rather than you know given opportunities to do something it's only again through (1) programmes like miscarriage association and Tommy's that kind of tell you, you know go and get something that's maybe a memorabilia behind it, especially where .hhh erm, myself and my partner we weren't given a-a proper due date↑ (1) so (.) erm, because we weren't in the-in the second trimester or [anything .hhh]

I: [mmm]

P: we weren't really told what we can do to kind of honour our baby (.) umm, so yeah it's kind of (.) it's not-it's not something that's kind of really spoken about in (.) in a more broader way, um (.) you know er*-I know slowly, slowly it's becoming there but* when you're going through it you-you're left with kind of the loss and not really knowing what to do with anything .hhh um, so yeah, there's a hhhlot of improvement

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that maybe media can kind of use to show that it's not as quick and easy as they-they're making out, essen[tially] (*sniff*)

I: [yeah], thank you=

P: =hheh

I: shall we take a quick breather, hh-are you okay hheh=

P: my nose (*sniff*)(*laugh*) (2) yeah (*both laugh*) (2) I feel really bad that I'm just ooof (*sniff*). I know, I know you're really patient, bless you (*laugh*)

I: you're doing so well, you're absolutely fine.

P: thank [you]

I: [just] remember, if it does get a bit too much, or:: certain questions you don't want to answer then-then that's absolutely fine as well.

P: I'll just wave my hand (*laugh*).

(*both laugh*)

P: Yeah-hheh (*sigh*).

I: (3) d'y-do you want me to continue?

P: yeah, hheh-I'm okay.

I: okay (*clicks tongue*) umm, so again, some of these questions (.) you may have touched upon, but erm I'll continue anyway, so (.) (*laugh*)

P: that's okay (*laugh*).

I: has your relationship with miscarriage or your understanding of it changed over time? If so, can you tell me about this?

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P: ye::a::h it's definitely changed, erm (.) like I said, erm, to the previous question (.) once you go through it you understand kind of (.) how much of an impact it has on your kind of (xxx) it's like all of a sudden I notice that everyone's pregnant (.) umm, whereas before I was like "ohh okay yeah they're pregnant", and that type of thing, .hhh or:: if I see like a new-born it's very much (.) you know, oh god (laugh) I'm gonna do it again (*sniff*), so um yeah and obviously I work in the education sector which probably doesn't help most of the time (.) erm .hhh yeah i-it kind of=yeah y-you very much, your eyes are very much more open towards kind of the world around you, erm, and honestly not hheh (*laugh*) not in a paedophilic way, you know you-you're just more aware of children(.) erm you know, parents, err, yeah, it's definitely the one where everyone's suddenly always pregnant (.) and you're like "why is everyone falling pregnant really quickly?" (1) Erm (*sniff*) (2) you kn- it sounds nasty in that, erm, and again a lot of women have-er said, who are in the same boat as me, said they'll always feel .hhh a sense of (.) jealousy towards other women and it's not that we're not happy for them, it's just .hhh for some reason we're rehally jealous at the same time .hhh erm. B-but yeah, it's definitely (.) definitely changed since obviously .hhh once you have it it's very different from (27:00) just knowing someone who has had it or just having the idea of what it is, yeah (*sniff*).

Appendix S. Sample of indexing on Microsoft Word during analysis stages (Cathy)

Key:
Content/thematic
Structure
Performance
Interactive
Context

I: OK (.) **thank you**, u:m (1) how is your u-understanding affected (.) by **common messages** about ↑MIscarriage?

P: (3) U::m (2) I think **one thing that I have found a bit (.) hard** is the-you:: know, you have to wait till 12 weeks to tell people (.) um::, and so **we-we'd ↑told our parents↑ and siblings** I think **the first time, before, um, the miscarriage happened.** **But the sec-second time,** I definitely wanted to tell my best friends and, you know, I think ended telling about ↑five(?) friends or something like that **before, um (.) the scan.** Um, and there is a strange one, because I still (2) like **there is still some people that I talk to quite regularly that we haven't really told them anything (1) um, and like some people at work I haven't told at ALL,** whereas other people at work I have told. And, um, (2) (*touch head*) I **think it's good to not tell everyone.** I think, um, **you can end up just feeling like that is all-all of your being** and I'm certainly actually at the (1) **initially straight after both miscarriages,** I **found it quite hard like ↑go↓ing to places where people didn't know what .hhh hhappened because it was**

all °consuming°. Um, but like as time's gone on, I think it's, it's nice that not everyone knows, um, so that you can be a bit more (.) normal.

I: Thank you. Um, how do you think miscarriage is ↑viewed in society and where do you ↑think these ideas come from↓?

P: (3) I'm not quite sure, like, it (1) maybe it's an age(?) thing, partly, but like my contemporary (1) at my age, I think, I don't know, is it (.) it feels more taboo maybe, um, like less (.) maybe taboo is not the right word, [30:00] but maybe it's just that, you know, fewer people have experience of it at this age and, u.m::, you know, people may be more scared to talk about it and that sort of thing. Um, whereas with some (.) quite a few older ladies like in particular, um-one lady from my church who, um, she'd gone through a miscarriage like years ago herself hhhand she was like a really good person, I expect, who knows about it. Um, I don't know, maybe it's not an age thing, maybe it's just that she was good to talk to, but yeah↓. I think I sort of worked out that in, *in like a-older age category, whereas like in the room with middle-aged women, like there would be a-a very large proportion, yeah, larger than you might be expect to (.) who've been through this themselves. Um, but yeah, it's not talked about much, °no°.

I: No. Thank you. Do you need a quick break or are you OK for me to carry on?

P: Uh, let's carry on.

I: OK. Um, what was the response of others, um, for example partner:: or family: members ↑? I, I know that you touched upon this but-

P: -UM: (.) so my husband, like he's been great, um, it's, I mean, the second one probably affected him **MORE** than the first. Um, maybe just sort of knowing (1) **I don't know**- **I just remember** us both being in the, in the scan the second time and it being a **shock and a surprise** and, you know, we both just felt like (.) "why is this happening to us again", **sort of thing**. So, yeah, that one was **definitely hard**=

I: **=[Yeah]**

P: [Um, a]nd my family, **I-I actually find it harder** to talk to my family about it than my friends. And **even though my mom's been through a stillbirth**, I don't think, um, we have like (.) **we have a good relationship but we don't talk about feelings all that much**, I guess **(trails off)** (1) and so, yeah, **it's not so easy to talk to them about it**.

I: **Thank you. Do you need a quick breather or are you OK?**

P: I think I'm OK.

I: Yeah? (1) OK (2) thinking about, um, **how you were making sense of things** and (.) I'm **curious** **what helped you to understand**, um, that experience, **so for example**, it might be **things that family and friends might have said or doctors, social media, films and societal, cultural or religious beliefs, etcetera?**

P: Um (.) so I'm a **Christian**. Uh, I think that probably has helped to have had, um, **lots of people pray for me** and, and things like that much, I think. **It does sort of bring some comfort**. Um, (2) yeah, it was (3) it's probably [xx] thing that's **influenced the most**. Um, but just generally having people, yeah, everyone sort of **↑Sitting with you and, yeah, the fact that you talk about stuff and that sort of thing, does help**.

I: **That's helped you process and make sense of it(?)**

P: °Yeah°.

I: **OK. Has your relationship with miscarriage or your understanding of it changed over time?**

P: (4) **Yeah::, definitely**. Um, **I'm not sure exactly how**, um, I think I said before like (.) I just didn't expect it would **happen to me before it did**. Um, and **now feels like it will happen unless I have help**, like **with the drugs and stuff**. Um (2) **I don't know (looks down)**. **I definitely (1) I think**, you know, **partly why I wanted to do this is=like I think it should be talked about more** and, **you know**, it should be more widely discussed and (.) **you know (.) people should be taught about it a bit more** and **that sort of thing**.

I: **Yeah↓ (agreement)**.

P: **↑Yeah↓**.

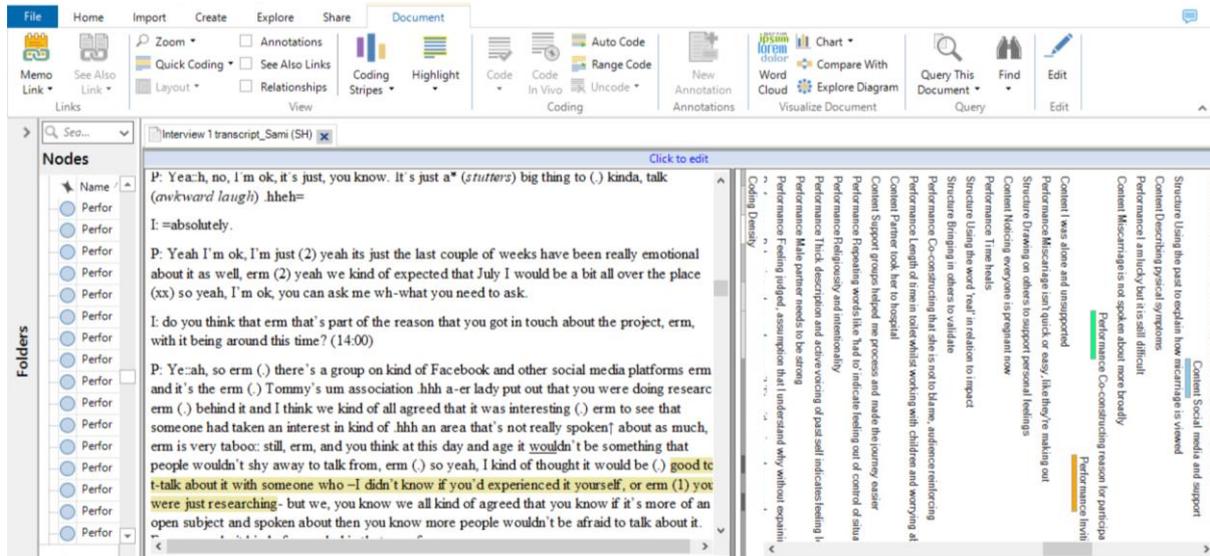
I: **Um, do you feel differently about it now compared to when it happened?**

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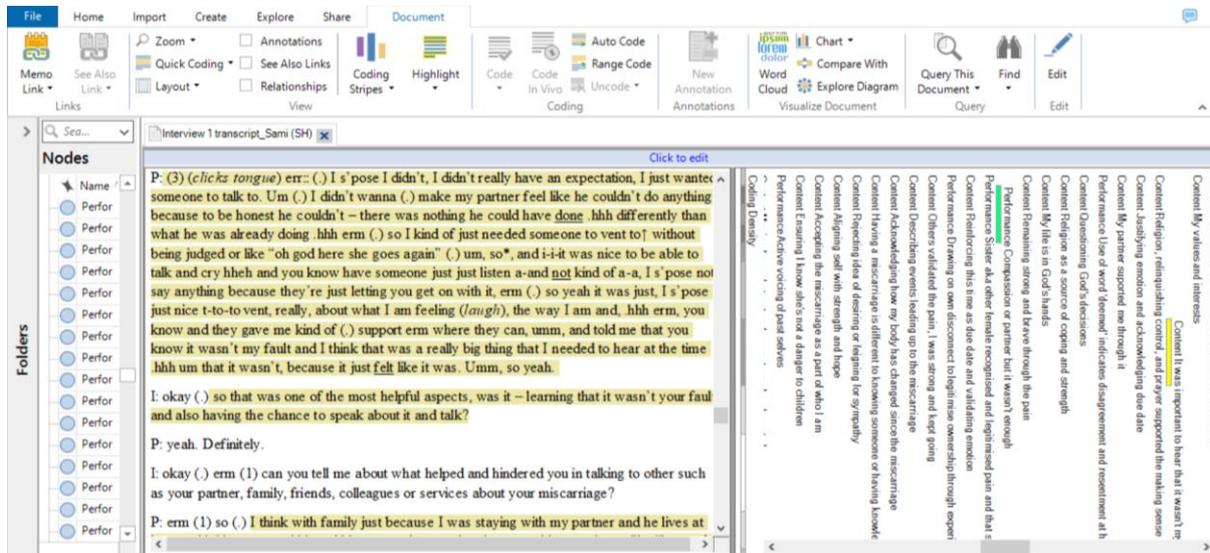
P: (2) For me, like (.) emotionally a bit different, obviously. I'm a bit upset again now, but it's, you know, it's so all-consuming when it happens, like I could not really think of much else at all whereas, um, nowadays, I do, just, I(.) like I feel much more normal:: and like I did before I was pregnant, so yeah .hheh.

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Appendix T. Samples of indexing using NVivo during analysis stages.



The screenshot shows the NVivo interface with a transcript titled "Interview 1 transcript_Sami (SH)". The transcript text is displayed in the main window, with several lines highlighted in yellow. On the left, a "Nodes" list contains multiple entries labeled "Perfor". The right side of the interface shows a list of nodes with associated text, including "Content Social media and support", "Content Describing physical symptoms", "Performance I am lucky but it is still difficult", "Content Miscarriage is not spoken about more broadly", "Performance Co-constructing reason for participate", "Performance Involvement", "Content I was alone and unsupported", "Performance Miscarriage isn't quick or easy, healing/re-making out", "Structure Drawing on others to support personal feelings", "Content Noticing everyone is pregnant now", "Performance Time heals", "Structure Using the word 'well' in relation to impact", "Structure Bringing in others to validate", "Performance Co-constructing that she is not to blame, audience reinforcing", "Performance Length of time in toilet whilst working with children and working at Content Partner took her to hospital", "Content Support groups helped me process and made the journey easier", "Performance Repeating words like 'had' to indicate feeling out of control of situ", "Performance Religiously and intentionally", "Performance Thick description and achievement of past self indicates feeling h", "Performance Male partner needs to be strong", "Performance Feeling judged, assumption that understand why without explain", "Coding Density".



The screenshot shows the NVivo interface with a transcript titled "Interview 1 transcript_Sami (SH)". The transcript text is displayed in the main window, with several lines highlighted in yellow. On the left, a "Nodes" list contains multiple entries labeled "Perfor". The right side of the interface shows a list of nodes with associated text, including "Content My values and interests", "Content Religion, relinquishing control, and partner supported the making sense", "Content Justifying emotion and acknowledging the date", "Content My partner supported me through it", "Performance Use of word 'learned' indicates disagreement and resentment at h", "Content Questioning God's decisions", "Content Religion as a source of coping and strength", "Content My life is in God's hands", "Content Remaining strong and brave through the pain", "Performance Compassion or partner but it wasn't enough", "Performance Sister aka other female recognized and legitimized pain and that s", "Content Reinforcing this line as she date and validating emotion", "Performance Drawing on own disconnect to legitimise ownership through open", "Content Others validated the pain, I was strong and kept going", "Content Acknowledging how my body has changed since the miscarriage", "Content Having a miscarriage different to knowing someone or having knowe", "Content Repeating idea of feeling or hoping for sympathy", "Content Aligning self with strength and hope", "Content Accepting the miscarriage as a part of who I am", "Content Ensuring I know she's not a danger to children", "Performance Active voicing of past selves", "Coding Density".

Appendix U. Reflective diary/scrapbook extracts

Date: April 2020

Stage: ethical approval

Title of entry: impacts of Covid-19

Thinking about how the current circumstances associated with CV-19 are affecting those who face miscarriage or who are going through miscarriage. It must be such a lonely time for individuals facing it alone, even for partners facing it together. Quarantine has not only limited social contact with family and friends, but also many other forms of distraction and self-care at an already isolating and lonely time. I wonder how this may impact those who do decide to take part in my research – will anything in particular be on their mind? Will this experience alter their dominant narratives of themselves and their miscarriage, or their memory of the experience? For example, if someone is feeling alone, low or anxious at this time due to quarantine restrictions, is this likely to evoke similar feelings to the time when they experienced their miscarriage?

Date: July 2020

Stage: data collection

Title of extract: reactions to the interviews

My own unknown journey with fertility crossed my mind. **My relationship with fertility is assumed and unexplored.** I wondered whether part of my reaction is due to me

NARRATIVE IDENTITY CONSTRUCTION FOLLOWING MISCARRIAGE

connecting with my own imagined future through the stories of my participants. Are my narratives/expectations about pregnancy, miscarriage and identity changing as a result?

Date: July 2020

Stage: data collection

Title of extract: contemplating my role/position in the interviews

In one interview I became more passive compared to others. It felt like more of a 'question and answer' exchange rather than a conversation, and the length of her answers seemed to disrupt the structure slightly. I noticed there was limited eye contact during her answers, which also seemed to alter the interactions. I started to feel quite uncontained and worried about whether I was interviewing correctly, how much to sit back and listen, and how much to guide her conversation. I'm glad I resisted the temptation to guide/structure, and wait for her to finish each stretch of talk. Though, my passivity does not negate reflection as to my influence on the narratives co-constructed. This deserved further thought.

Date: October 2020

Stage: post data collection

Title of entry: Narrative analysis workshop

Attended narrative workshop at uni with two other trainees who are also doing NI. Discussed tensions related to identity within a social constructionist framework and that directly asking questions about identity constructions/change isn't necessarily the best approach to collect this data. Some of my interview questions did ask questions relating to

identity/sense of self directly (this was more about interviewee's perceptions of themselves), though broader themes of identity are present throughout stories.

We also discussed the stance of NI in re-addressing power imbalance e.g. tellers are in control of how they share their story etc. Highlighted the importance of not being too structured with interview questions – tellers decide where they start/finish, what they include and how it is told. Since my data collection is complete, I was worried about imposing too much structure on the narratives presented. However, reflecting back on the interview process, participants were reminded that they did not have to share/answer anything they didn't want to, and I checked in about comfort/distress regularly. The interview guide was implemented flexibly according to what came up for individual participants.

Date: April 2020

Stage: analysis write-up

Title of extract: chaos narratives and 'messy stories'

Spoke to Hannah during one of our meetings about chaos narratives and the discomfort they can elicit in the listener/recipient to the story. We talked about the temptation to 'neaten up' stories which prompted me to think about how I am relating to the data. I wondered whether stories that feel 'chaotic' are associated with a lack of containment for the listener, which can sometimes feel distressing or uncomfortable. In addition, chaotic ordering of events or sequencing can be hard to follow and to make sense of in the listener's mind (thinking about the co-construction of narratives). I also wondered what

makes a story chaotic – how is it evaluated as such? What are the conditions that make a story chaotic, and is this context-dependent?

In my write up, I am also becoming aware that I am drawn to certain stories more than others, and am having to be cautious about how I approach this. It makes me wonder if there are storylines that I've not heard or not attuned to. I also have to come to terms with the fact that I can't represent every aspect of every story, no matter how central/important it might be. Editing down the stories to fit the word count has been quite a painful, slow process. I'm attached to the words and what they represent, and it feels uncomfortable to edit/reduce someone else's story. This is why it is important to own my position and remain transparent about my lens/approach to the project/analysis.