Exploring Women's use of Facebook pages to discuss their experiences of Miscarriage and Pregnancy Loss

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By

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ABSTRACT

Miscarriage and pregnancy loss are deeply personal and painful experiences for women and their families. These losses are publicly unacknowledged and represent an undeveloped area within social work practice and research. It is estimated that between fifteen and twenty percent of pregnancies end in miscarriage, this population of women encounter medical and social care spaces that do not adequately meet their needs for recognition, validation and support (SOGC, 2017). The present study explores the ways in which women use the online social networking site Facebook to seek out opportunities to share their stories and engage in exchanges of support with others who have miscarried. Furthermore, through a thematic analysis of posts and comments shared to the *"Miscarriage & Pregnancy Loss"* Facebook page, this study utilizes Feminist Standpoint Theory to examine how women describe their experiences of miscarriage and pregnancy loss, which yields three distinct themes. First, miscarriage is a multi-layered experience for women that involves physical, emotional, psychological and social levels of embodiment and meaning. Second, women acknowledge that interactions with medical professionals reproduce harmful ideas and language that minimizes their experiences. Subsequently, women resist and counteract these ideas and language in their comments and exchanges of support with one another. Third, women engage with the idea of a maternal identity, which for some, endures following miscarriage, while for others motherhood is framed as something they almost achieved. This exploratory research provides insights into the utility of online resources and support networks in developing an understanding of the impacts of miscarriage and pregnancy loss, and how women use these spaces to offer words of empathy and compassion to one another.

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Chapter 1: Introduction

According to the Society of Obstetricians and Gynecologists of Canada, approximately fifteen to twenty percent of pregnancies end in miscarriage (SOGC, 2017). For women and their families, pregnancy loss is a devastating and destabilizing event. The experience of miscarriage exists on many levels for women; physically women endure symptoms such as bleeding, cramping, and fevers during and after pregnancy loss. Emotionally, women report feeling isolation, sadness, guilt and shame as they grieve the bond and attachment they developed with their baby (Bellhouse, Temple-Smith, Bilardi, 2018). Women's embodied experiences of pregnancy loss and miscarriage, as well as their interpretations of support and how they go about seeking support following a loss, are underdeveloped in social work research. Existing ideas pertaining to miscarriage and pregnancy loss are shaped by medical authority exerted over women's reproductive health claiming that miscarriage is mainly a physical ailment that warrants medical intervention to resolve. Through this process women's mental and emotional well-being are divorced from their physical bodies which are deemed as being in a state of "crisis" (Cahill, 2001; Golan & Leichtentritt, 2016, p.149). The present study attempts to shed a further light on these discourses that have shaped women's experiences of miscarriage and expose how women talk about how they have been impacted by them using online spaces.

Moreover, the assumptions that are embedded in medicalized approaches to pregnancy loss perpetuate social silence and taboo surrounding the issue and contributes to women's experiences of isolation and exclusion following the loss (Garrod & Pascal,

2019). Research supports the statement that the ways in which healthcare professionals (namely physicians, nurses and sonographers), family, and friends react and respond to the disclosure of miscarriage have lasting implications for how women grieve and cope with the loss (Bellhouse et al., 2019). Invalidating comments from these stakeholders reduce the gravity of the loss and, contribute to feelings of shame, guilt and isolation regardless of the gestational age at which the pregnancy was lost (Bellhouse et al., 2019). Articles by Bellhouse et al. (2019), Gerber-Epstien, Leichtentritt and Benyamini (2008), Rowlands and Lee (2010), and Layne (2003) emphasize the importance of acknowledging and listening to women's "pregnancy and reproductive journey's" to provide context about the path that has lead participants to their current situation. These scholars posit that these histories carry a lot of weight for women and such presence must be acknowledged and validated in interactions with patients seeking information, care, and support (Bellhouse et al., 2019; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Layne, 2003; Rowlands & Lee, 2010).

Research by Bellhouse, Temple-Smith and Bilardi (2018), Gerber-Epstein, Liechtentritt and Benyamini (2008), and Meyer (2016) draw on women's descriptions of life after pregnancy loss to expose the nature of this vulnerable period and how support or lack thereof shapes their experiences. In these studies women reported feeling fragile and emotionally exposed when interacting with others, they were given mixed messages about how they should return to their normal life (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Meyer, 2016). Varying forms of continued support from family, friends, healthcare providers, and

coworkers in the weeks and months following a miscarriage signified to women that people cared about them, noticed and acknowledged their suffering (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Meyer, 2016). Physical support was characterized as other people making the effort to be there in person, receiving meals, providing childcare if women had other children in the home to give them time to process the loss. Additionally, women expressed that those who took the time to acknowledge their loss and continued to check in with them over time was beneficial to their wellbeing.

Conversely, women also reported copious negative experiences in seeking support from their family and friends. Women agreed that a large part of the difficulty of returning to everyday life is navigating the views of others on how you should handle the situation (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Rowlands & Lee, 2010; Watson et al., 2019). A participant in Gerber-Epstein, Liechtentritt and Benyamini's (2008) study stated "you get questions about what happened, and you have to explain. I remember that every question or somebody's look threw me off" (p.20). Similarly, Bellhouse, Temple-Smith and Bilardi (2008) found that often insensitive comments centered around moving on from the loss, future pregnancies, and trying to highlight the "silver lining" of miscarriage. Scholars cited that women are often told; "it wasn't meant to be", "don't worry you will get pregnant again", "you're stressing out about it too much, just relax and it will happen naturally" among others, following a miscarriage or pregnancy loss (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini,

2008;Watson et al., 2019). Additionally, scholars have found that it is considered common practice or expectation for women to wait to share that they are pregnant until they have made it through the first trimester. Scholars have labelled this practice "the first trimester rule;" women expressed that this rule discourages them from disclosing their loss and creates a cloud of silence surrounding the issue (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Rowlands & Lee, 2010; Watson et al., 2019). Additionally, the first trimester rule contributes to feelings of sadness, fear, shame and self-blame that women can experience following a miscarriage.

The present study aims to analyze how women describe their experiences of pregnancy loss and to connect their disclosures to larger themes related to how medical and social care can be improved for women who miscarry. These themes will be discovered from the textual productions made my women who have experienced pregnancy loss through Facebook posts directed at the realities of miscarriage. The purpose of this thematic analysis is to illustrate the importance of women's voices in creating approaches to support that address their needs. Additionally, the themes that are the most salient to women's experiences are grounded in the data and can offer insights to improve care for women and their families.

Locating the Researcher

My earliest recollection of encountering the reality of miscarriage was when I was a teenager, on a rainy weekend day my family and I were cleaning out a spare bedroom that up to this point had been used for storage. In emptying the contents of dusty boxes I

came across a piece of paper from a local funeral home addressed to my parents, enclosed was a small program which read “our little angel was called home”, with an image of two tiny footprints underneath the text. My Mom had previously mentioned that she had a miscarriage prior to getting pregnant with me; however, she nor my Dad had spoken openly about the experience, and I thought asking questions would upset them. As I handed the funeral program to my Mom tears welled in her eyes and she proceeded to tell me that she was five months pregnant with a baby boy whom they named Jacob, when they found out there was no longer a heartbeat and the baby had passed away. Later that day, she was admitted to the hospital and delivered the baby; she told me they were offered a funeral service, but they declined. I was struck by how isolated my parents felt during the experience, both later spoke about feeling fearful how others would act around them or address the loss. My Mom shared that she felt she lacked support from friends and family during this time and felt pressure to “get over it”, “return to her normal life” and “try again soon” as she was in her early thirties.

Similarly, when I told her about my interest in the topic, my aunt Heather told me approximately twenty years ago she wanted to have a second child and miscarried in her first trimester. In recounting the story to me, she shared that she found out she miscarried during a routine appointment, her obstetrician told her to go the nearest hospital and have a dilation and curettage (D&C). Before leaving the office, her doctor handed her a file folder of all the information gathered from her pregnancy up to that point; he told her not to look in the file, adding “don’t torture yourself by reading it”. She left the office angered by this statement; when she read the file, she discovered she had miscarried

twins. She was devastated by this news and was distraught as to how this information was kept from her for this long. She felt entitled to a conversation about how this happened and how this would impact future pregnancies, which she never got. Heather too echoed that she felt pressure to return to normalcy and try again quickly after the loss; she was told by a nurse in the hospital and later, her friends "its better it happened now, before they were babies". She shared with me that this phrase was deeply hurtful and contributed to her sadness and grief following the loss, so she began to retreat and avoided talking about it with anyone.

As a woman who has never been pregnant or experienced a miscarriage, I was socialized to think of the "silver lining" in these circumstances instead of sitting with these feelings or challenging where certain assumptions came from. These two examples illustrate many of the tensions, and problematic areas surrounding pregnancy loss care and support, both on the part of healthcare professionals (mainly physicians, nurses and sonographers) that I seek to address in this study. My goal is to emphasize the importance of honouring and making space for women's voices to guide the public conversation of how to best support women who miscarry, through highlighting the utility of social networking sites such as Facebook where women can gain informal support and engage in information-sharing and advocacy work.

Early on in my career as a social worker doing intake and assessment work for a community counselling agency, I was confronted with my own unchallenged assumptions about the ongoing impact of pregnancy loss in women's lives. The community counselling agency I worked for was not directly affiliated with a hospital or obstetrical

clinic in the area, most service users learned about our services via the internet and social networking sites such as Facebook and Twitter. Put another way, most women who were seeking counselling services were self-referred. The agency was funded to offer free short-term counselling to survivors of violence, otherwise fees for counselling were assessed on a sliding scale based on household income and family size. Therefore, most women who wanted timely and ongoing service had to seek out counselling they had to pay for. As part of the intake process (either in person or over the telephone), service users had to answer a set of standard questions about trauma, abuse, police and children's aid involvement, along with their reasons for seeking counselling services. I found that a staggering number of women disclosed previous pregnancy loss as a source of trauma for them, where they continued to experience grief and sadness months and even years after the loss occurred. In these moments after women disclosed these experiences, I felt compelled to make space for them to share more about what they went through. Furthermore, women described their relationship to the label of motherhood, for some it was something they had wanted for many years and were ecstatic at the possibility of having a baby; for others pregnancy came as a shock and they felt unsure of how they would be able to provide for a child. In the conversations with women, I found that miscarriage was a common experience in women's reproductive journeys, but that it was not openly discussed. Silencing this experience left women feeling isolated and excluded from conversations about fertility and motherhood following their loss. Service users I engaged with in this role, spoke about their fears of disclosing the loss to their friends and family as they were unsure how others would perceive and react to the news. Women

spoke about the many phrases or assumptions hurled at them on a daily basis by the friends, family and medical professionals following their miscarriage including “relax, you need to stop worrying about it so much and let it happen naturally”, “it wasn’t meant to happen now…it will happen when the time is right”, and “you should get over it and move on”, among others. Additionally, when sharing their reflections about their experiences accessing medical treatment and intervention, service users expressed feeling dismissed and unheard by the physicians, nurses and sonographers they encountered. They felt silenced by the experience, citing that sonographers and nurses did not give them any information about what was going on or what was going to happen next. Furthermore, when a physician engaged with them, women were not told how this happened or what this meant for future pregnancies. Following the D&C procedure, women shared that nurses and physicians referred to their pregnancy as “products” and “tissue” rather than a baby they had loved and bonded with.

These conversations compelled me to reflect on the ways in which I had been socialized to think about miscarriage and pregnancy loss and the assumptions I held about its lasting impact for women. As mentioned previously, I was socialized to offer the silver lining in situations involving sadness or grief because I thought it was my job to make people feel better, rather than dwell in these feelings. Instead, this work taught me that making space for these feelings and unanswered questions is pivotal to engaging with and building trust with women who miscarried. I became pulled by the question of how and where women find the support they are looking for, and how this information can improve social work practice. This process of unlearning and engaging with these topics

in a deeper way was revelatory to how I thought about designing and conducting the present study. Although miscarriage and pregnancy loss are sources of grief, sadness and trauma for many women, social work practice remains undeveloped in its approach to supporting women through this experience. Theoretically the topic of miscarriage is not given adequate attention from feminist scholars, therefore the issue is not integrated into resources and literature that is available to clinicians. Furthermore, with this lack of theoretical attention, issues of power, how women's bodies are objectified and medicalized in the context of pregnancy and childbirth and the ways in which women are oppressed and marginalized through this medicalization go unrecognized. Social work values including self-determination and person-centered care speak to the need to amplify and honour client voices when conducting practice; meeting the service users where they are in their current circumstances is crucial to building rapport and aligning with these values. Therefore, the field of social work can learn a great deal from research that highlights the voices of those who are marginalized by existing rhetoric and practices attempting to manage or resolve their current situation. In examining and reflecting on the textual productions made by women on the Facebook page, both clinicians and researchers can gain valuable insight into the experience of miscarriage and pregnancy loss and which approaches may be harmful to women, such as framing the issue as strictly medical, minimizing the bond and attachment women feel towards the baby they lost, or devaluing or rejecting women's expressions of grief following a loss. Furthermore, in constructing the present study I wanted to focus on the online space itself, exploring possible reasons why women seek out these platforms to share their story and

use their voices to express their frustrations and heartbreak over the experience and offer support to one another. Through analyzing these textual productions made by women I wanted to discover what women were actually saying about their experience of pregnancy loss outside of what has been written about them or for them by academia or the medical community. Through analyzing the text using insights from feminist standpoint theory I discovered crucial themes to understanding women's psychosocial experiences of miscarriage along with the gaps in medical and social care settings which are negatively impacting them. Additionally, given the nature of the social networking platform there was an added element of conversation and dialogue where women offered support to one another as well as responded to the content created by the creator of the page. From these textual sources I am also drawing conclusions about how medical and social care can be improved for women both in-person and finding alternative resources such as Facebook pages to direct women to after miscarriage.

Chapter 2: Review of the Literature

The following section of the thesis covers existing miscarriage and pregnancy loss literature, which formed the basis of my research questions. I argue that there is a clear disconnect between how the issue has been medically framed as strictly a physical condition where the female body is deemed as in a state of crisis that warrants a medical solution to resolve it, and how women themselves recall the experience. Furthermore, through this medicalized frame pregnancy loss has been socially and culturally constructed, thereby creating public discourse which women come up against following a loss. The ways in which women who have experienced pregnancy loss are confronted

with these discourses is through their interactions with medical professionals (mainly doctors, nurses and sonographers) as well as their family, friends and peers. Medicalized definitions and interventions have shaped how women think about, and navigate pregnancy loss on a physical and emotional level; similarly, feminists have underscored the women's health movement which emphasizes women taking responsibility for their own health and health literacy in pregnancy (Golan & Leichtentritt, 2016). Additionally, in this section I examine existing research that explored from women's perspectives the harmful implications of these widely circulated public discourses thereby making an argument for the validity of women's voices and authority over their own experiences. Lastly, I offer literature that explores the utility of online spaces such as Facebook and online forums for gathering data pertaining to a number of physical and mental health related issues thereby creating a case for the present study in examining the themes present in online spaces dedicated to miscarriage and pregnancy loss.

Miscarriage: History and Norms

As previously mentioned, pregnancy loss and miscarriage has been socially and culturally constructed and has taken on various forms, connotations and social meanings throughout time. Furthermore, the meaning of miscarriage is historically constructed; social movements have given miscarriage a variety of meanings and used it as a symbol for several political projects (Reagan, 2003). Reagan argues that normative representations of miscarriage have dramatically changed during the twentieth century from a "hazard" to a "blessing" to a "tragedy" (2003 p.359). At the beginning of the twentieth century, miscarriage was presented as a cause of physical harm to women; in

the middle of the century, miscarrying was framed as good fortune, and at the end of the twentieth century miscarriage was framed as a source of emotional devastation. I argue that some of these earlier representations of miscarriage and pregnancy loss still linger in both medical and public discourse which manifest in women's lived experiences. Therefore, these early representations of miscarriage have informed the medical and social understanding of the issue and reinforced unspoken assumptions and intentions behind such discourses.

Reagan (2003) examined letters written to Margaret Sanger from working class and low-income women seeking birth control to attest to the physical hardship of miscarriage. One mother wrote about her fear of dying after repeated miscarriages stating, "I get pregnant every two to three months and in a few weeks I miscarry. I realize it is killing me and soon I will be gone and then who will see to my little children?" (Reagan, 2003 p.359). Part of Sanger's struggle to win women's right to contraception was a fight to improve women's health; she wrote, "pregnancy imposes a heavy tax" (as cited in Reagan, 2003 p.360). Sanger exposed the physical harm women endured as a result of repeated pregnancies, including miscarriage, stillbirths and deliveries and declared the laws that created the situation unjust. Miscarriage was more than a private problem; it was a political one. Sanger urged that birth control not only made family planning possible, it could also prevent repeated miscarriages and stillbirths.

Unlike the representations of miscarriage in Sanger's early publications, when articles about miscarriage first appeared in popular women's magazines during the 1940's, miscarriage was assumed to represent the loss of a wanted children to married

heterosexual couples. The articles of the 1940's and 1950's offered hope by providing straightforward scientific information and reporting medical advances (Reagan, 2003). First, readers were told that they were not to blame for causing miscarriage. Second, the standard article reassured the reader that one or even multiple miscarriages did not mean that a woman would be unable to bear a healthy child. Finally, the articles explained why miscarriage occurred. Reagan comments on one testimony printed in *Today's Health* written by a man whose wife had miscarried. He writes, miscarriage "may not be so much a misfortune, but a blessing"; he adds "miscarriages usually occurs because of fetal deformities" (Reagan, 2003, p.360). Reagan argues that this would-be fathers' comments suggest the pervasiveness of eugenic beliefs and fear of the "abnormal" child (2003 p.361). Furthermore, doctors and science writers exuded confidence in medicine's ability to give all women babies. Embedded within these articles was a message about male medical power and female patient responsibility, that is, trust your doctor; follow his directions and he will provide healthy babies. If women followed their doctor's advice and took advantage of the latest medical knowledge, they could expect motherhood (Reagan, 2003). Although popular advice literature told women they were not to blame for miscarriage, the medical establishment suggested otherwise (Reagan, 2003). Medicine's promise of healthy babies required submitting to repeated examinations, accepting bed rest, ingesting pharmaceuticals and having operations. Again, medicine represented male power and female patients were pacified under the guise of ensuring a healthy baby (Reagan, 2003).

In the late-nineteenth and early-twentieth centuries, most medical discussion about

miscarriage centered on the management of the miscarriage-in-progress rather than prevention (Reagan, 2003). It was debated whether it was better to take a "conservative" position and let nature take its course by allowing the body to expel the fetus on its own; or, if "radical" treatment was warranted in which doctors operated to ensure that all fetal and placental materials were removed from the uterus to prevent infection (Reagan, 2003 p.360). However, by the 1950's medical science focused on prevention. Physicians offered several treatments to women who endured repeated miscarriages and stillbirths, including surgery, vitamin therapy, hormones, and psychotherapy (Reagan, 2003). Female emotions took center stage during the 1950's. According to specialists in obstetrics and psychiatry, women's anxieties about motherhood caused multiple miscarriages (Reagan, 2003). The underlying assumption of these assertions was that there was something psychologically wrong with women who suffered repeated miscarriages, which was termed "feminine maladjustment" (Reagan, 2003 p.362). Unmarried mothers, adoptive mothers, infertile women, and lesbian women were all subject to psychiatric scrutiny and adjustment. Miscarriage now meant not only failed motherhood, but failure to conform to feminine roles (Reagan, 2003).

During the 1980's, periodical coverage of miscarriage suddenly increased and emphasized a new message; miscarriage had become a personal tragedy (Reagan, 2003). Popular periodicals exposed women's mourning and emphasized the need for sympathy instead of reassurance. Grief was framed as a primarily female emotion and response to miscarriage. Reagan (2003) argues that a women's emotional response to miscarriage is not simply personal or individual; those emotional responses are culturally, socially and

historically produced. This scholarship by Reagan (2003) exposes several historically significant assumptions that continue to be reproduced in the current context of pregnancy loss and miscarriage including male medical power over passive female patients, miscarriage as blessing to avoid an abnormal child, and scrutinizing women for their inability to bear children.

Moreover, Meyer (2016) describes harmful sentiments thrown at women following pregnancy loss that are indicative of larger discourses regarding normative assumptions about timing, fetal personhood, and moving on from the loss. Meyer (2016) comments on the "first trimester rule" which has become a normative expectation for women where they do not disclose their pregnancy until they have made it through the first three months. This discourse is attributed to the prevalence of miscarriages that occur prior to the second trimester in pregnancy and also a social taboo around the issue of pregnancy loss. The first trimester rule further works to silence women's experiences of early pregnancy loss, thereby rejecting women's grief over the loss. While recounting her own experiences of support following multiple pregnancy losses, Meyer (2016) cites that she was told by her family and friends "it just wasn't your time" and "good thing it happened before it was a real baby" (p.1427). Meyer (2016) argues that these phrases reveal pervasive discourses about reproductive timing and what has been deemed socially and culturally as an acceptable time to have children. Lastly, these discourses fail to acknowledge the grief women experience regardless of how long they were pregnant. Instead, the construction of a "real baby" based on gestational age imposes that there is a hierarchy of what is considered legitimate grief (Meyer, 2016).

The selected literature highlights the ways in which miscarriage and its associated norms have been socially and historically constructed, giving pregnancy loss different meanings and connotations over time. The present study argues that these historical ideas surrounding miscarriage have persisted and shaped how miscarriage is framed and confronted by women in their daily lives. Also, these assumptions expose unspoken norms and intentions behind sentiments and reactions that form women's social experience of miscarriage which impact how women behave.

Medicalization of Miscarriage

Within the last forty years the majority of research and knowledge production about pregnancy has centered around a medicalized and patriarchal understanding of the female body, whereby pregnancy and childbirth has been framed as a condition which warrants medical intervention to ensure the desired outcome of a healthy child (Layne, 1997). Women are framed as passive patients over whom physicians can exert control and dominance, thereby eradicating women's voices and control over their own bodies (Cahill, 2001). Furthermore, literature examining pregnancy loss in the current context relies heavily on these medicalized notions of intervention to resolve the "crisis" or "condition" occurring within women's bodies, the form of embryos or fetuses that are no longer viable, have genetic abnormalities or have stopped growing (Cahill, 2001).

There are many different terms used to describe the medical and bodily events that encapsulate miscarriage and pregnancy loss (Abboud & Liamputtong, 2003; Adolfsson et al., 2004; Bommaraju et al., 2016; Gaudet et al., 2010; Wright, 2011). Distinctions among

terms are largely delineated by gestational age rather than women's own understanding of them. The terms mostly commonly cited in the literature include miscarriage, early pregnancy loss, stillbirth, fetal death and perinatal loss. Gerber-Epstein, Leichtentritt and Benyamini (2009) define miscarriage as "a spontaneous termination of a pregnancy at an early stage, before the embryo is capable of surviving outside the womb" (p.1). However, Abboud and Liamputtong (2003) characterized miscarriage as a loss that occurs "prior to three months gestation" (p.38). Furthermore, the term "pregnancy loss" was used by multiple scholars to describe different experiences. For example, Engel, Rempel and Burns (2012) use these terms to describe a "spontaneous loss of pregnancy prior to twenty weeks gestation" (p.1), which is equated with miscarriage by other scholars. For other scholars such as Bommaraju et al. (2016), pregnancy loss can encompass "the spontaneous or purposeful termination of a pregnancy beyond the first few months of gestation" (p.64). Moreover, losses that occur later in pregnancy or closely after giving birth are also categorized as separate experiences in the literature. Golan and Leichtentritt examine the experience of stillbirth among women; these authors define stillbirth as "the loss of a baby prior to delivery, or the delivery of a baby showing no signs of life" (Golan & Leichtentritt, 2016, p.148). Scholarship found in nursing and medical journals accept that a spontaneous loss that occurs after twenty weeks gestation can be classified either as a "stillbirth" or "fetal death" (Layne, 1997; Wright 2011).

Examining the various terms used to describe pregnancy loss is important to the present study because these categories and characterizations of miscarriage carry social meaning. Furthermore, these terms can be framed as separate grieving experiences both

by medical professionals (such as physicians, nurses and sonographers) and the family and friends of women who miscarry. Consequently, these separate definitions have implications for how grief and maternal attachment are constructed in women's experiences. I am using the terms "miscarriage" and "pregnancy loss" purposefully as they are the most inclusive and encapsulate many of the different experiences that women can have. I did not want to impose one of these aforementioned definitions or terms in the present study as they were not grounded in the language used by women. It was from these sources that the issue had been socially constructed, which pathologized the female body and her emotional state following miscarriage (Cahill, 2001). Additionally, my literature searches led me to many articles in social science disciplines which focus on describing women's experiences of the loss, highlighting various positive and negative factors that contributed to their healing journey. I found these articles lacked attention to the ways in which women define support and what kinds of support they need following this loss. Furthermore, I was compelled to think about the many women in these articles who reported that they did not receive the support and information they needed following miscarriage and ask how they compensated for this.

Interactions with Medical Professionals

By examining research which explores interactions women have had with such professionals as physicians, nurses and sonographers, the current problems in the approaches to care are evident. Furthermore, how women are treated in these spaces may have harmful consequences for their ability to process and seek out additional support following miscarriage. In other words, interactions which expose harmful language and

unchallenged assumptions about miscarriage may be internalized by women and may propel them to seek alternative avenues for accessing support and information. The insights posed by this literature illustrate a clear problem in the ways in which miscarriage is discussed and framed by those in the medical community which in turn have shaped public discourse surrounding the topic of pregnancy loss.

During the events of miscarriage and pregnancy loss women will most likely will come into contact with many medical professionals including doctors, nurses, and sonographers who are charged with assessing and confirming the loss as well as removing the pregnancy from the women's body (Bellhouse et al., 2019; Watson et al., 2019). Following these medical interventions women are often referred to their family doctor for follow-up assessment and treatment. Within the literature women have vocalized the significance of these interactions to the overall impact of the miscarriage (Bellhouse et al., 2019; Meyer, 2016; Watson et al., 2019). In most cases the initial contact with these professionals is their entry point to their new reality of pregnancy loss. Engel, Rempel and Burns (2012) conducted a study examining emergency department medical professionals (doctors and nurses) knowledge and practices regarding miscarriage and pregnancy loss. The majority of healthcare providers who participated reported that "miscarriage can have a significant impact on women and their families, and they should not be expected to just get over the experience" (Engel, Rempel & Burns, 2012 p.6). Additionally, the authors found the provider's confidence to be the most significant predictor of continued engagement and providing information to the patient. Providers who reported feeling confident in their knowledge and training about pregnancy loss

reported higher rates of engagement, resource gathering and completing referrals for follow-up care in the community (Engel, Rempel & Burns, 2012). Interestingly, the authors found that the more experience a provider had with caring for patients enduring pregnancy loss the less inclined they were to make space to provide information to patients and mobilize follow up support unless it was initiated by the patient themselves (Engel, Rempel & Burns, 2012). When healthcare professionals were asked what advice, guidance and information they provide to women and their families, most participants responded they gave patients information about physical recovery after miscarriage, reassured them that pregnancy loss is very common and grieving is normal (Engel, Rempel & Burns, 2012). However, a significant portion of participants indicated they felt that responsibility for advice and guidance belonged to another professional. The results of this study highlight the gaps in training and information given to medical professionals in the emergency department regarding miscarriage and pregnancy loss. Additionally, common discourses regarding the prevalence of miscarriage and how patients should get over the experience were exposed as unchallenged assumptions that are held by professionals, which impacts their approach to patient care (Engel, Rempel & Burns, 2012).

Articles by Bellhouse et al. (2019) and Watson et al. (2019) asked women about their experiences engaging with medical professionals during and after their miscarriage. Both articles found these interactions were significant in shaping women's experience of the loss, as well as exposed harmful assumptions and dominant discourses that are perpetuated in these interactions. Watson et al. (2019) found that women were not

adequately informed or supported by healthcare providers; participants reported feeling dismissed and stigmatized by the professionals they engaged with. Many participants noted that professionals lacked the sensitivity they needed during this difficult time and did not provide access to community supports or follow-up care to which they thought they were entitled (Watson et al., 2019). Participants reported continually being told to "get control over their emotions" and were not given adequate information as to what was going to happen after the procedure was completed (Watson et al., 2019, p.135-136). Put another way, women were not told that they could hold their miscarried child, they were not told about making funeral arrangements, and they were not given the option to memorialize the loss by taking pictures with their child, dressing or bathing them. Women stated that although they felt disoriented and were enduring physical discomfort following a D&C procedure that they would have appreciated options to grieve their loss such as having memorabilia to look back on years after the loss (Watson et al., 2019). Women in this study concluded that these harmful interactions made them feel isolated and excluded from the conversation about their own bodies; thus, contributing to feelings of self-blame, inadequacy, failure, and shame.

Similarly, Bellhouse et al. (2019) interviewed women about their interactions with healthcare providers following pregnancy loss and found that women experienced inadequate care and stigmatization during their miscarriage. Several key themes emerged from these interviews in which women described their interactions including lack of information regarding the cause of the loss or implications for future pregnancies, lack of follow up, insensitivity, dismissive attitude, and dishonesty. Like previous studies

mentioned in this review, providing women with adequate information regarding their loss, and what they should expect following the loss, is crucial to providing adequate care (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Rowlands & Lee, 2010; Watson et al., 2019). Women who were not given these necessary pieces of information expressed feeling highly distressed and unprepared for what might happen during and following the miscarriage (Bellhouse et al, 2019). Almost all women reported a lack of follow up from healthcare providers, which was highly desired for emotional and physical wellbeing. Additionally, almost all women described being distressed by insensitive comments and terminology used by healthcare providers. This was often interpreted as signifying that healthcare professionals did not care about them or understand the grief and loss associated with their experience (Bellhouse et al., 2019). Participants described provider's dismissive attitudes towards pregnancy loss care as a "cold and clinical approach to talking about the loss" (Bellhouse et al., 2019 p.141). Women did not appreciate this approach to care; instead they wanted their pain acknowledged and validated. A final subtheme found in this article was dishonesty whereby a number of women described feeling angry and frustrated in the lack of transparency and honesty exhibited by their healthcare providers. Participants shared that nurses and sonographers would not tell them if anything was wrong and passed on the responsibility of confirming the loss to another professional. The articles by Bellhouse et al. (2019) and Watson et al. (2019) conclude that women would benefit from consistent, and transparent engagement from healthcare providers who

acknowledge the significance and the impact of the loss; and who offer resources, follow-up and options for memorialization.

Peer and Community Supports

Within the literature support takes on a variety of forms and scholars agree that women's support networks are critical to the healing process following miscarriage and pregnancy loss (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Rowlands & Lee, 2010; Watson et al., 2019). In terms of community supports directed towards miscarriage and pregnancy loss, obstetric clinics and hospitals are the typical entry point for women and their partners to engage in services (Watson et al., 2019). In Ontario, Bill 141 entitled the "Pregnancy and Infant Loss awareness Research and Care Act" was passed in 2015 and required research to be undertaken and programs to be developed for pregnancy loss and infant death (Watson et al., 2019 p. 133). Additionally, the Pregnancy and Infant Loss (PAIL) network out of Sunnybrook Hospital in Toronto offers both trainings for staff and resources for people in need of support following a loss. There are two issues that are present with the current states of these supports. First, training is not mandatory for all hospital staff that may encounter the issue in practice; and second in this system hospital staff are still the gatekeepers to this information (Watson et al., 2019). Since miscarriage and pregnancy loss are not widely discussed, women must rely on gathering information from medical professionals or accumulate resources themselves. Furthermore, if hospital staff assess the situation and do not offer women access to these supports and resources, she would have no way of knowing they are available to her. Similarly, community agencies are often not

aware of these resources and trainings, therefore clinicians are unaware of the potential benefits of additional training and resources for supporting women. As a result of this disconnect the quality of care that women receive both in the hospital and within the community may be compromised, leaving women dissatisfied and isolated following miscarriage.

Scholars who have prioritized the voices of women who have experienced pregnancy loss describe that women benefit from ongoing forms of support including physical, emotional and social support. Many scholars assert that women find tremendous comfort and support from other women who have also experienced miscarriage and pregnancy loss (Bellhouse et al., 2019; Bellhouse, Temple-Smith, Bilardi, 2018; Gerber-Epstein, Leichtentritt, Benyamini, 2008; Meyer, 2016; Rowlands & Lee, 2010; Watson et al., 2019). Furthermore, women report leaning on their partners for support following pregnancy loss, adding that they often feel closer to their partner because they experienced the loss as a couple who were expecting to be parents. Fewer studies examine the impact of pregnancy loss on men; those that have suggest that men also go through a grieving period after miscarriage (Abboud & Liamputtong, 2003; Bellhouse et al., 2019). However, these studies illustrate that men often look to their female partners to gauge how they should grieve the loss (Abboud & Liamputtong, 2003; Bellhouse et al., 2019). Alternatively, some women report that their partner also expected them to return to normal following the loss and were unaware of the multi-layered impact of the loss (Adolfsson et al., 2004; Gaudet et al., 2010). Additionally, these women reported that their partners could not understand the depth of their pain because his body did not

endure the same experience, nor did he bond with the pregnancy in the way they did (Adolfsson et al., 2004; Gaudet et al., 2010). Given the limitations of support women have cited from their family and friends, they turn to online platforms to express their grief and to seek support from other people who have experienced pregnancy loss.

Peer Support and Social Networking Sites

Research on the utility and impact of engaging in peer support in online settings is an emerging area of interest in the fields of health care and mental health services. I was intrigued to look into the dynamics of online spaces as a way to find out where women who have miscarried go for support when the other areas of their lives, whether it be from their friends, family, or healthcare providers, do not give them the adequate time and space to ask questions about or grieve the loss. An article by Naslund et al. (2016) asserts that online peer-to-peer support is becoming a prominent form of social interaction and is one of the most transformational features of the internet. Additionally, multiple studies have found that online support groups, forums and chat rooms serve as important venues for discussing sensitive subjects such as women's reproductive healthcare and mental health struggles (Gold et al., 2012: Naslund et al., 2016: Swartwood et al., 2001).

The broad term "social media" refers to interactive web and mobile platforms through which individuals and communities share, co-create, or exchange information, ideas, photos, or videos within a virtual network (Naslund et al., 2016). Online social networking represents a prominent form of communication in many people's lives. For individuals struggling with stigmatized or socially taboo issues such as miscarriage, social media may make it possible to connect with others who share similar experiences who are

seeking to disclose this information without having to reveal one's personal identity (Naslund et al., 2016). According to Naslund et al. (2016), the decision to reach out and connect with others to discuss these taboo experiences, typically occurs at a time of increased instability and when individuals are facing significant life challenges. Some examples of these instances may include suffering multiple miscarriages within a short period of time, relationship breakdown following the loss (either with significant others or family members) and receiving a diagnosis or further information about future pregnancies following miscarriage (Gold et al., 2012). Seeking support and social connection is therefore a critical point in the lives of women who have miscarried; and the decision of who to reach out to may have implications for their long-term healing and well-being. Social media overcomes geographic boundaries and time constraints, allowing users to choose whether or not to actively create content, disclose personal information, post comments, or passively view content posted by others (Naslund et al., 2016). Research suggests that within an online network both individuals who choose to share content or connect with different users, as well as those who choose to seek further information without interacting with others, can experience important benefits (Naslund et al., 2016: Swartwood et al., 2011). Compared with spontaneous face-to-face encounters, social media users maintain greater control over their support needs and experience as they can choose their own level of engagement and the extent to which they interact with others (Naslund et al., 2016: Swartwood et al., 2011). On social media women who have experienced pregnancy loss can choose whether to post content and how quickly they wish to respond to comments and can revisit conversations or seek

greater clarity at their own pace (Gold et al., 2012).

Platforms such as Facebook represent a user-driven environment, where individuals with Internet access through their mobile device or computer can have a voice and the opportunity to express themselves and connect to a larger community (Naslund et al., 2016: Swartwood et al., 2011). Additionally, social networking sites pose an alternative avenue for individuals facing difficult life circumstances, social isolation, or fears about how others will view them, which may prompt them to seek information or support online (Naslund et al., 2016: Swartwood et al., 2011). In engaging with others in an online space, much can be discovered about what to expect, suggestions for coping and healing, and how to approach conversations with physicians, friends, and family about the loss. Research conducted using these platforms can be useful in informing those in powerful positions as to what women and their families need during the time following miscarriage (Naslund et al., 2016: Swartwood et al., 2011). Naslund et al. (2016) argue that online peer support networks challenge pervasive societal stigma and discrimination by giving diverse patient groups their own voice and opportunity for self-expression. Swartwood et al. (2011) examined the exchanges between individuals engaging in an online community devoted to grief and found that online spaces act as a "cyber refuge from the larger social order where grief was unwelcome" (p.164). Alternatively, Capitulo (2004) studied messages from participants enrolled on a perinatal loss mailing list (also known as a listserv). She found that every member reported experiencing a redefinition of self because of the loss; she termed this theme a "shared metamorphosis" (Capitulo, 2004, p.8). In other words, women had to reconcile a motherhood identity with the reality of

now being without their child and grapple with the social norms of grief as well as the loss of maternal identity. Additionally, Capitulo (2004) found that women engaged in various practices in order to process the loss, which included holidays and anniversaries, openly talking about memories of their child to celebrate them and acknowledge that they had lost a "real" being that they had bonded with. Women also engaged with pregnancy symbols, spirituality and religion to assist them in making sense of the loss and create space where grief could happen (Capitulo, 2004). In general, qualitative studies that have examined the culture of online perinatal loss groups have noted a strong sense of community and support which is beneficial to users.

Similarly, Gold et al. (2012) analyzed internet message boards geared towards miscarriage and stillbirth through an anonymous survey. In general, women expressed great satisfaction with the pregnancy loss message boards in terms of learning new information and recommending the boards to others who have experienced a loss. The researchers discovered that these spaces enabled women to not feel alone in one's experience, feel validated and safe amongst other women who had experienced a loss and facilitated women to move forward (Gold et al., 2012). The diminishment of isolation was the most common by-product of the message boards; many women noted feeling that only someone who had the same experience could truly understand what it felt like. Women also described a strong sense of support, comfort and community from the message boards (Gold et al., 2012). Women identified peers on the support group as friends and people who were like family and reported a sense of close community with others they had met online. Another common theme was that the boards were a validating

environment where it was acceptable to talk about a deceased baby and where grief could be normalized (Gold et al., 2012). Participants also felt validated by having a site to talk openly about their babies and their birth experiences since this often led to awkward and uncomfortable situations in their real lives. Online it was safe to talk about their pregnancies and infants even when it was perceived as socially unacceptable offline (Gold et al., 2012). Women noted that they had a need to tell their stories and internet support sites were one of the few or only places they could freely discuss this information. The internet was also seen as different from in-person groups or interactions because people could feel free to post their true feelings and have a non-judgmental audience (Gold et al., 2012). This was often linked with the themes of privacy and anonymity, particularly for women who had terminated a pregnancy due to fetal anomaly or maternal health (Gold et al., 2012). Furthermore, the authors found that posting content on the message board was sometimes an easier way to communicate about emotional topics (Gold et al., 2012). Multiple women noted that they felt more comfortable on the message board because people could not see them if they were upset or crying and that the board format gave them time and space to compose their thoughts if they became emotional. Finally, women discussed the ways in which the message boards provided reassurance that they could survive their grief because the other people had done so or that others like them were able to have good pregnancy outcomes in the future (Gold et al., 2012). The research conducted by Gold and colleagues is relevant to the present study because it provides evidence for further development of resources and communities that women can access and benefit from following miscarriage. In the present study, the use of

a Facebook page dedicated to experiences of miscarriage and pregnancy loss will be examined further in terms of how women use the space to comment on their struggles, respond to content generated by the page administrator and share their stories of loss.

Chapter 3: Theoretical Framework and Methodology

Literature by Linda Layne (1997) documents the silence that surrounds the topic of miscarriage and pregnancy loss and its relationship to feminist theories. Layne (1997) posits that feminist scholars have explored the patriarchal systems of oppression that impact women's decisions (or lack thereof) regarding their reproductive freedom, leading to an aversion or hesitation to extend the analysis to experiences of pregnancy loss. Additionally, Layne (1997) argues that feminist scholarship grapples vigorously with the question of how women continue to be oppressed through various systems and cultural norms which shape their role within society often citing messaging and social norms where women's value is measured against their role as wives, mothers and caregivers. In other words, feminists have worked tirelessly to divorce the evaluation of women's worth from their ability to bear children.

Consequently, this focus on women's choice or desire for motherhood creates an implicit tension and a gap when addressing issues of infertility, miscarriage and pregnancy loss where scholarship on the issue is falsely categorized as advocating pro-life and religious rhetoric which is often opposed to the objectives or insights of feminist scholarship (Layne, 1997). According to Layne (1997), the pro-choice debate has paralyzed feminists in articulating an agenda for addressing the issue of pregnancy loss because it would mean that scholars would have to acknowledge and conceptualize the

presence of fetal or embryonic personhood, which aligns with the rhetoric of pro-life advocates. As a result of this apparent paralysis, feminists have studiously avoided engaging in conceptualizing fetal personhood, which would validate or confirm the being that women are mourning. Moreover, the topic of fetal personhood illuminates the larger cultural construction of miscarriage and pregnancy loss, and its impact on the lives of women and their families which warrants more critical attention and analysis. Therefore, the most prominent barrier to a comprehensive understanding of pregnancy loss is inconsistent feminist theoretical attention (Layne, 1997).

Feminist Standpoint Theory

With these tensions in mind, I searched for a branch of feminist theory that would align with the ways in which women construct their reality after enduring pregnancy loss and would support the prioritization of women's voices in uncovering the nature of the truth of their experiences. Therefore, I chose feminist standpoint theory to assist me in shaping my research questions and design. The goal of early feminist scholars including Hartsock, Harding and Hekman was to define the nature of the "truth claims" that feminists were advancing and to provide methodological grounding that would validate those claims (McClish & Bacon, 2002 p. 29). A "standpoint" is the product of distinct experiences that develops into an epistemically privileged perspective from which the nature of relevant social relations is visible (Harding, 2004 p.7-8). Hartsock (2019) claims that it is women's unique standpoint in society that provides the justification for the "truth claims" of feminism while also providing an entry point through which to analyze reality. According to Harding (2004), knowledge is socially situated and determined by the

knower's social position, particularly by the power relationships that structure their life.

More generally, feminist standpoint theory can be thought of as having three main claims. First, knowledge is socially situated, meaning one's identities and social location shapes their worldview. Second, marginalized groups are aware of the interplay between their identities and existing power relations working to oppress and marginalize them in their daily lives. Third, research should begin with the lives of those marginalized to better understand these power dynamics (Brisolara, 2014). All research then, is shaped by one's standpoint, which determines both the questions asked and the range of potential answers. Feminist standpoint theorists assert that research should be grounded in women's experiences, which, as Harding explains, should act as a "significant indicator of the 'reality' against which hypotheses are tested" (Harding, 2004, p.40). Consequently, theorists proposed approaches that would unearth the differences in standpoints by questioning categories and assumptions; gathering claims to knowledge from people through relationships, cooperative interactions and connections, in order to "see through the eyes" of women experiencing oppression (Brisolara, 2014 p. 36). Additionally, through this process of interrogating women's experiences of oppression, theorists leveled critiques against how women are treated by medicine and how medicine has staked the claim of authority over women's bodies, reproductive health, and reproductive choices. As mentioned previously, through a medicalized lens pregnancy loss is framed as a condition where a women's body is in "crisis" which warrants medical intervention in order to resolve or alleviate such crisis (Cahill, 2001; Golan & Leichtentritt, 2016). Through this process, the physical experience of miscarriage becomes separated from the

emotional and psychological impacts of the loss. Consequently, women are both disempowered by the medical model and given power (and responsibility) to make their own decisions regarding their pregnancies. Therefore, women who miscarry may occupy multiple standpoints where their voices are subordinated, including their relationship with their obstetrician, with other women, and within online spaces where the rhetoric of the women's health movement is taken up. Through this process of subordination, blame may be exerted on women for making certain decisions during pregnancy that could have led to their miscarriage (Golan & Leichtentritt, 2016). Whether it is through relationships with healthcare providers or in the spaces where women support each other, women who have miscarried are saturated by the dominant or normative perspectives surrounding pregnancy loss as well as the truth of their own lived experience of miscarrying. While reflecting on this idea of medicine claiming authority over pregnancy and childbirth, I came to believe that there is a lack of attention or accountability with regard to pregnancy loss that goes beyond the physical D&C procedure. In other words, women's emotional and psychological reactions to the conformation of miscarriage and the D&C procedure are often not acknowledged within traditional healthcare or support settings, nor are reflected in the development of strategies for best practice. Furthermore, academic, and medical scholars often write about pregnancy loss for the purposes of understanding what happens in the body when miscarriage is occurring; instead of examining the harm that is inflicted on women by these approaches to care. Feminist standpoint theorists assert that women's experiences of oppression and marginalization are embodied and are impacted by their interactions with their environment. Therefore I sought out data sources that

encapsulated the multi-layered embodied experience of pregnancy loss that existed outside of academia and medicine to interrogate the issue of miscarriage by leaning into what women are actually saying and why they have sought out through online platforms to gather information and support.

In the case of miscarriage and pregnancy loss, historical methods of practice and research focused on the negative psychological implications of the loss including depression and symptoms of post-traumatic stress disorder in relation to the gestational age at which the pregnancy was lost (Brisolara, 2014). This approach negates women's interactions with their environment following miscarriage, instead it individualizes the problem and blames women for their inability to cope or function following pregnancy loss. Whereas, feminist standpoint theorists acknowledge and validate women's accounts of oppression as truth (Hekman, 1997). Furthermore, standpoint theorists posit that an epistemology generated from the standpoint of an oppressed group such as women is more valid than those of the knowledge of those in dominant positions in society (McClish & Bacon, 2002). Those who are disenfranchised must understand the perspective of those in power to survive, however the reverse does not hold true (McClish & Bacon, 2002: Swigonski, 1994). Hartsock calls this phenomenon "a duality of levels of reality," which enables oppressed groups to attain a deeper level of knowledge that both explains and critiques the perspective of the dominant group (Hartsock, 2019, p. 51). As standpoint theory has evolved, it has incorporated insights from Crenshaw's concept of intersectionality to account for the reality that women occupy multiple standpoints and, therefore, inhabit many realities which can impact how they view the world and their

experiences (Henwood & Pidegeon, 1995). Feminist Standpoint theory is helpful in shaping my research questions to align with the objective to highlight women's voices and the ways in which women who have experienced miscarriage use social networking sites such as Facebook pages to share their experiences. Specifically, Hartsock's (2004) explanation of dual levels of reality has propelled me to think about the relationships of power and dominance regarding pregnancy loss. In this study I want to explore how women talk about their experiences of miscarriage in a space that was created by them and for their voices, reflections and critiques rather than a forum dedicated to medical professionals creating content and disseminating information regarding pregnancy loss. Furthermore, through feminist standpoint theory researchers can question how women's stories of miscarriage contribute to our understanding and knowledge of their experiences, and how such knowledge can spark change in women's social care and available supports. Moreover, standpoint theory compelled me to pause to think about how this research could contribute to uncovering a counterhegemonic discourse about pregnancy loss (McClish & Bacon, 2002). Hekman (1997) purposes that feminist standpoint theory should be defined as a counterhegemonic discourse that works to destabilize hegemonic discourse. In the case of my project, the dominant discourses and norms surrounding miscarriage and pregnancy loss are shaped by the medical model, which defines pregnancy loss as a medical issue that warrants medical intervention. Furthermore, notions and experiences of support following pregnancy loss are shaped by these factors and so is the language that is used to describe the significance of the loss in women's lives.

Methodology

In selecting a methodology for this project, I had to reflect on the reasons why I was pulled towards the topic of pregnancy loss and miscarriage and what I wanted to contribute to the cannon of research for the McMaster School of Social Work and the field at large. Drawing on my practice experience, I recognized that there was a problem in the way that medicine and related helping professions approached miscarriage and their treatment of women reflected this. Women reported to me that they felt silenced by their health care providers where their psychosocial experiences of pregnancy loss were not acknowledged or validated; and further these professionals minimized their pain by referring to their baby as "tissue" or "products". Additionally, women disclosed feeling scrutinized for their inability to bear children, being told to "relax and let it happen naturally" or "you're worrying about it too much" which they found dismissive and harmful. In terms of a contribution to the social work field I wanted to create something that was tangible and accessible for both students and practitioners to integrate into their learnings and practice. Furthermore, in completing this thesis I wanted to look for opportunities to improve my own practice and deepen my understanding of an issue that impacts many women. I wanted to choose a methodology that would be grounded in the textual creations made by women on the Facebook page, which were representative of their truth and unique voice. I also aimed to frame miscarriage and pregnancy loss in a more empathic, multi-layered and embodied manner in order to provide insight about areas for change or future research that will develop the field further.

Thematic Analysis

According to Braun and Clarke (2012), thematic analysis is a method to systematically identify, organize, and offer insight into patterns of meaning across a data set. This approach to analysis allows researchers to see and make sense of collective or shared meanings and experiences such as miscarriage. Thematic analysis differs from other analytic methods that seek to describe patterns across qualitative data in that it is flexible in its approach to data analysis and its epistemological orientation to social phenomena (Braun & Clarke, 2006). Therefore, thematic analysis can offer a more accessible path of analysis in qualitative research. Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences are the effects of a range of discourses operating within society (Braun & Clarke, 2006). Furthermore, thematic analysis can be a method that works both to reflect reality and to unpack or unravel the surface of reality. Vaismoradi, Turunen and Bondas (2013) explain that the aim of thematic analysis and its many sub-methodologies is to examine "narrative materials from life stories by breaking the text into relatively small units of content and submitting them to descriptive treatment" (p.400). Braun and Clarke (2006) assert that a theme is something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set. In terms of my orientation to data analysis I am using theoretical thematic analysis in that the themes themselves are linked to my theoretical orientation. Feminist standpoint theory provided the epistemological understanding of women's identities and

claims of truth, which propelled me to seek out data sources that encapsulated women's worldview pertaining to miscarriage and pregnancy loss. Therefore, the overall goals of my research requires the interpretation of the thematic content of the data pertaining to miscarriage and pregnancy loss. I explicate the significance of the patterns and their broader meanings and implications for social work research and practice. In subsequent sections of the thesis I will describe how I took on Braun and Clarke's (2012) six stages for focusing the data coding, analyzing and interpreting the emerging themes.

Research Questions

I chose to use a thematic analysis after beginning my literature search and contemplating what was feasible given the allotted time I had to complete the project. The initial literature searches yielded many resources from medical journals (usually conducted by physicians, nurses and psychiatrists) explaining the various terms used to differentiate women's various experiences such as stating the difference between stillbirth and early miscarriage. Based on my practice experience I knew that pregnancy loss and miscarriage had more dimensions that went beyond the physical experience or a psychological description of how women cope. Women had disclosed to me that they did not find their social networks supportive or aware of their suffering; often times folks in their lives contributed to their pain through insensitive comments and pressuring women to "try again" or "get over it and move on". Consequently, I thought, where do women go, when everyone in their immediate environment (physicians, nurses, friends and family) are not meeting their needs? Then, I thought of the ubiquity of the internet, and how it is a way of alleviating feelings of anxiety when faced with uncertainty or

ambiguity, with health information both from professional voices as well as other women going through the same experience (Barber & Salam, 2013). I reflected on moments in my life where I was not given adequate information or support following a challenging life situation, concluding that online spaces can be a great source of validation and comfort after such events. The most common gatekeeper of these spaces is social networking sites such as Facebook, where users can join and follow various groups and pages dedicated to a myriad of issues, movements, and interests. Therefore, a thematic analysis seemed applicable and beneficial. Such approach would allow me to look at online content and text created directly by women who have experienced pregnancy loss, to analyze the central themes within their experiences, and to glean insights about what the field of social work could learn from their textual productions. Lastly, in examining text, I thought it would be beneficial to understanding social practices and norms that are harmful to women, so I may better my social work practice in the future.

Moreover, through this study I generally, wanted to answer the question of *How women use the Miscarriage & Pregnancy Loss Facebook page to describe their experience after a loss?* and *What can medical and social care professions learn from the posts and comments created on the Facebook Page to improve care for women?* In analyzing the themes present on this specific page, I wanted to explore the ways in which women comment on and respond to the content on the page, and how they reproduce, resist or contrast medicalized, patriarchal ideas, which have shaped the current cultural understanding of pregnancy loss. Additionally, I endeavored to understand if themes pertaining to grief following pregnancy loss were present through women's descriptions

of their experiences and how they engaged with one another. Finally, in the text and comments which discussed support and what women need to process and honour the loss, I wanted to examine the text for key themes and possible tensions where women had differing approaches to issues of medicalization and maternal identity. Through this process of analysis and discovery I gleaned insights for a hegemonic shift in the way we discuss pregnancy loss and how we support women as they process and heal from the loss.

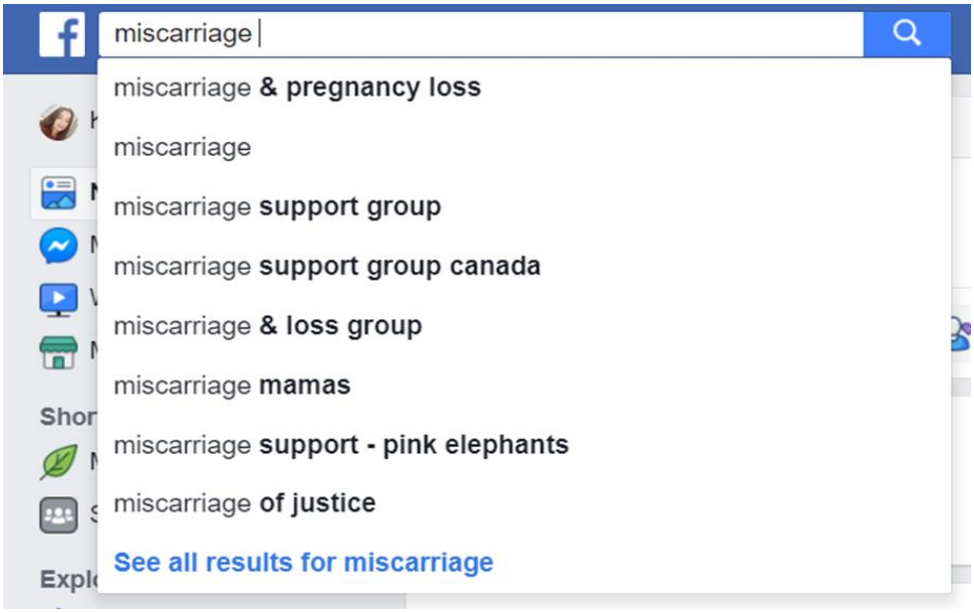
Chapter 4: Methods

Once I decided on a thematic analysis as my analytic approach, I began searching for pages and groups using the social networking site Facebook. I was looking for a page that did not require an additional profile or request to the administrator of the group to gain access, as this would require ethical clearance from the university and further disclosure on my part if I were to extricate data from the group. Furthermore, in these private groups the assumption is that every member has experienced pregnancy loss and miscarriage; my presence as someone who has not directly experienced this may have been intrusive to the group when women need the space to acquire information and support following their loss.

I followed the requirements of the Tri-Council Policy Statement (2018), which states that research ethics board review is not required for research that uses cyber-material that is publicly available with uncontrolled access and where there is not an expectation of privacy. Despite not requiring ethics board approval, however, there were still important ethical considerations for my project. When using a Facebook page as my

data source, informed consent is an important consideration. Willis (2019) asserts that Facebook pages are one instance where informed consent could be difficult to obtain and could be waived because the data is treated as textual and is available publicly. Additionally, I thought a page that was accessible to all Facebook users may attract a wider group of women to comment on and respond to the content on the page, therefore more experiences and voices could be represented in the data. As a way to ensure data anonymization and provide further protections to women who contributed to the Facebook page, I changed the usernames of those whose comments are analyzed in depth in subsequent sections of this project. While the data was publicly available, I wanted to ensure as much as possible the anonymity of the textual data I was analyzing (Willis, 2019; Zimmer, 2010). Keeping in mind the insights of feminist standpoint theory (Harding, 2004), I wanted to honour the "truth claims" women were making through their comments within these online spaces and frame it as an outlet that was separate from their everyday lives. In other words, women sought out this space because it was different from their daily life and daily interactions with physicians, nurses, family and friends. To begin my search I typed the term "miscarriage" into the search bar on my individual Facebook page, which yielded many results and variations of the term including "support group" and "miscarriage & pregnancy loss" (as seen in Image 1 below).

Image 1

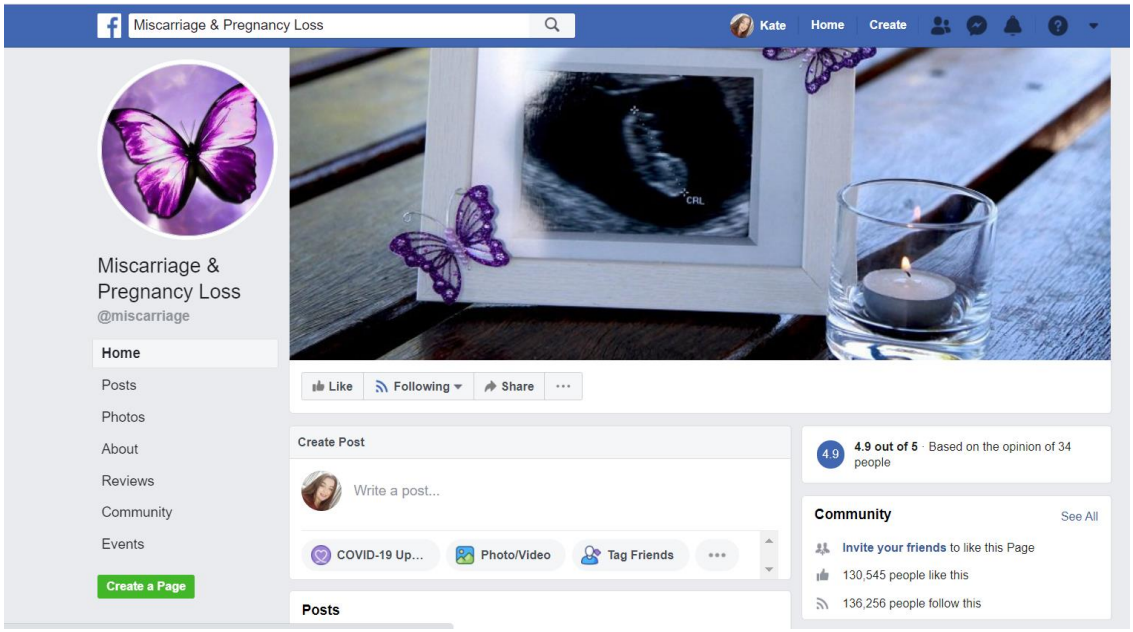


I chose to explore the results for the search terms “miscarriage & pregnancy loss” and found a page called “Miscarriage & Pregnancy Loss” (as seen in Image 2 below). Depicted in Image 2 is the “home” section of the page, where the administrator creates and shares posts for the users to see. The most frequent form of content within the page is images and quotes about the grief and sadness following the loss; either the administrator will create their own post or share content, which was first was posted on a different page. In either case, users can view and comment on the image or quote that is posted, and their text is visible to everyone who is viewing the page. The profile image is a purple butterfly, which is a common symbol in neonatal intensive care units to symbolize stillbirth and perinatal death (The Purple Butterfly Project, 2020). Also, the background image depicts a framed image of a sonogram of a miscarried baby, again decorated with purple butterflies on the picture frame. In the “About” section of the page the administrator created a mission statement describing the purpose and values of the page

and the goals for the community they wanted to create. The page was founded in the year 2010 and its mission is to:

> *"[Provide] Support for bereaved parents who have lost their babies through miscarriage, stillbirth and neonatal death. You do not need to suffer in silence, you are not alone and have the right to grieve. We will offer you comfort, support and understanding without negativity and judgment."*

Image 2



I chose this page because its mission statement aligned with the goals of my research project, which were to highlight women's voices as they go through this difficult experience and attempt to understand how they use this medium to meet their needs for support and further information. Furthermore, the above mission statement alludes to the social taboo and silence surrounding the issue, which is of interest for this study. For the

purposes of completing the analysis I chose two posts from the "Miscarriage & Pregnancy Loss" page to analyze both the text of the actual post and the comments created by women who follow the page. These posts were chosen based on their level of engagement with users; I selected posts that had extensive comments where women were creating their own text responding to the content. Additionally, I chose these posts based on their ability to encapsulate and represent women's varied voices and experiences of miscarriage, specifically the emotional and social impacts of the loss. Moreover, to maintain user's privacy and confidentiality I changed their usernames as to decrease the risk of being identifiable in the following sections of the research. After collecting my data, I placed all the chosen text onto a singular word document and saved it in a password protected computer and file storage folder.

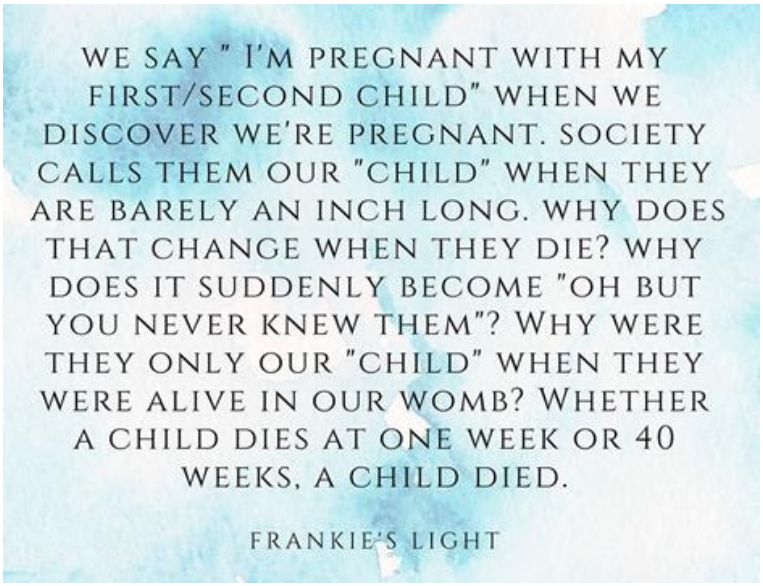
The first post I chose was a quote originally created for the Facebook page "Frankie's Light" which was created by a woman in memory of her stillborn child. This separate page is also a community organization dedicated to supporting parents following their loss; the page promotes clothing drives where users can donate baby clothes that are given to hospitals where women can have the option of dressing their deceased baby after delivery for the purposes of memorialization and closure. The quote taken from "Frankie's Light" was reposted by the administrator to the home section of the "Miscarriage & Pregnancy Loss" page. The quote (also shown in Image 3 below) reads;

> *"We say 'I'm pregnant with my first/second child' when we discover we're pregnant. Society calls them our child when they are barely an inch long. Why does that change when they die? Why does it suddenly become 'oh but you never*

knew them?' why were they only our child when they were alive in our womb?

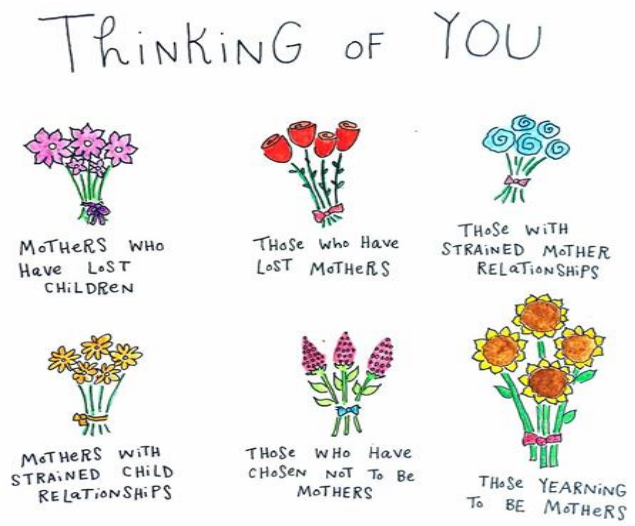
Whether a child dies at one week or 40 weeks, a child died."

Image 3



The second post I chose for this project was posted to the "Miscarriage & Pregnancy Loss" page on Mother's Day (May 10, 2020). The post is an image created by artist and writer Mari Andrew (as seen in Image 4 below), which has become a widely circulated illustration on social media in conversations about maternal relationships and identity. The image was posted with the caption "wishing you a gentle Mother's Day [heart emoji] you are seen and you are loved".

Image 4



I chose this image because of both its emerging cultural significance and popularity on social networking sites, and the response from women on the "Miscarriage & Pregnancy Loss" page. With this post in particular, I was interested in analyzing the number of replies made to comments where women disclosed their experiences of grief and lack of social recognition following their pregnancy loss. Consequently, I chose this post as it aligned with my research objective to elevate women's voices in conversations about pregnancy loss.

Building on previous sections of this project, I wanted my method of analysis to be representative of women's voices and align with both the objectives of feminist standpoint theory and the goals I set out for this research. I thought it would be helpful to create secondary questions that build on my initial research problem to assist me in coding and categorizing my findings. I asked the following three questions of the posts and comments I chose from the Facebook page:

a. What are the central themes of miscarriage highlighted in the text?

b. What tensions (if any) exist in the ways in which women address miscarriage and pregnancy loss through their engagement on the Facebook page?

c. How do women talk about the care they received at the time of miscarriage?

To organize, code and thematically analyze the data I used the six steps outlined by Braun and Clark (2012), which assisted me in arriving at my findings and implications for the field of social work. The following table briefly illustrates my process of working through the following steps:

Table 1:

Steps	Description of the Process	Application to the selected data sources
1. Familiarize yourself with the data	Reading and re-reading the data, taking note of initial ideas.	Initially separating the posts and treating their content individually, the post from Frankie's Light produced comments directed at women's disclosures of miscarriage and pregnancy loss and the care they received during this time. Moreover, the second post produced comments about maternal identity where women offered supportive words to one another and acknowledged the social significance of maternal identity on Mother's Day.
2. Generating initial codes	Coding interesting features of the data in a systemic fashion across the entire data	At this stage I printed out a hard copy of the posts and their comments and made initial codes based on the

	set, collating data relevant to each code.	language and messages present in the text. This was the beginning stage of of organizing the data into meaningful categories and relating them back to the guiding questions I posed. In this stage I combined both posts and treated them as one large data set. Some of the codes included but were not limited to: referring to the pregnancy as a baby, referencing gestation (in weeks or months), describing emotions and emotional reactions to the loss, commenting on the prevalence of minimizing grief, commenting on medical solutions and terminology, and asserting an enduring maternal identity following miscarriage.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.	I collated the codes into five major themes within several subthemes with some overlap between them, where codes were applicable to multiple theme groups. The themes included: support in online spaces, interactions with medical professionals, maternal identity, acknowledging and validating the loss, and experiences of grief and coping following miscarriage.

4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map of the analysis.	After reviewing extracts of data and the tentative themes I created a thematic map. The map outlines the various connections between codes and overarching themes. Through this process I was able to decipher which themes had enough similarity to collapse into one another. My thematic map can be seen in Appendix 1 of this document.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story my process of analysis tells, generating clear definitions and names for each theme.	At this stage I had found five themes within the data, I returned to the coded extracts of the data to ensure that these themes truly encapsulated the messages and intentions of the textual productions created by women. Additionally, I returned to my research questions to ground the codes and themes and assess whether I have found answers to these questions. Through this process I refined and selected text and exchanges between women that illustrated these themes and provided context about the online space and how it was used to support women.
6. Producing the report	The final opportunity for analysis. Selection of vivid compelling extract examples, the final analysis of selected	In the findings and discussion sections of this project I discuss three themes and their implications for future

	extracted, relating the analysis back to the research questions and literature.	miscarriage and pregnancy loss research and the provision of medical and social care. The themes are: Miscarriage as a multi-layered Embodied experience, Interactions with Medical Professionals, Constructing an enduring maternal Identity

Familiarizing Myself with the Data

Initially I printed out hard copies of each of the posts and corresponding comments, I separated the posts from one another and familiarized myself with the comments that each of the posts produced and noted initial differences in the topics covered in each post. For example, the first post from Frankie's Light produced comments directed at women's reflections on their own experiences seeking medical care at the time of miscarriage. These posts often encompassed women's disclosures of pregnancy loss and how they were impacted when the existence of their child was discredited or challenged by those to whom they had disclosed. Alternatively, upon my initial reading of the second post and comments, I noted that women grappled with this idea of maternal identity following miscarriage, and some of the women offered support and reassurance to women who disclosed this tension. In reading and re-reading the text I found that some women did not elaborate on their experiences of miscarriage and simply offered their support or engaged with the post through sentiments such as "I agree", "this happened to me" or through various emoticons. Although these pieces of data contribute

to the overall mission of providing women space to support and engage with one another, these shorter comments were removed from the data set to provide a greater focus and concentration of longer textual comments with which to complete the analysis. This process enabled me to focus the scope of my project and the themes that would answer my research questions.

Generating Initial Codes

After finalizing the list of comments I would be analyzing I printed out a hard copy of the data and began highlighting words and phrases that resembled patterns within the data. At this point I combined the two posts and their associated comments into one large data set to analyze the multi-layered nature of the stories that women wrote on the Facebook page. I noticed patterns about how women engaged with the content of the initial post and with one another and how they described their own experiences at the time of miscarriage. Consequently, I compiled a list of ideas and messages present in the data that were interesting and began to answer the guiding questions I previously mentioned. The tension I had in creating codes was in differentiating between data-driven versus theory-driven codes. In their article Braun and Clarke (2012) separate the task of coding as either data or theory dependent. I did have guiding questions that I asked of my data sources and were grounded theoretically, however, my questions were also geared towards what existed in the data itself. Furthermore, feminist standpoint theorists assert that research should be driven by women's experiences and identities as sources of truth and social change, therefore I viewed my approach to coding as both data and theory driven. I manually worked through the data, highlighting words and phrases that

conveyed interesting messages and writing down codes in the margins. After completing this task, I wrote out a secondary list of codes in a notebook, adding examples of the words, phrases and messages that were encapsulated in the code.

The following section describes the codes I created to signify and begin to organize patterns within the data. The codes included: referring to the pregnancy as a living being and women did this through describing their lost pregnancy as their "child", "little one", "baby" and by using pronouns to address their loss. Another code was referencing gestation where women stated the weeks or months since their miscarriage or the age at which the pregnancy was lost. Also, women described emotions and emotional reactions to the loss using words such as "devastated", "hurt", "pain", "terrified" and "helpless". Next, users commented on the prevalence of minimizing grief they displayed through phrases such as "get over it and move on" "people think they're nothing", and "I have a living child so it shouldn't matter". Another code was how women commented on medical solutions and the use of medical terminology such as describing how the D&C procedure impacted them, that medical intervention was deemed necessary, and commenting on how doctors referred to their baby as "excess tissue". Additionally, some tension emerged between women who asserted an enduring maternal identity following miscarriage by calling themselves mothers while others described almost becoming a mother or accepting that they may never be a mother. Another interesting feature that emerged from the data was women's willingness to engage with the messages conveyed in the post stating how the text resonated with them or affirming that they shared the same experience. Additionally, women commented about the pressure to move on after a loss

through their disclosures of their experiences with their coworkers, friends and family. Also, within the data the need for acknowledgment after a loss was prominent in women's disclosure of instances where people in their immediate environments did not let them address their experience. Within the comments on the selected posts exchanges of support between women were visible where they would reply to one another and offer words of compassion and empathy following disclosures of pain and suffering. Women also used or alluded to religious language and imagery when speaking about their experience and offering words of support others. Interestingly, some users used the space to offer advice, silver linings and success stories following disclosures of miscarriage. The last code I created from the data was projections of "what ifs" or images of lost children where women would construct their child in a particular way and reflect on how their lives would be different if their child had survived.

Searching for and Reviewing Potential Themes

After identifying and deciphering the various codes that emerged from the data, I created additional lists that collapsed various codes together and this propelled me to examine the ways in which the codes were similar and different from one another. This involved me going back and forth between the raw data and the list of codes numerous times after taking some time away from the data and returning with fresh eyes. In returning to the raw data I was looking to re-examine the messages and intentions present in the comments posted by women using the Facebook page in relation to the content created by the administrator of the page. Re-examining this conversation and engagement among women yielded five larger overarching themes: support in online spaces;

interactions with medical professionals; constructing an enduring maternal identity; acknowledgment and validation following the loss; and experiences of grief and coping following miscarriage. As this table demonstrates, some codes overlapped with the five themes, which emphasized to me as the researcher that they were prominent within the data and may be crucial to answering my research questions. The following table briefly outlines these five themes and their corresponding codes:

Table 2

Support in Online spaces	Interactions with Medical Professionals	Maternal Identity	Acknowledgement and Validation	Grief and Coping
-Engaging with the content on the page. -Exchanges of support with other users. -Provide advice, silver lining and success stories	-Medical solutions -Medical terminology -Reference to gestational age -Minimizing grief and loss -Pathologizing women who miscarry	-Attachment and bonding -"Still a Mother" -Referring to the loss as a "baby" -Exchanges of support with other users -Women who do not see themselves as a mother	-Referring to the loss as a "baby" -Provide advice, silver lining and success stories -Emotional reactions and responses to the loss -Resisting medical terminology -Exchanges of support with other users -Religious imagery and language	-Pressure to move on from the loss -Referring to the loss as a "baby" -Emotional reactions and responses to the loss -Social avoidance of grief -Exchanges of support with other users -Projections of "what ifs" or images of lost children -Provide advice, silver

				linings and success stories -Minimizing grief and loss

Defining and Naming Themes

At this stage I reflected on the distinct elements within the thematic map (seen in Appendix 1) and the codes that overlapped with one another. I then returned to my research questions: *How women use the Miscarriage & Pregnancy Loss Facebook page to describe their experience after a loss?* and *What can medical and social care professions learn from the posts and comments created on the Facebook Page to improve care for women?* This helped to guide me through this stage of my analysis to refine the distinct features of the data into a cohesive story. At this stage I had found five themes within the data, I returned the the coded extracts of the data to ensure that these themes truly encapsulated the messages and intentions of the textual productions created by women. Below in Tables 3 and 4 are examples of the coded extracts of data, the initial codes they produced, and the broader themes represented:

Table 3:

Data Extract	**Initial Codes**	**Larger Themes**
Post from Frankie's Light: "We say 'I'm pregnant with my first/second child' when we discover we're pregnant. Society calls them our child when they	- Reference to the loss as a baby - Reference to gestation - Use of Medical terminology	- Interactions with Medical Professionals - The need for acknowledgment and Validation

are barely an inch long. Why does that change when they die? Why does it suddenly become 'oh but you never knew them?' why were they only our child when they were alive in our womb? Whether a child dies at one week or 40 weeks, a child died."	- Minimizing grief and loss - Emotional responses and reactions to the loss - Need for acknowledgement and validation - Need for support	- Grief and Coping Behaviours
Response from Leah J.: "I hated that. When i was pregnant with my 3rd baby, the doctor's kept calling it a baby. But when i had a miscarriage they started calling my baby 'excess tissue'. It was heartbreaking." **Reply by Kristielee H.:** "I can relate to this. When I had a miscarriage, I had a scan a week later and the guy was like, the tissues all gone. No that was my baby, acknowledge it." **Reply by Laura B.:** "When I had to have a d&c to take away my baby because I wasn't miscarrying naturally, I was having contractions as they gave me a pill. The surgeon said "wow	- Referring to the loss as a baby - Medical solutions - Medical terminology - Emotional responses and reactions - Minimizing grief and loss - Medical terminology - Referring to the loss as a baby - Need for acknowledgment and validation - Need for support - Medical solution - Referring to the loss as a baby - Medical terminology - Need for acknowledgment and validation - Pathologizing women who miscarry	- Finding and engaging in support in Online spaces - Interactions with Medical Professionals - Need for Acknowledgement and Validation - Grief and Coping Behaviours

she's in a lot of pain, maybe she's trying to expel something". I was thinking, something?? That's my baby."	- Minimizing grief and loss	

Table 4:

Data Extract	**Initial Codes**	**Larger Themes**
Response from Milany B.: "Happy Mother's Day to all.. this would have been my first year of being a mother but unfortunately lost my first and second baby last year.. my due date would be 5.20.20 and 8.28.20 but I lost mine."	- Does not identify as a mother following miscarriage - Reference to maternal identity - Reference to loss as a baby - Reference to gestation	- Maternal Identity - Finding and engaging in support in online spaces - Grief and coping behaviours
Reply from Amber L.: "I'm so sorry! That pain is unbearable. You are still a momma to those sweet angels!"	- Exchanges of support - Emotional responses and reactions - Maternal identity following miscarriage - Religious images and language - Resisting medical terminology	- Need for Acknowledgment and Validation - Grief and coping Behaviours - Maternal Identity - Finding and engaging in support in Online spaces
Reply to Amber L. from Annette B.: "Sorry Amber for your lost I thought maybe you would	- Exchanges of support - Minimizing grief and loss - Pressure to move on	- Grief and coping behaviours - Need for acknowledgment and validation

be better you can always try again".	- Pressure to try again	

Through this process I refined and selected text and exchanges between women that illustrated these themes and provided context about the online space and how it was used to support women. Drawing on Braun and Clark (2012), I endeavored to select themes that 1) had a singular focus and did not try to cover too much; 2) were related and built on one another but did not overlap; and 3) directly addressed my research questions. I decided to collapse "medical terminology" and "medical solutions" into the larger theme of signifying the salience of interactions with medical professionals and make that its own theme. This theme emerged as important because when women would discuss their experiences with regard to the disconnect between public discourse and their private experiences of pregnancy loss, medical professionals often perpetuated this disconnect, thereby impacting women's emotional wellbeing following the loss. Within this theme women both took up and resisted medicalized language when describing their interactions with healthcare providers and asserted their need for acknowledgment of their child. Additionally, the theme of maternal identity emerged from the data as a point of tension, where some women identified as a mother following miscarriage while others referred to motherhood as something, they "lost" or "almost had". Finally, I collapsed the themes "need for acknowledgment and validation" and "grief and coping" into one theme describing the miscarriage as a multi-layered and embodied experience. In other words, women talk about miscarriage as an event that impacts them physically, emotional, psychologically and socially. These levels do not exist in a vacuum, instead they interact

and build on one another to shape women's experiences that they have written about on the Facebook page. The following sections explicate the themes "Miscarriage as a multi-layered Embodied experience", "Interactions with Medical Professionals", and "Constructing an enduring maternal Identity" in further detail, drawing on textual extracts from the selected posts and discussing the larger implications of these themes.

Chapter 5: Findings

The "Miscarriage & Pregnancy Loss" Facebook page is setup as a space for women to read and respond to content created by the administrator of the page and reply to comments from other users. This gives women the option to either view the content without engaging with others, but still reap the benefits of reading content created by women who have miscarried, or to engage with the content on the page, disclose their experiences, ask questions, offer and receive support from other women. It is from these exchanges of support and dialogue among women engaging with the selected posts that three key themes emerged. In reaction to both of the selected posts (the repost from Frankie's Light and the Mother's Day post) women offered their responses and reflections to the messages and they used the spaces to describe their experiences at the time of miscarriage. Furthermore, women used the space to describe how these experiences have impacted them and their healing process. The exchanges between women illuminated interesting insights into how women need to be supported after miscarriage and exposed the ways in which women both resist and take up medicalized hegemonic discourse. Women also affirmed one another's experience of grief and validated the existence of a "real" child that they lost. It is from these exchanges of

support between women that the following themes emerged. First, miscarriage encompasses physical, emotional, psychological and social experiences for women. Second, encounters with medical professionals have the power to shape the impact of miscarriage on women. Women utilized medicalized language in ways that minimized their emotional pain and suffering while also resisting such language, by asserting that their baby was real and deserves to be acknowledged. Third, women grappled with the idea of maternal identity following miscarriage. For some, maternal identity is a label that endures after the loss while for others it is something that is contested or framed as something they almost achieved. Furthermore, these themes were salient in the content posted to the Facebook group vis-à-vis women's responses to the content posted, their disclosures of their experiences, and in their replies to one another where they offered words of compassion, validation or guidance. The ways in which women used the platform to access and engage in support with one another following miscarriage, points to potential areas of further research as well as developing further resources that offer women similar benefits.

Miscarriage as a Multi-layered Embodied Experience

The first theme that emerged from the data was pregnancy loss as a complex and multi-layered event and embodied experience that has impacts which can extend for months, and years after miscarrying. Miscarriage is not only felt in one's body; the experience has emotional, psychological and social implications, which coalesce and create meaning that underpins one's understanding of the event. Furthermore, as an embodied experience, pregnancy loss involves the construction of a fetal body working in

tandem with the woman's in the exchange of space and resources. Therefore, women interpret this relationship in various ways and make meaning from pregnancy; when the pregnancy ends that relationship is lost and the body, mind and heart are left to recover. As mentioned previously in the review of relevant literature, attention must be paid to women's reproductive journeys to grasp the significance and lasting impact of pregnancy loss. In mapping the journey from pregnancy to miscarriage women construct meaning at various stages of the experience. In the case of pregnancy after a previous loss, women struggle with the complexity of anticipation and excitement about becoming a mother while also experiencing anxiety and grief over a previous loss that did not reach the milestones they are currently experiencing. One user Donna M. described her experience in the following comment:

> "Exactly I was only a couple weeks along when I lost my last baby I still loved my baby it still hurt and it most certainly affected me in many different ways just like it would if I lost this one and I'm almost 17 weeks along everyday I think about the what ifs and why isn't she moving I'm terrified I will lose her as well a miscarriage affects a woman no one can realize unless they have been through it I want to cry everyday over my last child but I can't I have to be strong"

In this comment she describes the anxiety of potentially miscarrying this pregnancy after a previous loss, reflecting on her bodily experiences as potential markers or symptoms of miscarriage. Furthermore, the bodily experience of pregnancy encompasses physical sensations which are indicative of specific markers of development or stages in pregnancy. Donna alludes to the example of fetal movement as an indication

that her baby is alive and healthy, adding that she thinks of these physical sensations everyday as she gets closer to her due date with her current pregnancy. She alludes to the social pressure and emphasis placed on the ideal outcome of a healthy baby, where women take on the emotional labour of worrying and gathering information about how they can ensure this outcome. Furthermore, she discusses the pain of the previous loss noting that her miscarriage was early on in her pregnancy, and she still "loved" her child and was deeply impacted. Her comment also addresses the reality that the impact of miscarriage is not widely recognized or understood by those who have not experienced it. Also, she comments on the emotional implications of the loss, stating that she frequently feels emotional and cannot express herself because she feels she must mask these feelings by being strong.

Moreover, these embodied experiences are not acknowledged or accepted as real following miscarriage as depicted in the following comments from Amaris S. and Kris K:

> "Today is the 17th month since I lost my little one. Supposedly I was 7 weeks but I bled a lot and they couldn't see my baby in the scans yet. I definitely felt her still fighting but the day before I miscarried, I felt that she was gone. My D&C was pretty traumatic because no one acknowledged my pain and loss. My family and my ex didn't support me when I was pregnant either so I was emotionally & physically exhausted". – Amaris S.

> "I miscarried my daughter at 20 weeks on the 19th. It hurt so much when I think of how I couldn't help her. My boyfriend and [I are] trying the best we can to keep

each other up. Today is a down day. No matter what it's nothing I can do to make it better". – Kris K.

Beginning with the first comment by Amaris S., she describes her miscarriage at seven weeks where she "felt" her baby "fighting"; her use of language here is representative of pregnancy as an embodied experience. She created meaning out of her physical sensations of pregnancy and her emotional attachment to her child, the use of the word "fighting" is indicative of this symbiotic relationship during pregnancy that women are acutely aware of. As highlighted in pregnancy loss literature, women are tasked with discerning various bodily events and sensations as either benign or symptomatic of miscarriage. Bleeding or spotting can be common in one's first trimester and not be harmful to the mother or child, yet it can also signify miscarriage. Thus, women must be hyper-aware of these sensations along with the fear, anxiety and the sadness that they can inflict. Furthermore, if women do not miscarry on their own, they are given a D&C procedure to the deliver the pregnancy. In her comment Amaris S. states that this was "traumatic" for her and was intensified by the fact that "no one" acknowledged her "pain and loss". The distress of the D&C procedure was experienced by Amaris S. on multiple levels including the physical sensations of pain and discomfort, the emotional connotations of pain as well as grief, and the social experience where her experience was dismissed by those around her. She added that she was "physically and emotionally exhausted" following the procedure, which again indicates that miscarriage is a multi-layered experience. Similarly, in the second comment by Kris K. she describes feeling powerless as she could not "do anything" to help her child as she miscarried. Her

comment touches on the disconnect between assertions made by proponents of the women's health movement that tell women they need to be in control of their health outcomes and the reality of miscarriage.

The emphasis on women's ability to control pregnancy outcomes can have negative consequences for women who miscarry. As seen in the previous comments, women internalize this rhetoric and feel powerless in miscarriage. This social pressure to keep "doing" and taking on the responsibility to ensure a healthy pregnancy puts women in a position to shoulder blame and guilt in the event of pregnancy loss. In a comment by Mandy H. she states:

> "This is so true. I have started talking to my belly and praying to God to let this one be the one that "sticks" as soon as the test showed a positive. Most of my miscarriages were very early but I still knew I was pregnant even it was only a couple of days".

Using the word "stick" to describe her yearning for a successful pregnancy, again signifies the relationship between mother and baby during pregnancy as an embodied experience. Additionally, she notes that she still "felt" pregnant even though she eventually miscarried. Within this first theme, the social experience of miscarriage is salient within the data, including the social responses and reactions to women's disclosures and grieving behaviours. The selected comments below describe the ways in which women's experiences of grief and pain are invalidated in their immediate environment, and their reflections of how public discourse impacts them. The text highlights the ambiguity commonly associated with pregnancy loss, where aspects of the

event are not widely recognized as valid or worthy of prolonged periods of grieving. Within this theme there are many unchallenged assumptions about the nature of the impact of pregnancy loss. For example, because their child was not a "real" being that women had the opportunity to parent, extended periods of grief are framed as abnormal and unjustified. Additionally, the selected comments illustrate the impact of these hurtful comments and assumptions that women endure in their daily lives further highlighting larger unchallenged assumptions pertaining to socially acceptable grief following pregnancy loss. In her comment, Ashley A. describes the comments made to her by her work colleagues after her miscarriage, how they impacted her emotionally, and how she changed her behaviour to cope with and avoid future comments: She writes:

> "I hear things like this all the time, more so from people at work. I've been told I need to get over it and move on, give up already it's obviously not meant to happen, focus on your job and do not show any emotion, how much more money are you going to waste on it, etc. Those are some of the worst things you can say to someone going through this loss. After my last pregnancy loss, 3 weeks ago I shut down. I communicate with people a lot less these days because I'm tired of the negative comments. Not everyone is negative but those comments weigh harder on you than the supportive ones."

Ashley A. asserts that these sentiments are hurtful to her and impact her ability to process and heal from the loss. Furthermore, Ashley A. identifies in her post that perceptions of pregnancy loss to "get over it" and that there is little or nothing to mourn are dominant in public consciousness, but that these perceptions can be unhelpful for

women trying to grieve their loss. Additionally, this comment alludes to the obligation women feel to perform "healing" which means they no longer talk about the loss. Of equal importance in these interactions is the reaction of others to the disclosure of pregnancy loss and how this shapes how the miscarriage is socially experienced. As Ashley A. highlights, death and grieving can be viewed as taboo topics which result in people avoiding social settings. The phrases Ashely A. has encountered are used to redirect the conversation when some women may actually want to make space for their lingering feelings of grief and sadness. In the case of multiple miscarriages or infertility women experience numerous cycles of grief; as a result, this form of redirection and social isolation may be intensified.

Alternatively, women who miscarry in subsequent pregnancies after giving birth to a child may also experience an ambiguous loss that is not validated or dignified in societal perceptions. This phenomenon is illustrated in a comment by Kim H.:

> "Going through my second miscarriage right now but it's ok according to some because I have a living child so it shouldn't matter. Nobody seems to care about the hole those loses have left in mine and my partner's souls. It's not that I'm ungrateful for the child I do have it's just that my family isn't complete"

This comment describes the disconnect experienced by women who miscarry after birthing children where their grief is deemed unnecessary or abnormal because they have already had a "successful pregnancy". Additionally, this comment highlights the process where women who miscarry and want more children are framed as greedy and ungrateful for the child(ren) they do have. As stated previously, the nature of miscarriage is framed

as an ambiguous loss because women did not parent their unborn child or "know them intimately". Furthermore, Kim H.'s comment depicts the social experience of pregnancy loss while parenting other children as comparative in nature which she deems as problematic. Instead, she asserts that her subsequent miscarriages were complex and painful because she could not make sense of losing pregnancies after birthing other children and wanted to "complete" her family.

Interestingly a comment by Kellie C. connects the text from the post to her experience of losing an infant postpartum, which demonstrates how grief and loss can be framed as acceptable or not in the context of miscarriage:

> "Even when its not a miscarriage people act like this, I lost my son at 13 days old and got told its not like you knew him for years why aren't you better by now."

In this comment the writer treats miscarriage and perinatal loss as two distinct experiences that are socially recognized, yet the social expectations surrounding grief are synonymous. The last words of the quote "why aren't you better by now" is an apt description of the norms around grief that permeate public discourse. As Kellie C. highlights, these norms are associated with timelines and circumstances in which grief is permitted. Kellie C.'s comment illuminates how pregnancy loss encompasses a variety of experiences that denote separated timelines of acceptable grief, and that these timelines are enacted within the social experience of miscarriage.

These comments By Kim H. and Kellie C. also allude to the social pressure women feel to "move on" from miscarriage and pregnancy loss and this often means getting pregnant again. As was demonstrated in the Facebook posts, it is an unchallenged

assumption that women should want to continue to try and have children following a loss. Furthermore, the concept of a "rainbow baby" or "rainbow pregnancy" is a socially recognized and celebrated event as it signifies the end of grief and that women have "moved on" from the loss. In comments by Sharon S. and Charlotte B. the text they produced reinforces these norms that women should want to keep trying until they achieve the family they desire. They write:

> "Never give up hope! I lost twins shortly after they were born. Try as long as you can and keep praying. I had five children after that." – Sharon S.
>
> "I lost two babies to miscarriage in my early twenties, but I found the strength to keep trying and I was blessed with three healthy children. If it happened to me it can happen to you too. The key is to relax and let it happen when its supposed to." – Charlotte B.

These comments demonstrate common sentiments surrounding miscarriage that women went on to have children following miscarriage and that these future pregnancies can offer support and hope for those viewing the page. However, the phrases "never give up hope" and "let it happen when it's supposed to" instill more of a silver lining approach to pregnancy loss as opposed to acknowledgement and validation of the current loss that other women proposed. These comments highlighted that when women disclose pregnancy loss they may be met with advice about what they should do or a story of a happy outcome rather than met with empathy and compassion. Through these women's posts the double bind that women experience following miscarriage where their private embodied account is contested through social interactions becomes visible.

Moreover, the concept of a "rainbow pregnancy" or "rainbow baby", a label given to subsequent pregnancies and children after miscarriage, emerged in posts as a socially recognized and celebrated event. A "rainbow pregnancy" may represent one's effort in wanting to become a mother, while also trigger grief and sadness stemming from the previous loss. In a comment by Liz G. she describes her experience of grieving her miscarriage in her subsequent pregnancy, she writes:

> "I had a little boy who was stillborn two years ago and it was by far the most devastating experience of my life. I cried non-stop for months and I still cry now. I was told by my family 'please keep trying, you deserve the family you want' and I still want a big family. I am now three months pregnant with another little boy, and I LOVE my rainbow baby but I still feel sad when I think of the baby boy I lost, wondering how things would have been different if he was here now"

This comment highlights the mixed emotions women experience in subsequent pregnancies following miscarriage. They may be excited and anticipating welcoming a new baby while also mourning the child they miscarried as milestones pass. Additionally, Liz G. alludes to the social pressure placed on women to try again following miscarriage and that they should want to try again. A comment by Michelle K. builds on this idea and describes her thinking process about "trying again" following her miscarriage, she writes:

> "This Mother's Day will be tough, I had a miscarriage about 7 months ago and both my boyfriend and I agreed to take some time before we think about trying again. To be honest I am scared to try again. But every time I have seen my family since then they ask me when we are going to try for another child. As if another

baby is supposed to fill some kind of void and then they will know that I am 'better' or that I am 'healed'".

The above quote highlights the social pressure for women to "try again" following miscarriage, often at the expense of grieving or making space to process the loss with loved ones. Interestingly, Michelle K.'s comment describes rainbow pregnancies as indicative of healing or women being "better" following pregnancy loss, which the Facebook group posts highlighted was not representative of women's experiences. It is possible that positioning rainbow pregnancies as healing or being better could be connected to the social taboo surrounding death and grief where socially acceptable timelines of grief are enacted through these sentiments of "moving on" or "healing". Additionally, within the social experience of miscarriage and as reflected in women's social media posts, women are performing "healing" or "moving on" by talking about, actively "trying again", and having subsequent children. Recognition of women's grief and making space for it was echoed in the posts and comments shared by women on the Facebook page as an aspect of their healing journey that was missing. For many women the healing journey following miscarriage begins within their interactions with their healthcare providers. The ways in which such providers handle grief can have a negative impact on women.

Interactions with Medical Professionals

The "Frankie's Light" post describes the different ways that miscarriage is known and experienced including women's private experiences of miscarriage and how the issue is understood through societal perceptions and norms. The post normalizes the celebration

of pregnancy through language denoting the existence of a “child” or “baby”. However, as the post outlines, these labels are suddenly erased for women when miscarriage occurs, and women interpret this erasure as dismissing their attachment to and the meaning they create from their experience of pregnancy. The author of the post highlights the tension that women encounter between the view of a fetus as equivalent to a baby that is growing inside their mother and how following miscarriage this view is dismissed and the child is not considered a “real” being that existed. Numerous comments shared in response to this post also addressed this tension between the private experience of pregnancy loss and societal perceptions. In a comment by Charley E. she addresses how these mixed messages shaped her experience:

> “Because the society we live in is screwed up and people think they know better. From the moment a baby is conceived they are growing, when they leave us and we lose our precious beings people think they’re nothing, because they didn't see the light we see. Never the less we will always love and cherish those baby(s) we have lost till the day we die”.

Charley E. is commenting on the connection that she developed with her unborn child women during pregnancy and how this bond was the source of immense sadness and grief when her miscarriage occurred. As Charley E. highlights this bond can extend for months and even years after miscarriage and she believes it deserves acknowledgment and validation. Charley E. also highlights how women contest societal perceptions about pregnancy loss through her own acknowledgment and validation of her grief and by using the term “baby” in her comment. The tensions between women’s views and experiences

of pregnancy loss and how miscarriage is known through societal perceptions and discourses became visible and evident when women described their interactions with medical professionals during the time of miscarriage. Leah J. and Kristielee H. describe their experiences with doctors who confirmed the loss:

> "I hated that. When I was pregnant with my 3rd baby, the doctor's kept calling it a baby. But when I had a miscarriage they started calling my baby 'excess tissue'. It was heartbreaking." – Leah J.

> "I can relate to this. When I had a miscarriage, I had a scan a week later and the guy was like, the tissues all gone. No that was my baby, acknowledge it."
> – Kristielee H.

Both selected comments highlight how women come up against the medicalization of miscarriage and how this is particularly salient in the spaces that women receive perinatal healthcare. Specifically, Leah J. stated that her doctors use of the words "excess tissue" to describe the loss was harmful to her after the pregnancy had been referred to as a "baby" up to that point. Both Leah J.'s and Kristielee H.'s comments resist the medicalized ways that miscarriage may be known and practiced by those working in healthcare spaces; these women insist that the "tissue" the doctors are referring to was their baby. Through their assertions, these women are acknowledging and validating their embodied experience and the bonding they experienced with their baby. Laura B. relayed a similar experience in her comment:

> "When I had to have a d&c to take away my baby because I wasn't miscarrying naturally, I was having contractions as they gave me a pill. The surgeon said

"wow she's in a lot of pain, maybe she's trying to expel something". I was thinking, something?? That's my baby."

Like the previous comments, Laura B. describes her surgeon's choice of words to describe her child as hurtful; again, arguing that her connection to her baby was erased throughout her experience in this medical setting. Moreover, all the selected comments demonstrate how women's interactions with medical professionals can shape women's experiences of miscarriage. These interactions and use of medical language such as "excess tissue" can have lasting effects with regard to how women feel about the care they received, as well as how they view their pregnant bodies and the loss of their pregnancy.

Constructing an enduring Maternal Identity

As mentioned previously the second post selected for this project uses an illustration by writer and artist Mari Andrew which has become a widely circulated image on social networking sites on Mother's Day. The image describes six distinct yet hidden experiences contesting the celebratory connotations of the holiday thereby making visible the loss of children and infertility. The comments and engagement with this widely circulated illustration highlighted the following themes: the loss of a desired and recognized maternal identity, the importance of memorializing the baby that was lost, and the pressure to "try again" until a "happy outcome" is achieved.

Building on the previous claim made by women that miscarriage is not widely considered a "real" loss by those in their familial, medical, and social networks due to the fact that women did not "know" or "parent" the child they lost, this logic also extends to

the categorization of motherhood. As reflected in the Facebook posts, women discussed how motherhood is known societally through the act of parenting live children, and having children signifies one's membership in the social group of "mothers". Women's posts also identified how those who miscarry and have no living children may not be socially recognized as mothers. For many women who participated in the Facebook page, Mother's Day was a milestone that signified the loss of a socially recognized maternal identity. A comment written by Kimberly M. addressed that lack of acknowledgement for her loss while also feeling obligated to celebrate Mother's Day with others:

> "I was just thinking about how nice it would be to be acknowledged as the mom I almost was, I have come to acknowledge that I am no longer meant to be a 'human's mom, just a fur mommy but it would have been nice to be acknowledged by my family, but instead, I planned a Mother's Day meal and cooked for my mom and for my sister's 1st Mother's Day."

As denoted in Kimberly M.'s post, she has not fully accepted a maternal identity and has put parameters around the label of 'mother' in the light of her pregnancy loss. Kimberly M.'s post exposes a tension that was present within the data where the idea of maternal identity was both reinforced and resisted amongst women through their own textual productions and in the ways that women supported each other on the Facebook Page. Kimberly M. states that she was "almost" a mom, signifying that when the pregnancy ended, she no longer aligned herself with the label of a "mother". This was an interesting point of contention within the data because other women did take up maternal identities that endured beyond miscarriage and were a source of reassurance, validation

and memorialization.

Women asserted maternal identities through their words of affirmation to others on the post, referring to themselves and others as “still mothers” to lost children. Women reinforced maternal identities by asserting that their experiences of pregnancy loss were real and valid, by referring to their pregnancies as their “babies”, “children”, and “little one’s” and by using images to memorialize the loss. The following exchange between three users depicts this tension between taking up and resisting a maternal identity:

> “Happy Mother’s Day to all.. this would have been my first year of being a mother but unfortunately lost my first and second baby last year.. my due date would be 5.20.20 and 8.28.20 but I lost mine.” – Milany B.
>
> “I'm so sorry! That pain is unbearable. You are still a momma to those sweet angels!” – Reply from Amber L.
>
> “Sorry Amber for your lost I thought maybe you would be better you can always try again”. Reply to Amber L. from Annette B.:

The first comment by Milany B. describes her reflections pertaining to the impact of Mother’s Day, stating that she would have been celebrating her first Mother’s Day prior to miscarriage. Although she does not explicitly reject the label of motherhood, she does not claim it or integrate it into her comment. Amber L. responds in a way that asserts that Milany B. is still a mother to the child she lost. This response is mostly likely intended to offer acknowledgement, support and reassurance during this time when motherhood is glorified and celebrated. Due to the nature of the online space I cannot

verify how this response was received, whether it was taken as supportive or as a way for others to impose their worldview onto the recipient. Amber L's reply alludes to memorialization of the loss as well as religious language and images that are often associated with miscarriage such as angels. Interestingly, Annette B's response is different from Amber L. where she states, "I thought maybe you would be better, you can always try again". This response highlights the pervasiveness of the social pressure to move on from miscarriage and try for another baby. Additionally, Annette B's comment alludes to socially acceptable forms of grief and the length of time women are afforded to mourn the loss. In terms of constructing a maternal identity after pregnancy loss, Annette B.'s response may be a demonstration of assurance and support that Amber L. can still become a mother. In this case, women assert the label of motherhood to offer continued hope to women who experience miscarriage; these assertions may be used to reinforce the importance of this identity as a goal and may be a tactic of supporting others who want to continue to try and have children.

Memorializing the loss of children using the image of an angel was a common practice in women's posts and offers insight into how women process the loss of their child. Offering support in this way, again demonstrates women's desire for acknowledgement regarding their loss and the grief they are experiencing. Additionally, a comment by Monica D. describes her process of attaching meaning to her loss through the construction of a heaven as a way to memorialize the child she lost and thereby reinforcing her maternal identity:

"People can be so insensitive to something they know nothing about! I lost 5

babies to miscarriage, and it doesn't matter if I lost them at 6 weeks or 11 weeks. They were growing inside of me. And even though they aren't born, they are alive in heaven and we will meet them some day." [crying emojis]

Although not all women used the image of an angel to memorialize their loss, it was common for women to imagine through their posts what their child would have looked like if they had survived. From my review of the Facebook posts, women seemed to find comfort and peace in constructing these images of a full grown "angelic" or perfect child that was unencumbered by connotations associated with death such as illness, or genetic/chromosomal abnormality. The images commonly used to memorialize pregnancy loss did not illuminate a universal approach to processing the loss, rather women's Facebook posts demonstrated the individual nature of the experience and how women wrestled with their maternal identities both in terms of resisting and reinforcing such an identity. Furthermore, the use of such language and imagery highlights the construction of a maternal identity that continues after miscarriage regardless of the age of gestation when the loss occurs. By constructing the mother and child relationship in this way as something that extends beyond societal perceptions of the physical world, a maternal identity allows for continued grief and memorialization to be integrated in women's daily lives.

In summation these three themes emerged from the data as salient experiences women wrote about using this online platform. The significance of women's experiences following miscarriage are just as important as those at the time of the event. Using a thematic analysis supported by feminist standpoint theory to uncover salient features

present in women's comments and exchanges of support, miscarriage was framed as a multi-layered embodied experience for women. Second, interactions with medical professionals were sources of pain for women because they were not acknowledged or validated by their providers, instead their baby was referred to as "excess tissue" or "products". Women resisted this medicalized language through their own disclosures and the words of support they offered to one another, asserting that they lost a "baby" and their grief deserves to be acknowledged. Third, women grapple with the idea of taking on a maternal identity following miscarriage, where some reassure both themselves and others that are mothers, while others resist this label describing motherhood as something they almost achieved. The following section discusses these finding in relationship to academic literature pertaining to constructions of fetal personhood within miscarriage care and the phenomenon of disenfranchised grief and its connection to pregnancy loss.

Chapter 6: Discussion and Conclusions

This research project sought to answer the following research questions; first, how do women describe their experiences of miscarriage and pregnancy loss using the "Miscarriage & Pregnancy Loss" Facebook page? And second, what can medical and social care professionals learn from the posts and comments created on the Facebook page to improve care for women? Through a thematic analysis of two Facebook posts and the engagement amongst women in the comments, three significant themes emerged in relation to women's experiences of miscarriage. Miscarriage has physical, emotional, psychological, and social implications for women and is an embodied experience. It is from these various dimensions of being that women create and attach meaning to their

experiences, shaping the ways in which women process the loss. Additionally, encounters with medical professionals hold significant weight for women who have miscarried, negative experiences leave women feeling isolated and their grief is minimized. Within their posts and comments on the Facebook page women addressed the language used by medical professionals to describe their loss. Language such as "excess tissue" and "products" was experienced as harmful by women who instead asserted that they lost a "baby" and this loss deserved acknowledgement. Furthermore, women engaging with the content and each other on the page grappled with the idea of maternal identity following miscarriage and pregnancy loss. For some they construct and implement an idea of motherhood that endures beyond the loss, and for others they reject this idea and frame motherhood as something they almost achieved.

These three themes answered my first research question as well as provided insight into how medical and social care can be improved for women experiencing pregnancy loss. In the following section I outline two concepts present in the data that if taken up by practitioners could help to improve care for women. Allowing space for women to share and imagine the person they lost via miscarriage acknowledges that the loss is real and validates the existence of a being to whom they were bonded. What women's posts illuminate is the importance of acknowledging fetal personhood for women who experience pregnancy loss. Incorporating the notion of fetal personhood when encountering women who have miscarried can include referring to the pregnancy as a "baby" and by a chosen name given by the family and offering women options to memorialize the baby they lost. Similarly, pregnancy loss and miscarriage are largely

framed as an ambiguous loss whereby social work and feminist literature pertaining to the topic is underdeveloped (Layne, 1997). Consequently, with this lack of attention to pregnancy loss and miscarriage in academic scholarship and in care that does not meet their needs, Doka's concept of disenfranchised grief provides a potential explanation for the social silence surrounding the topic which women alluded to in the data (Doka, 1989). By framing pregnancy loss as a source of disenfranchisement for women, practitioners can begin to interrogate their own assumptions and approaches to support and care. Furthermore, Bellhouse et al. (2019) cited insensitive comments and lack of information as key factors that impact women's experiences. Women were told repeatedly by professionals to "relax and everything will be fine" and "that severe stress can have negative ramifications for the pregnancy" (Bellhouse et al., 2019, p.141). Consequently, women internalized these comments from professionals and blamed themselves and their bodies for contributing to or causing the miscarriage to occur (Bellhouse et al. 2019). Women stated that they would have appreciated these professionals taking the time to inquire about their reproductive journey and answer their questions rather than make assumptions about how they would react to the loss (Bellhouse et al., 2019). In summation the concepts of memorialization, fetal personhood and disenfranchised grief emerged within the data and point to tangible ways in which women's voices on the Facebook page can inform practitioner's approaches to support and care for women both at the time of miscarriage and after.

Fetal Personhood and Memorialization

Feminist scholars have been reluctant to concede that embryos and fetuses are

equivalent to babies and children, therefore feminist discourse and theorizing has stagnated around the issue of pregnancy loss (Layne, 1997). Literature by Layne (1997) and Keane (2009) has urged others to adopt a view of personhood as constructed and negotiated, rather than inherent, thus resolving this tension. Layne (1997) and Keane's (2009) assertions enables the development of a feminist discourse of pregnancy loss. In constructing a concept of fetal personhood, scholarship acknowledges the significance and lasting impacts of miscarriage for women while also creating a pathway for research to build on or refute existing knowledge of the topic using women's voices and narratives (Keane, 2009; Layne, 1997). Scholars who utilize qualitative interviews to gather data, ground their insights in women's narratives, therefore they accept the participant's definition and construction of fetal personhood when describing their experience (Layne, 1997). Therefore, allowing space for women to construct their own ideas of fetal personhood is crucial to understanding women's experiences of pregnancy loss and miscarriage (Keane, 2009; Layne, 1997). Therefore, exploring the meanings associated with fetal personhood holds tremendous value in gaining a deeper understanding of the significance of pregnancy loss for individual women and across groups of women. Fetal personhood in the data commonly translated to participants referring to the pregnancy as their "baby", "child," or by a name they had chosen for them; not only did women view their pregnancies as human beings that they had lost, their pregnancy loss also represented the loss of maternal identity and halted dreams of family life (Keane, 2009).

Fetal personhood and memorialization can take on many forms in women lives and this was apparent in women's Facebook posts vis-à-vis comments from Charley E.,

Laura B., and Amber L. Within the literature the most common visual representations of miscarried babies are the images of angels and the use of ultrasound images (Keane, 2009). As reflected in earlier research women speak about these representations both as a purposeful choice for their own processing and healing from the loss or as imagery that is thrust upon them in the form of hospital resources, religious texts and online support spaces (Keane, 2009; Reagan, 2003). Women interviewed in studies by Gerber-Epstein, Leichentritt and Benyamini (2008), Adolfsson et al. (2004), and Gaudet et al. (2010) expressed that creating a way to memorialize the child they lost made the experience feel real and validated, allowing them to process their feelings of grief as their baby was seen as an actual material being. Similarly, Keane (2009) found that these angel and ultrasound images are widely circulated among internet support sites and campaigns. This was apparent in the imagery used by the creator of the Facebook page and this was also reflected in the comments and exchanges of support between women. According to Keane (2009), these images represent an accessible public discourse which has developed its own conventions and methods of constructing the "realness" of lost babies (p.155). Furthermore, pregnancy loss memorialization is framed by the ideology of "intensive mothering" prevalent in the current North American context. Intensive mothering rhetoric demands that mothers selflessly dedicate their time, energy, and love to their child, who is viewed as sacred and innocent (Keane, 2009 p.155). In pregnancy loss discourse, maternal love is presented even more powerfully as an unwavering force that transcends time and space (Keane, 2009 p.155). Keane (2009) argues that internet memorials allow mourners to express their emotions and their creativity; they are interactive productions

which may be permanently in progress. The author can represent the loss of a unique and irreplaceable child in a culturally relevant way. Keane (2009) argues that this is most commonly done by the "textual production of an idealized and conventional image of a gendered childhood" (p.159). In the present study this was demonstrated by women describing the child they lost using gender pronouns or referring to them as their son or daughter. Additionally, women also did this by crafting an image of an angelic child that represented their loss.

Alternatively, the angel and ultrasound images can impose a specific religious or political agenda that could negatively impact women's experiences of pregnancy loss; the use of these images could be presented as the "correct" or "proper" way to memorialize their loss and in doing so their grieving process is being dictated to them rather than dictated by them (Reagan, 2003). In an article by Reagan (2003), she examined how symbols of memorialization such as ultrasounds, angels, and baby footprints have political and religious implications when they are incorporated in hospital resources and literature for patients following pregnancy loss. Reagan (2003) suggests that today's pregnancy loss movement draws on both the pro-life and feminism movements to comprehend and define miscarriage, female emotion and motherhood. Social movements have given miscarriage a variety of meanings and used it as a symbol for several political projects. Reagan (2003) argues that the meanings of miscarriage has been historically and culturally constructed to align with these political projects. The most recent movement that shaped the meaning of miscarriage is the pro-life or anti-abortion movement. This movement constructs fetal personhood as beginning at conception and as having all rights

afforded to living persons (Layne, 1997; Wright, 2011). Additionally, these movements draw on religious texts that characterize unborn children as sacred, and those who die are seen as angels who live eternally in some form of "heaven" (Reagan, 2003). Consequently, these movements and religious texts have shaped the language used to describe fetal personhood and memorialization manifesting in hospital materials and online memorial campaigns (Keane, 2009), as well as within online social media spaces where women seek and provide support to each other. Lastly, the representations of angels and ultrasound images do not accurately characterize every woman's experience or chosen method of processing or memorializing the loss.

The concept of fetal personhood is important for medical and social care settings because it allows women to share the ways in which they are processing the loss and acknowledge the impact of miscarriage more generally. This allows healthcare providers and social workers to meet women where they are in their healing journey, allowing them the power to determine how they would like the pregnancy to be acknowledged in these spaces. This approach can help establish trust and rapport between providers and women and positively shape women's experiences seeking care and treatment following the loss. By making space for a construction of fetal personhood as women define it when providers encounter miscarriage, providers are validating women's embodied experiences and acknowledging the lasting impact of the loss. Furthermore, offering women opportunities to memorialize the loss provides them space to process the loss, assign it meaning, and grieve.

Disenfranchised Grief

As reflected in the chosen Facebook posts and comments there are many societal perceptions regarding pregnancy loss and miscarriage that women come up against in their daily lives, and this includes if, when, and how to grieve. The social and cultural constructions of miscarriage and its associated grief are heavily influenced by medical authority exerted over women's pregnancies, which assert that any complications or risks require medical solutions and monitoring. Furthermore, posts and comments on the Facebook page highlight the disconnect between the gestational age of the pregnancy, which is used by medical professionals to assess, diagnose and treat miscarriage, and the embodiment of pregnancy, miscarriage, grief and loss that women experiences physically and emotionally. Women integrate medicalized understandings of miscarriage into their descriptions of their experiences, comment on the impact of medicalized approaches, and assert their own view that sometimes resists a medicalized approach.

In the context of women supporting each other, or in familial and social networks another approach that may negatively impact women's experiences of miscarriage is the norm of offering advice or a success story after women disclose their experience. What emerged in the present study is that women want others to make space for their grief and meet them where they are in their healing process. In other words, the advice or success story may be well intentioned, however the language used can have a negative impact on women who are seeking support and validation following miscarriage. Furthermore, the sentiment of "relax and let it happen when its supposed to" discredits the reality of infertility that women may be facing and imposes that idea that there is a socially

constructed ideal “time” that pregnancy and raising children should happen for women. This idea troubles the concept of control that is integral to the women’s health movement discourse; women are often told that they should be in control of their bodies and their pregnancies. In the case of miscarriage, however, women must sometimes give up control in order to have a happy outcome.

Hazen (2003) asserts that the many complexities of reproduction and mothering; namely, pregnancy, fertility and infertility, miscarriage, and abortion amongst others are considered taboo due to the physicality, sexuality and emotionality which characterize these events. Fertility, pregnancy and birth are socially constructed as normative functions of the female body which are socially celebrated. When these processes are interrupted by infertility and pregnancy loss, these complexities are compounded and there is a social and public silence as to how women are to grieve the loss. The cloud of impenetrable silence that surrounds the phenomenon of pregnancy loss and miscarriage has been linked to Doka’s (1989) concept of disenfranchised grief as a means of uncovering the ways in which these losses are minimized or ignored. Doka (1989) defines disenfranchised grief as, “grief that persons experience when they incur a loss that is not, or cannot be openly acknowledged, publicly mourned, or socially supported” (p.4). Additionally, he suggested that grief can be disenfranchised when the relationship, the loss and the griever are not recognized. With respect to relationships, the assumption of closeness and its affordance of acceptable grief merely extends to spouses and immediate kin; unsuspected, past or secret relationships are not widely recognized or socially sanctioned as permissible. Disenfranchised relationships can include associations which

are well accepted in theory but not appreciated in practice or in instances such as parental attachment to a lost pregnancy. It is deemed socially acceptable for women to attach to their unborn children from the moment they learn they are pregnant; maternal bonding behaviours such as displaying sonogram photos, decorating a nursery, or referring to the pregnancy by a chosen name are examples of the ways in which women perform maternity and femininity. Furthermore, disenfranchisement arises from a failure or unwillingness on the part of society to recognized that miscarriage involves "real loss" of a "real being" that women and their families attached to and mourn (Hazen, 2003). In this process of societal rejection and stigmatization the disenfranchised griever must grapple with the socially sanctioned norms of grief and their embodied experiences associated with the loss. In the case of miscarriage, women's grief is ignored, actively denied, or minimized by society all while they are living with the physical implications of the loss. Women who miscarry can experience bleeding, pain, cramping, and fevers following the loss thus creating an embodied tension within themselves where their bodies are responding to a destabilizing and traumatic loss, while society actively discredits these experiences and their resulting grief. Hazen (2003) argues "grief is further disenfranchised when guilt, shame, negative social sanctions or secrets are attached to the loss" (p.149).

The tenets of disenfranchised grief were present in the current study through the comments and exchanges between women on the Facebook page. Women discussed the numerous insensitive comments spoken to them from those in their immediate environment. Women alluded to socially sanctioned norms of grief both in what they

expressed in their posts, and because they were both seeking out avenues of support outside of the traditional face-to-face norms and their immediate environments. In seeking out the Facebook page for support it indicates that their needs are not being met within their immediate environment, and that they experience pregnancy loss in ways that produce feelings of shame and other embodied reactions that are not widely acceptable to speak about openly.

The literature on disenfranchised grief has largely been connected to stillbirth and perinatal death, which have been characterized as ambiguous losses that stem from the dynamic between the psychological and emotional presence of an infant and their physical or material absence (Lang et al., 2011). Both Lang et al. (2011) and Garrod and Pascal (2019) suggest that this sense of ambiguity is experienced by women internally and socially following the loss, which contributes to the intensity of their grief. There is ambiguity about the viability of the pregnancy, about the physical process of losing the pregnancy, around the arrangements for the remains and in sharing the news of the loss. Overwhelmingly in the literature women assert they want answers to two fundamental questions following a miscarriage: first, what happened to the fetus? or what caused the loss?, and second, what does this mean for future pregnancies? (Bellhouse et al., 2019). Consequently, women are not always given adequate answers to these questions that are sensitive to their feelings of grief or in ways that acknowledge their suffering and their desire to honour and validate their unborn child's existence. Furthermore, Hazen (2003) posits that a sense of failure frequently pervades ambiguous losses such as stillbirth or perinatal death; negative social sanctions including pregnancy outside marriage, or the

termination of a pregnancy, uphold the silence surrounding pregnancy loss and allows shame, isolation and disenfranchisement to be compounded.

Moreover, pregnancy after a previous miscarriage is a largely accepted and celebrated life event that has been socially constructed as an active demonstration of "moving on" from the loss. Scholars, pregnancy loss awareness campaigns and online support networks have labelled this subsequent fetus a "rainbow baby" or "rainbow pregnancy" (Reagan, 2003; Rowlands & Lee, 2010). As demonstrated in comments by Liz G. and Michelle K., a rainbow pregnancy can include conflicting emotions as women are anticipating a new baby while also mourning their previous loss and navigating milestones on the way to becoming a mother. Additionally, pregnancies after previous losses may include norms surrounding expressions of grief and what forms of grief are deemed acceptable for women to engage in. In a study by Gaudet et al. (2010) the authors found that women reported that when a new pregnancy is announced it is expected that grieving miscarriage ends and the norms of bonding and attachment to the current pregnancy are rewarded and expected. The quote by Liz G.in the current study along with the work of Gaudet et al. (2010) illustrate the socially acceptable and recognizable timelines for grief following miscarriage, which are often tied to the expectation of "moving on" and "trying again"; in this process the impact of the loss is discredited and minimized as not "real" because women did not "know" or get to "parent" their child. Furthermore, the implication is that grief has no place in subsequent pregnancies because it takes away from the immersive experience of bonding to and parenting future children (Gaudet et al., 2010). These norms were both reinforced and contested in the text and

comments on the "Miscarriage & Pregnancy Loss" Facebook page and produced themes that addressed the harmful norms surrounding pregnancy loss as well as gave voice to women's experiences. Women asserted the importance of acknowledging miscarriage as the loss of a "real" being that they are bonded to and validating their feelings of sadness and grief regardless of the gestational age at which the pregnancy was lost. Furthermore, through their comment's women described pregnancy loss as an embodied experience that involves suffering on multiple levels and the loss of their maternal identity which deserves recognition.

As was reflected in women's Facebook posts and has been illuminated through previous research, women have adopted language of "moving on" to describe their experiences and disclose their previous loss or losses. Although publicly "rainbow pregnancies" are framed and celebrated as a way for women to move on from their previous loss and succeed in building the family they desire, privately this experience can be vastly different from the normative presentations of joy, celebration and moving on (Garrod & Pascal, 2019). Following pregnancy loss, women are told variations of the sentiments; "you will have another baby", "don't give up hope", "you can try again", and "it will happen when its supposed to"; these phrases exemplify the ways in which grief is minimized or ignored leading to disenfranchisement. These sentiments along with copious others reveal entrenched discourses working to eradicate grief by performing continued reproduction, signaling the end of grief and refocusing attention on one's ability to bear children. Again, this emphasis on "happy endings" or "happy outcomes" is echoed in the women's health movement which emphasizes women reclaiming control

over their pregnancies and birth outcomes (Layne, 2003). In this process of reclaiming control, pregnancy loss is framed as within the realm of individual control and responsibility. As a result, grief is minimized and the continued bond with the lost pregnancy is ignored. Garrod and Pascal (2019) examine these complexities within the paradox of a seemingly celebratory life event, amidst still grieving the previous loss. These authors found women experience overwhelming feelings of anxiety and fear embarking on the journey of pregnancy following a loss and these feelings are heightened at significant milestones in the current pregnancy (Garrod & Pascal, 2019). The authors found that following a pregnancy loss woman reported overwhelming feelings of isolation and exclusion. Women spoke of a lack of social validation for the enormity of their loss, with the expectation that time allowed for grieving was finite before they were expected to "move on" with their lives (Garrod & Pascal, 2019). Additionally, women's feelings of isolation were exacerbated by a "wall of silence", fueling their experience of disenfranchised grief (p.11). Family and friends appeared uncomfortable talking about the loss or seeing mementoes (footprints, handprints, photos); thus, what had been public through the announcement and celebration of impending pregnancy had reverted back to the private arena (Garrod & Pascal, 2019). Garrod and Pascal (2019) argue that the significance of the loss in these circumstances is often missed, with the focus on the potentially life-threatening situation the woman has just been through (and not the pregnancy that has been lost), or the perceived "choice" that the woman made to voluntarily end her pregnancy. Moreover, when another pregnancy is announced, it is as if society exhales a collective sigh of relief, as it appears that the woman is moving on

and has come to terms with her previous loss. Therefore, Doka's concept of disenfranchised grief should extend to all pregnancy losses regardless of gestational stage. Utilizing this concept can allow for scholars and practitioners to reform current approaches to care that perpetuate these discourses about grief which fuel the silence surrounding miscarriage. Disenfranchised grief can provide direction for both future research on the topic of miscarriage and strategies for social workers to improve approaches to care that are more person-centered and catered to women's needs.

Limitations

Reflecting back on the process of completing this research project, I think that I was able to contribute some important insights regarding the ways in which women talk about their experiences and what this means for miscarriage and pregnancy loss care. However, I recognize that this research is limited in several ways, the most prominent to me being timing and a smaller dataset I chose to analyze. Initially when I began thinking about how to research this topic and what I wanted to know about it, I thought about doing something arts-based where women could create an original work of some kind, to depict the salient elements of their experiences. As the year progressed and I had other commitments that I had to balance my time with, I found this approach too daunting and decided to explore alternatives to collecting data without having to obtain ethical clearance from the university. At that point I decided to try a critical discourse analysis (CDA) to meet these goals. Over the next few months, I struggled to teach myself how to conduct a CDA and frame my study in a way that aligned with this methodology. I felt that each time I thought or understood or mastered some aspect of the process, I was

wrong or was not fully grasping how my topic aligned with the methodology. In the process of editing and discussing my project with my supervisor, I had to reflect on what I wanted to contribute to the McMaster School of social work, which I did not think I could accomplish with a CDA. Looking at what I had already written and the timeline I had left I decided it would be best to alter my chosen methodology from a CDA to a Thematic Analysis of the text and comments on the Facebook page. Consequently, my final weeks before submission consisted of starting the process of analysis over again to ensure I was creating a cohesive story, re-writing sections of the project that were no longer applicable and writing sections that were still outstanding. In this condensed time my singular focus was meeting my deadlines, therefore some aspects of the analysis and writing process were rushed. In this process, I focused on the main themes and features of the data that answered my research questions and that I had discussed with my supervisor, therefore some other interesting key features, or themes may have been overlooked or may have not been fully fleshed out. This included some of the key features of the data related to the social experience of miscarriage including social pressure from friends and family to move on from the loss or the ways in which their expressions of grief are rejected in their daily lives. Moreover, since I only selected two posts and their comments, the data is limited to themes produced and reinforced in these sources. Furthermore, with a limited dataset, I limited the number and potential breadth of comments and insights women could express on the subject. I chose the posts based on their level of engagement with users and temporality. At the time of data collection I was looking for posts that represented both what women were actually saying about

pregnancy loss outside of what has been written about them or for them by the medical community as well as how their posts represented the current state of medical and social care. Therefore, I selected two items that were posted within the last six months. Again, this restricted the depth and breadth of the process of analysis and the potential for generalizability. In terms of content, I think my focus on the medicalized aspects of pregnancy loss (solutions, terminology and interactions with professionals), although it is useful, may have taken focus away from other themes that could have been given more attention that captured aspects of the experience that may be underdeveloped or minimized in academia. For example, an alternative theme presented in the data and relevant literature that is underdeveloped is the importance of healthcare providers making space for understanding women's reproductive journeys when encountering miscarriage. Exploring how women feel about motherhood and previous experiences of pregnancy is valuable information for medical professionals and social workers who care for women at the time of miscarriage and is a way to make space for and individualize women's care experiences. Additionally, present in the data were examples of how women's expressions of grief were rejected by those in their environment, thus alluding to a hierarchy of acceptable grief behaviours that in many ways are based on the gestational age of the pregnancy. More specifically, Facebook page users commented that women who had a stillbirth were afforded more time to openly grieve than those who miscarried during their first trimester. Lastly, in giving more attention to the numerous examples of harmful statements women cited within the text I could have potentially created a focused list of "things not to say" either as a care provider, friend or family

member looking to support someone who has miscarried and proposed a strategy for meeting women's needs that was grounded in the data. These alternative themes could have provided interesting insights into the ways in which social work practice is underdeveloped in its approach to miscarriage and pregnancy loss and offered some strategies for practitioners who encounter it in the field.

Another factor impacting the generalizability and transferability of the analysis is the online space itself. Facebook is a global social networking site, although women are aware that their comments and disclosures are made public on the page, I had no way of knowing where these women live or the particular healthcare and social care systems they are interacting with in their daily lives. Additionally, ethically I could not contact the women to clarify any personal information or inquire about where they live, or their socioeconomic status. In one vein, this was potentially beneficial as women whose voices are silenced by the systems they interact with in their daily life, are given the opportunity to tell their story. However, I had no way of verifying if these women were marginalized by existing systems due to factors such as race, ability, gender-identity and/or sexuality. Therefore, the comments on the selected posts may only represent a specific subset of women's voices and may not be applicable to all women who miscarry.

The present study is limited to my own subjectivity as the researcher, whereby I am not an objective interpreter of the data. Through the stages of analysis, the data as well as my own interpretation of the text was driving the inferences and defining the interesting features of the data. Additionally, being a person who has not experienced miscarriage or pregnancy loss I was interpreting the data from that worldview. Also, my

social location as a white, cisgender, heterosexual, able-bodied woman influenced the process of organizing and interpreting the data which limited the themes and insights I generated. Furthermore, I chose to analyze textual productions rather than do interviews with women who have miscarried, therefore I did not directly ask women questions pertaining to their experience or have the opportunity to ask them clarifying questions about the intentions behind their comments. Again, this limited the insights and interpretations I made from the data during the thematic analysis.

I think my analysis was limited because I did not look at the interplay between multiple identities that women who miscarried can hold, I treated miscarriage as an overall identity and experience of potential oppression and marginalization. I did not focus on the experiences of marginalized women who miscarry, which could have yielded important and nuanced insights into how their experiences are unique. Racialized women, Indigenous women, queer women, older women, and women experiencing disabilities all have unique stories pertaining to miscarriage and pregnancy loss that may differ from normative constructions. This is a product of existing power structures that may have been present within the Facebook page where marginalized women avoid engaging in these spaces for fear of scrutiny and further rejection. Therefore, the analysis of the utility of engaging with the content on the page and exchanges of support between women is limited as it may not represent voices of marginalized women or be representative of all of the women who view the content on the page. Lastly, I think my research is more exploratory in nature, describing salient elements of women's experiences of miscarriage and pregnancy loss. My research provides evidence of the utility of online resources and

support networks for women to share their experiences, to be validated and bolstered by other women who share the same experience. Consequently, it does not provide concrete strategies for health and social care providers to improve their care and treatment of women; instead, my project may provide practitioners food for thought which they can interpret and integrate into their various practices or point towards areas for further research.

Implications for Social Work

My research project provides social workers some exploratory knowledge of how women describe their experiences of miscarriage and pregnancy loss and how online resources and platforms can be beneficial for women. Additionally, this project provides opportunities for practitioners to interrogate their own assumptions about miscarriage and how they have approached it with service users and offers new perspectives that is grounded in women's voices. In completing this project, I recognize the need for more attention to be paid to furthering miscarriage and pregnancy loss research in the field of social sciences and more specifically social work to address inequalities in the quality of medical and social care women receive around the world. More specifically, social work research needs to interrogate existing approaches to grief and loss and challenge their applicability to miscarriage to create resources for practitioners to improve their skills and understanding of the impact of pregnancy loss for women.

In terms of direct practice with women, miscarriage and pregnancy loss can be a traumatic experience for many women that can extend months and years after the loss occurs, therefore it needs to be met with empathy and compassion. Furthermore, this

experience can become part of women's identity and deserves to be acknowledged and validated in medical and social care spaces. I think both medical and social care providers need to make space for women's the constructions and meanings that women ascribe to miscarriage; in order to build rapport with service users, social workers must meet them where they are at in their reproductive journeys. This lack of consideration for women's own private relationship to the pregnancy and the construction of their unborn child has harmful impacts for women who miscarry. Minimizing and dismissing the significance of this bond and attachment, leaves women feeling isolated and may intensify grief and loss following miscarriage. Furthermore, the meanings that women construct about their loss can vary between women who take up a realized idea of fetal personhood and motherhood and those who do not or actively resist these constructions. Through this practice women's voices are dismissed and they are left with the remnants of the liminal space between childlessness and motherhood. Put another way, the vestiges of the social norms associated with pregnancy such as bonding and attaching to a "baby" are not erased at the time that a woman miscarries and/or the child is removed from her body. Rather, women argue this attachment persists and warrants public attention, empathy and validation. In acknowledging the presence of a "real" being that is being mourned, women who have miscarried are included in the public conversation in how we understand the experience of pregnancy loss. These exchanges illustrate how women use online spaces such as Facebook to resist the medical terminologies that discredits the existence of a baby that they are mourning, and to assert that their experience is valid and deserve recognition. Even women who are passively viewing the content on the page can

draw on these words of reassurance from others for support and validation and support that their experience was meaningful and is worthy of attention. Regardless of how women take up these constructions following miscarriage, social workers should respect these perspectives and take the time to explore women's reproductive journeys in a way that honours their voices and boundaries.

Now that Bill 141 has been passed into law and the PAIL network has created resources for practitioners and women, we are beginning to see shifts in the public taboo and silence surrounding the issue, however I think that women need more than reassurance that miscarriage is a common phenomenon. I propose that the current medicalization of pregnancy loss frames the experience as primarily a physical experience, thereby discounting the emotional and social implications of the loss. I think that social work can help fill in the gaps in medical and social care settings, offering women timely, ongoing and accessible services and opportunities to memorialize the loss. Again, social workers must interrogate their own biases regarding the issue and reflect on the ways in which they (and other helping professions) contribute to and reinforce harmful ideas about the legitimacy of grief following miscarriage. Moreover, I think this project points towards potential growth in the utility of designing and implementing online resources that women can access if they believe it to be the best option for them, or if their immediate environment is not meeting their needs. Online resources and support networks provide an accessible and cost-effective alternative to in-person services that may be harmful for women. In expanding the ways in which social work conceptualizes both the impact of miscarriage and how best to support women, we can engage in a

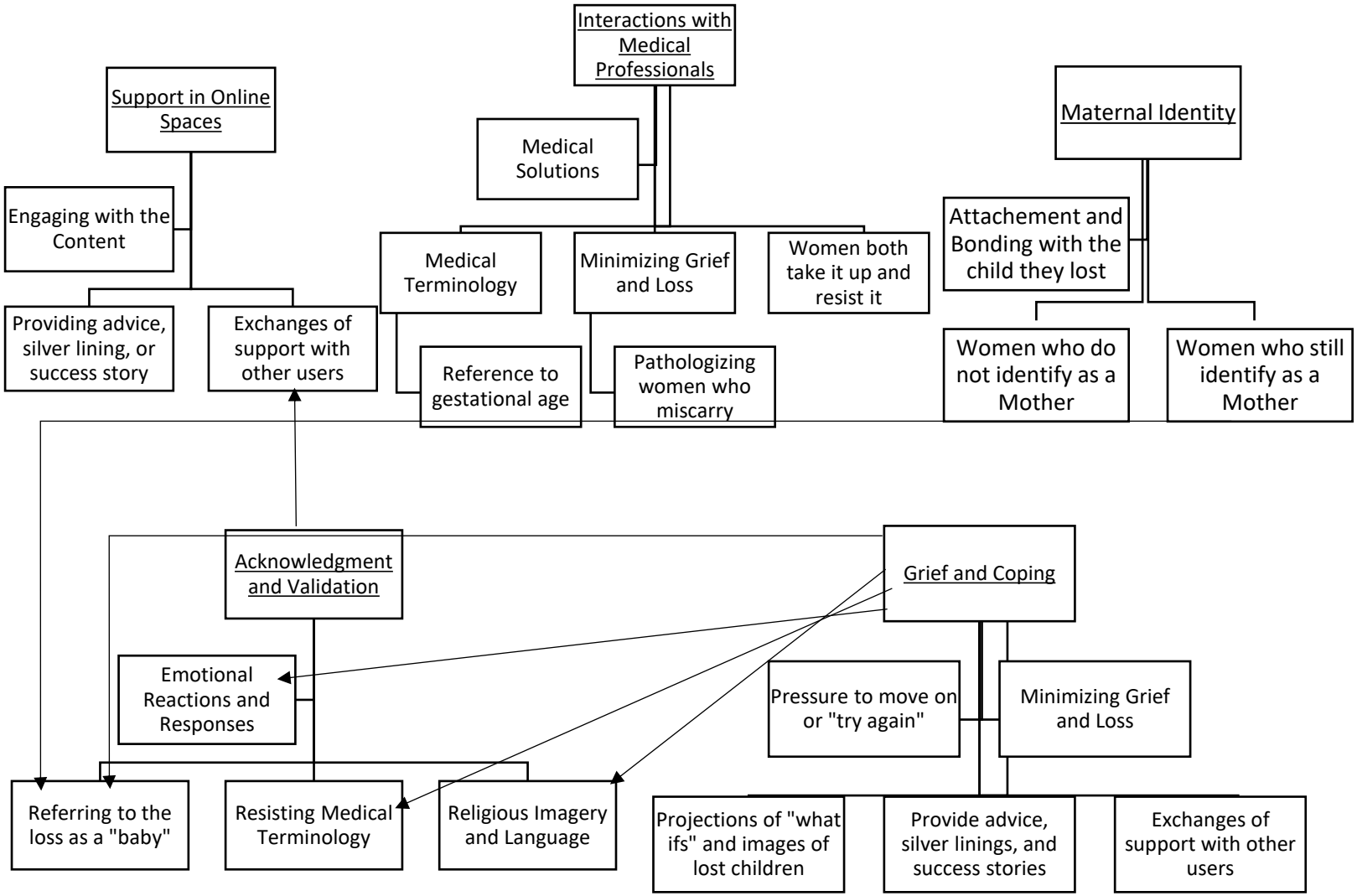
process of unlearning and integrating what women are actually saying about their experiences to improve care and opportunities for support.

Conclusions

This research project highlights three key themes in relation to how women describe their experiences of miscarriage and pregnancy loss through which insights into the utility of online support spaces are offered. Using a thematic analysis supported by feminist standpoint theory to uncover salient features present in women's comments and exchanges of support, miscarriage was framed as a multi-layered embodied experience for women. Second, interactions with medical professionals were sources of pain for women because their pregnancy loss was not always acknowledged or validated by their providers; instead their baby was referred to as "excess tissue" or "products". Women resisted this medicalized language through their own disclosures and the words of support they offered to one another asserting that they lost a "baby" and that their grief deserves to be acknowledged. Third, women grappled with the idea of taking on a maternal identity following miscarriage. Some reassured themselves and others that they are mothers, while others resisted this label describing motherhood as something they almost achieved. Additionally, within the comments on the Facebook page, women wrote about the harmful ideas and assumptions that are commonly held and perpetuated about grieving pregnancy loss and how this online space made them feel supported and connected to a larger community of women who have miscarried. Furthermore, this research points to existing gaps in research and social work practice that do not address the specific needs of women experiencing miscarriage and pregnancy loss in medical and

social care spaces. My hope is that I can take what I have learned from this research and apply it to my clinical practice and that other social work students find my work useful and informative for their own work.

Appendix 1: Thematic Map



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