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BREAKING THE SILENCE: EXPLORING THE IMPACT  
OF PREGNANCY LOSS ON WOMEN WHO DELAYED  
CHILDBIRTH AND REMAIN CHILDLESS

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of Master of Arts (Clinical Counselling) in part fulfilment of the  
Modular Programme in Clinical Counselling.

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## **Abstract**

Pregnancy loss and involuntary childlessness have long been recognised as having potentially devastating impacts on women who desire to be biological mothers. Despite the existence of a number of studies in these areas, no research has been undertaken which explores the relationship between postponing pregnancy, pregnancy loss and childlessness. This phenomenological study explores the lived experience of six women who underwent pregnancy loss at an advanced maternal age and remain childless. The findings illustrate the multiple losses that result, not only is there a loss of a hoped for child but also of an expected, anticipated future. The study explores how women experienced these painful processes as deeply isolating, how they impacted on their sense of self and how they struggled to rewrite a new future. The research demonstrates the continuing silence surrounding pregnancy loss and involuntary childlessness and highlights the fundamental importance of acknowledging the immediate pain and the lingering sadness associated with being childless. It contributes to an understanding of the multiple losses experienced and in doing so, hopes to raise awareness in counsellors of the depth of the existential crisis and the need for the multiple losses to be acknowledged and validated.

## Declaration

This work is original and has not been submitted previously in support of any qualification or course.

Signed

Amanda Sives

November 2014

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Finally, I would like to thank the six amazing women who had the courage to respond positively to my call for participants. I was privileged to meet you, to hear your stories and to share some time with you. I hope you feel this dissertation captures your experiences.

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## Chapter 1. Introduction

“And looking back now it is striking how much silence there was”.

Sylvia [343.21]

### 1.1. Background

Pregnancy loss has long been recognised as having potentially devastating impacts on women who desire to be biological mothers (Brier, 2008). In recent years, infertility and involuntary childlessness have likewise been investigated and have been found to have a profound effect on women’s identities and sense of purpose: the repercussions have been argued to be life-long (Black & Scull, 2005; Daniluk, 1996; Wirtberg, Moller, Hogstrom, Tronstad, & Lalos, 2007). In addition, the higher age at which women have their first child has led to a growing interest in the reasons behind delayed parenthood (Tough, Tofflemore, Benzies, Fraser-Lee, & Newburn-Cook, 2007). Despite the existence of a number of studies in these areas, no research has been undertaken which explores the relationship between the three issues. Given recent figures highlight that one in five women in the UK are childless at aged 45 compared to one in nine in 1946, it is clear that research is required to explore those experiences of childlessness (ONS, 2013). Whilst not all of these women will be involuntary childless, a significant number will have faced the pain of pregnancy loss, have not fulfilled their desire to be a biological mother and a growing number will have delayed childbirth until a later stage in life. Given that no specific research has been undertaken into the multiple losses experienced by this group of women, the study will provide a valuable insight into the range and depth of emotional impacts of postponing pregnancy, pregnancy loss and involuntary childlessness, thereby facilitating a deeper understanding among the counselling community.

The central focus of this dissertation is the impact of loss and whilst it is not the aim of the work to explore grief, it is important to highlight the specific nature of grief arising from pregnancy loss and involuntary childlessness. Whilst earlier studies of childlessness tended to draw on traditional models of

bereavement (Houghton & Houghton, 1984; Monach, 1993), later studies have focused on the particular nature of grieving as “although the loss of an adult loved one is painful and sad, the loss of a longed for pregnancy is unique and needs to be recognised as such” (Jaffe & Diamond, 2011, p. 91). For the purposes of the discussion, grief surrounding pregnancy loss and involuntary childlessness will be assumed to be disenfranchised, defined by Doka as: “the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported”(Doka, 1989, p. 4).

## **1.2. Rationale**

The rationale for undertaking this study was personal and academic. At the age of 40, having found the right partner and feeling the time was finally right, I decided I would like to have a child. Six months later, we were overjoyed to be pregnant. Nine weeks later, I miscarried. It was a total shock but at the time I felt quite optimistic: we had managed to conceive once so it should be possible for it to happen again. It took eight fraught months. At the 12 week scan, having already had two “reassurance” scans at the early pregnancy unit, the baby was found to have a severe abnormality and a termination was strongly recommended. This was the final time I conceived. The sense of loss was immense and impacted on all aspects of my self. For the most part, the pain was hidden from view. The sense that nobody else could really understand my loss silenced me for a long time. Gradually, with the help and support of my husband, of my therapist and through my own determination not to be defined by my grief, I was able to move forward. The experience, however, left a significant imprint on me along with a desire to break the silence that continues to surround the double pain of pregnancy loss and childlessness, particularly as it relates to the experience of women, who through circumstance or choice, delay starting their family.

### **1.3. Aims and Objectives**

The aim of the study is to explore the impact of pregnancy loss(es) amongst a particular cohort of women: namely those who are childless and who experienced the loss(es) towards the end of their fertility. It seeks to examine the extent to which women consciously delayed their pregnancies, which the literature appears to suggest is the case, and whether there are additional emotional impacts connected to these earlier choices when grieving the loss of biological children and motherhood.

A key objective of the work is to provide space for the hidden losses to be heard and to be understood by others. Pregnancy loss and involuntary childlessness continue to be taboo subjects: social embarrassment, misunderstanding and inappropriate 'trying to be helpful' comments are common responses. In shedding light on the experience, through a small-scale phenomenological project, through the voices of six women who also seek to enhance awareness, I hope the profound destabilising impact it can have will be better understood.

### **1.4. Overview of the Dissertation**

The research question guiding the dissertation is:

How do women experience pregnancy loss at the end of their fertility in the context of delaying starting a family and their current childless status?

Chapter one has explored the rationale, aims and objectives of the research. It is followed in chapter two by an exploration of the available literature on postponing pregnancy, pregnancy loss and involuntary childlessness. Chapter three explores the methodology underpinning the study. In chapter four, the findings are presented and this is followed, in chapter five, by a discussion of those findings in the context of the literature. Chapter six presents a short conclusion and suggestions for further research.

## **Chapter Two. Literature Review**

### **2.1. Introduction**

The research question guiding this thesis requires a review of three inter-related groups of literature: postponing childbirth, pregnancy loss and involuntary childlessness. Given the limitations of space, each of these three areas will be briefly reviewed with a specific focus on the most relevant studies<sup>1</sup>. As the review will highlight, whilst there are a multitude of studies on pregnancy loss and a growing literature on childlessness and postponing childbirth, there is no research which focuses on the impact of all three together.

### **2.2. Postponing Childbirth**

Studies focusing on the delay in childbirth have been expanding in recent years, reflecting, no doubt, the higher age at which women in western societies give birth to their first child. According to the Office for National Statistics, the average age for first birth in the UK in 2013 was 30 (ONS, 2014). In addition, women over 30 gave birth to 46% of babies in 2006 compared to 30% in 1986 “illustrating the postponement of childbirth” (Tromans, Natamba, Jeffries, & Norman, 2008, p. 9).

Education and employment have been identified as the most significant factors delaying childbirth in a number of quantitative studies. These assume women make conscious choices about their fertility and they do this in the context of wider employment opportunities and changing gender roles. In this altered social environment, postponing childbearing in order to complete a higher education and forge a career has been widely acknowledged to be significant in explaining the higher age first birth rate: although there is some disagreement about which is more significant. Wu and MacNeill conclude “our

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<sup>1</sup> The search history can be found in appendix two.

findings suggest that work is the dominant determinant of older motherhood.” (Wu & MacNeill, 2002, p. 209). In contrast, another study noted that the higher age first birth rate is a result of “progressively later average ages at completing education” (Bhrolchain & Beaujouan, 2012, p. 322). Research which focused on the influences impacting the timing of motherhood undertaken with women between the ages of 18 and 50 also underlined the importance of education and work: “Most women described a life plan that included establishing independence through postsecondary education and a career, and then starting a family”(Benzies et al., 2006, p. 630).

Research analysing the impact of education and work on childbirth tends to operate under the assumption that women have both a sufficient level of knowledge about their fertility and control over their reproductive capacity. Recent studies in Canada and the UK, however, demonstrate that men and women lack sufficient knowledge about fertility decline and assisted reproductive technology to make informed choices (Daniluk & Koert, 2013; Maheshwari, Porter, Shetty, & Bhattacharya, 2008; Tough et al., 2007). In addition, in terms of control over fertility, whilst it is the case that women have more access to contraception and fertility treatment than ever before, this does not guarantee successful childbirth. A recent qualitative study has demonstrated that “women rarely make a conscious choice to delay pregnancy” and that women felt “that timing of childbearing depended on a complex interplay of factors which were outside of their control, such as relationship, health and fertility” (Cooke, Mills, & Lavender, 2012, p. 36).

There appears to be a dearth of literature about other factors which might lead to a delay in childbirth: one area which has been identified has been finding the right partner. In a survey of childless men and women who intended to have a child in the future, partner suitability was among the top four issues identified as significant in the decision-making process (Tough et al., 2007, p. 190). In a highly significant study of high-achieving career women in the United States, Hewlett draws attention to the difficulty of finding a partner with whom to have a child when a woman works in a high pressured and competitive environment (Hewlett, 2003). More recently, a qualitative study

has explored the lived experience of women who delayed childbirth and their findings suggested that “the biggest influence on childbearing decisions was the need to have the right partner” (Cooke et al., 2012, p. 34). This is the only study that could be located that looked at the specific experience of women who had delayed childbirth in the UK.

This brief review of the literature on postponing pregnancy has demonstrated the dominance of a discourse around the impact of education and career as the main factors influencing the timing of motherhood. The studies have been primarily quantitative in thrust and tended to assume that women have control over their reproductive process. This likely reflects the level of control that women perceive themselves to have, but as the research findings of a number of studies demonstrate, there is poor knowledge amongst women and men about fertility decline and the potential complications of advanced maternal age. There is only one study, qualitative in nature, which highlights the extent to which women who had delayed pregnancy felt that their level of control was illusory.

### **2.3. Pregnancy Loss**

Since a ground-breaking study by Kennell et al in 1970, there has been a plethora of studies undertaken into the impact of pregnancy loss (cited in Dick & Wimpenny, 2012, p. 161). They have ranged from examining the nature and length of grief, factors explaining the incidence of depression and anxiety and post-traumatic stress disorder (Badenhorst & Hughes, 2007; Engelhard, Hout, & Arntz, 2001; Kersting & Wagner, 2012; Leff, 1987; Lok & Neugebauer, 2007; Moulder, 1998; Neugebauer & Ritsher, 2005). Other studies have focused on specific cohorts, such as African-American women (Van & Meleis, 2003), adolescents (Tonelli, 2006), and male partners (Korenromp et al., 2005; McCreight, 2004). In addition, there are studies that compare the impact of different forms of pregnancy loss (Iles & Gath, 1993; Keefe-Cooperman, 2004-2005; Kersting et al., 2005), pregnancy following previous pregnancy loss (Franche & Bulow, 1999; Geller, Kerns, & Klier, 2004;

Petersen, 1994) and studies which focus on the long-term impact of infertility (Wirtberg et al., 2007).

These studies have been primarily quantitative in nature, used large cohort groups and a number of measurement scales including specifically designed ones such as the Perinatal Grief Scale, the Perinatal Bereavement Grief Scale and the Perinatal Grief Intensity Scale (Brier, 2008). The quantitative studies have tended to focus on exploring the factors which are more likely to lead to complicated grief, anxiety, depression or traumatic symptoms following a pregnancy loss (Neugebauer & Ritsher, 2005; Schwerdtfeger & Shreffler, 2009; Shreffler, Greil, & McQuillan, 2011) These have been complimented by a smaller number of qualitative studies which have used a variety of appropriate methods, such as the grounded theory approach (Van, 2012-2013) and Interpretative Phenomenological Analysis (Maker & Ogden, 2003). These studies, as expected from a qualitative approach, have focused on a much smaller cohort group and tended to explore the perceptions and meanings of pregnancy loss as well as the coping strategies developed to manage the level of grief (Corbet-Owen, 2003; Hazen, 2003; Manca & Bass, 1991). There are no studies which explore delay, pregnancy loss and childlessness.

Whilst none of the published material explores delay, maternal age and childlessness are mentioned in research exploring the short and longer-term impact of pregnancy loss. When maternal age has been factored into quantitative and qualitative studies, it has generally been found to be an insignificant element when assessing the propensity to suffer long-term consequences of pregnancy loss (Neugebauer et al., 1992). Indeed, Mann et al argue, based on their quantitative study, that “increasing age was protective against both depressive symptoms and grief. Perhaps greater maturity is associated with more effective coping skills” (Mann, McKeown, Bacon, Vesselinov, & Bush, 2008, p. 277). Yet research by Swanson contradicts this, “the lack of association between maternal age and emotional strength would suggest that the tendency to view oneself as emotionally resourceful is not associated with chronological age” (Swanson, 2000, p. 202). She notes from

her clinical observations that “although a sense of loss is not tied to age, the experiences of threat or challenge or both are greater for older women who fear that their childbearing options are diminishing” (Swanson, 2000, p. 195).

Where previous studies do show a convergence, it is in the extent to which childlessness has an adverse impact on grief and depression following a miscarriage. Schwerdtfeger and Shreffler found that “women who have the dual experience of pregnancy loss and childlessness have the most fertility-related distress”(Schwerdtfeger & Shreffler, 2009, p. 222). In a study by Stirtzinger, which examined the levels of grief of 175 women one year after a miscarriage, “women with no living children and over thirty years of age showed the most depressive symptomatology” (Stirtzinger, Robinson, Stewart, & Ravelski, 1999-2000, p. 242). A study by Kersting and Wagner exploring complicated grief following a perinatal loss concurred with this finding, “childless women who suffer a miscarriage have significantly higher levels of grief than women who have children” (Kersting & Wagner, 2012, p. 189). This finding is supported in additional studies (Franche & Bulow, 1999; Friedman & Gath, 1989; Maker & Ogden, 2003; Neugebauer et al., 1992).

The range of research which explores pregnancy loss originates from a variety of different sources: primarily medical and therapeutic. It covers a vast array of related subject matter and uses both quantitative and qualitative methods. Given the limitations of space I have concentrated on those studies which have directly addressed the parameters of this research, namely the impacts of maternal age and childlessness on grief following pregnancy loss. Maternal age is not seen to be significant except in one study whereas childlessness is recognised as an important predictor of prolonged grief. No previous studies have discussed the impact of postponing childbirth.



## 2.4. Involuntary Childlessness<sup>2</sup>

There is a vast range of publications exploring the experience of involuntary childlessness. In the vast majority of cases, these studies are qualitative as they seek to explore the meanings attributed to childlessness. The studies can be sub-divided into those which focus on both infertility and involuntary childlessness and include the reasons why it occurs, the type and nature of medical interventions, the impact of childlessness and how to cope (Cooper & Glazer, 1994; Daniluk, 2001; Menning, 1988; Monach, 1993; Pfeffer & Woollett, 1983). Other studies focus more specifically on the experience of involuntary childlessness (Anton, 1992; Black & Scull, 2005; Cooper-Hilbert, 1998; Houghton & Houghton, 1984). Given the constraints of space, this review will focus on four of the key themes which emerge in the literature: the multi-layered nature of the loss, grieving, identity and adaptation.

Experiencing involuntary childlessness is multi-layered and complex: it is not only about the loss of a specific child, but as Black and Scull point out, “it is the loss of everything the child represents for us” (Black & Scull, 2005, p. 179). At its heart, it represents “the loss of one of the most fundamental and taken-for-granted choices, the bearing of children” (Monach, 1993, p. 181). The loss impacts in multiple ways. Previous studies demonstrate some of the aspects: being pregnant and giving birth to life, giving unconditional love to children and grandchildren, being a mother and the connection it gives within wider society, genetic continuance and the support of adult children in later life (Anton, 1992; Cooper-Hilbert, 1998; Houghton & Houghton, 1984).

A central aspect of grieving childlessness is its hidden nature. This is reflected in a number of studies. Anton explains “it is silent, hidden from all but the women who experience it” (Anton, 1992, p. 2). The unseen nature of the loss can make it difficult to acknowledge, or recognise, that the associated emotions are part of a grieving process. As Menning notes, “It is a strange

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<sup>2</sup> It is important to note that there are a number of articles which explore issues of voluntary childlessness (Gillespie, 1999; Letherby, 2002b). These will not be discussed in this review given the focus on involuntary childlessness.

and puzzling kind of grief...There is no funeral, no wake, no burial, no grave to lay the flowers on. And friends and family may never even know" (Menning, 1988, p. 116). The normal social conventions that define bereavement are absent in the case of childlessness and yet the feelings of grief can be overwhelming. The difficulty of sharing the loss can mean that "many of these women become isolated in their grief due to the loss of their existing supports, as others are often unable to tolerate the intensity of the experiences and to understand grief from a loss that is unrecognized" (Harris, 2011, p. 175).

The hidden nature of the grieving is compounded by the stigma associated with being childless in a pro-natalist<sup>3</sup> society. Several authors comment on this aspect of the phenomenon. Alexander et al's study of older women found that: "these women's regrets were shaped and formed in the context of a culture that defines womanhood predominantly through childbearing and that forces women to evaluate themselves continually against the pressure of this cultural prescription" (Alexander, Rubenstein, Goodman, & Luborsky, 1992, p. 618). Given the pro-natalist pressures and social expectations, infertility is a "secret stigma" for many women who experience it (Whiteford & Gonzalez, 1995, p. 28). The sense of stigma implies a level of shame leading to involuntary childlessness being a taboo subject. As Jody Day, founder of Gateway Women, wrote in 2012, "like all taboos, the way its policed is that talking about it is seen as shameful and embarrassing" (Day, 2012, p. 86). The shame is associated with a strong sense of having failed as a woman: "the lived experience is all too often one of failure, the failure of the treatment and the failure of the woman" (Whiteford & Gonzalez, 1995, p. 35).

The impact on identity or sense of self can be devastating, particularly for women who have postponed childbearing as "generally, they are people who feel they have control over their lives, who believe that hard work and determination will produce desired results" (Glazer & Cooper, 1988, p. xx). Their inability to control their fertility and achieve the expected outcome is not

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<sup>3</sup> According to Peck and Senderowitz, "A key element in pronatalist thought is the age-old idea that women's role must involve maternity – that woman's destiny and fulfilment are closely wedded to the natal, or birth experience" (Peck & Senderowitz, 1974, p. 1)

only devastating but also strikes at the heart of a sense of self: it has been described as an “identity shock” (Matthews & Matthews, 1986, p. 645). For many women and their partners then, part of the grieving process involves rebuilding a central aspect of their identity, in many cases, as individuals and as a couple.

Several studies explore the process of moving forward from the despair of involuntary childlessness, either through the decision to stop infertility treatment or to terminate attempts to become pregnant through natural conception. A number of authors provide practical advice for those struggling to come to terms with their new reality. These include coping strategies in the short term, the creation of alternative nurturing outlets and alternative parenting (Anton, 1992; Black & Scull, 2005; Daniluk, 2001; Day, 2012). Central to the process of moving forward seems to be being able to “reconstruct a meaningful life vision that did not include biological children. This reconstruction involved a re-evaluation of their beliefs, needs, and priorities” (Daniluk, 1996, p. 95). There is also an awareness of the likely long-term impact. This leads Letherby to argue that the process is one of adaptation to the new reality rather than resolution: “resolution is inappropriate not least because as the life course continues, ‘infertility’ and ‘involuntary childlessness’ may take on a different significance” (Letherby, 2002a, p. 285).

There is an extensive range of literature focusing on the meaning and experience of involuntary childlessness. All of the studies note the profound and devastating impact that childlessness can have on women who desire to be biological mothers. Whilst a number of the studies do recognise that the loss of childlessness is often accompanied by other losses, either pregnancy losses or failed infertility treatment, there is no specific discussion that explores the multiple impacts and none of the literature explores involuntary childlessness specifically in the context of decisions to delay childbirth.

## **2.5. Conclusion**

In concluding it is evident that constraints of space have necessitated a brief review of a vast amount of literature. The aim has been to summarise material

of direct relevance to the subject matter. It has been shown that whilst there is a developing understanding of postponing pregnancy, the majority of the studies until very recently have been quantitative in nature and have only just begun to address the meanings that women themselves give to their decisions to delay pregnancy. These studies demonstrate that the reality of delay differs considerably when compared to the image of control and choice which the quantitative research presents. The literature on pregnancy loss and involuntary childlessness shares a focus with its impact on the nature of grief but the studies tend to generally approach the issue from a different methodological standpoint. There is no study which explores how pregnancy loss and childlessness has been experienced in the context of delayed pregnancy.

## Chapter 3. Methodology

### 3.1. Research Design and Philosophy

As the literature review highlights, quantitative and qualitative methods have been used to explore the three central issues underpinning this research. Quantitative methods have been more commonly used in studies of pregnancy loss and pregnancy postponement whereas qualitative methods have been more prominent when researching issues connected to involuntary childlessness. In approaching this study, a number of methods were considered: however, quantitative methods were discarded at an early stage given the nature of the research topic. As Muijs explains, quantitative research “is explaining phenomena by collecting numerical data that are analysed using mathematically based methods” (Muijs, 2011, p. 1 citing Aliaga and Gunderson (2000)). As he elucidates, quantitative methods are particularly useful when analysing large groups with the aim of ascertaining trends, working with large data sets or seeking to assess hypotheses (Muijs, 2011).

A qualitative methodological approach, in contrast, seeks to “develop an understanding of how the social world is constructed. The notion of the world being ‘constructed’ implies that we inhabit a social, personal and relational world that is complex, layered and can be viewed from different perspectives” (McLeod, 2011, p. 3). This is a significant difference from the quantitative approach in that qualitative research recognises the multiple realities that exist and seeks, through a variety of data collection methods, to capture subjective experiences and the meanings people give to them. It takes an inductive rather than a deductive approach and, in doing so, places the participants’ voices and meanings at the centre of the research.

The qualitative approach has resonance for this study for a number of reasons. First, the research is concerned with a specific group of women whose lives have followed a different trajectory from the majority of women: it is not seeking to ascertain trends or present a broad based analysis of a

common experience. Second, the research aims to explore the rich and multi-layered experience of impactful losses: the issues being investigated do not lend themselves to a set of closed questions, survey research or statistical analysis. Third, the work is committed to giving space and voice to participants whose painful experiences have tended to remain hidden from view. This necessitates sensitive, face-to-face interactions that are mindful of the emotional wellbeing of the participants who are being asked to recall deeply personal and painful periods in their lives. A methodological approach that allows for sensitivity and flexibility rather than measurement and categorisation is, therefore, most appropriate for this study.

Qualitative research includes a rich range of approaches and methods. Given the focus of this study is on the lived experience of a small group of women, the study was underpinned by a phenomenological research design. Finlay explains that in a phenomenological inquiry, “the focus is on our personal or shared meanings, as distinct from the objective physical world explored by science. The aim is to clarify taken-for-granted human situations and events that are known in everyday life but typically unnoticed and unquestioned” (Finlay, 2011, p. 15). Existing within this phenomenological tradition, there are a number of specific approaches (Finlay, 2011; McLeod, 2011).

This research study follows the Interpretative Phenomenological Approach (IPA) as outlined by Smith et al (Smith, Flowers, & Larkin, 2013). It was chosen for four reasons. First, IPA has been widely used in the field of psychology and health, it has been critiqued and found to be a useful approach (Brocki & Wearden, 2006; Lopez & Willis, 2004). Second, IPA has a “focus on meaning and sense-making in a particular context, for people who share a particular experience” (Smith et al., 2013, p. 45). It differs from other qualitative methods in the focus on sense-making and it differs from other phenomenological research in its explicitly interpretative aspect. Third, it recognises there is an active role for the researcher in terms of their engagement with the data: a double hermeneutic is in operation. As Smith and Osborn explain, “The participants are trying to make sense of their world; the researcher is trying to make sense of participants trying to make sense of

their world” (Smith & Osborn, 2003, p. 53). The explicit recognition that a researcher will bring her own interpretation to the data reflects a more accurate representation of the analytical process in that it acknowledges the interaction between researcher and the data. Finally, and on a practical level, IPA has a clear, structured and methodical approach to data analysis: this makes it particularly useful for the researcher who is new to phenomenological research methods (Smith et al., 2013, p. 81).

### **3.2. Sampling and Recruitment**

Given the highly specific nature of the research, the sampling strategy was purposive. As Mintz states this is particularly useful when the “goal is to acquire deep understanding of some phenomenon experienced by a carefully selected group of people” (Mintz, 2010, p. 3). Any other method (random or probability sampling) would not have allowed me to gain access to participants who had directly experienced the phenomenon being explored.

The recruitment process began once ethical approval had been obtained from the University of Chester. Originally, it was restricted to counsellors. Given the specific nature of the research, I decided to contact two counselling organisations: the British Association for Counselling and Psychotherapy (BACP) and the British Infertility Counselling Association (BICA). BICA’s executive committee approved the original call for participants in June and the advert was circulated to members in late July (appendix 3). The advert was posted on the BACP research noticeboard in mid-June and TherapyToday.Net in mid-July (appendices 4 and 5). One response was received from these adverts. This led to the decision in early July to re-apply for ethical approval to widen the scope of the call to women who had experienced pregnancy loss at the end of their fertility and remained childless. Once ethical approval had been obtained, permission was sought from two organisations which worked specifically with women who have experienced infertility and involuntary childlessness: More to Life and Gateway Women (appendices 6 and 7). Both organisations were contacted in late July and they agreed to send out an amended call for participants on their social network

sites in early August (appendix 8). These yielded a number of positive responses.

Prospective participants contacted me via an email to express an interest in participating in the research. Following email communication in which I responded to further questions and ensured that participants were aware of the purpose and process of the research, mutually convenient dates and times were made for the interviews. Prior to meeting, the participant information sheet and informed consent form were emailed to the participants to ensure they were fully aware of the nature and purpose of the research and were aware of their role in the process (appendices 9 and 10). All expressed their willingness to participate and interviews were arranged for August and early September.

Five of the participants were white British and one was of South Asian British heritage. They were between the ages of 44 and 56 and lived in southern England. Five were employed (teacher, counsellor, dietician, businesswoman and occupational therapist) and one was looking for work.

### **3.3. The Process of Data Collection**

Although there are a variety of qualitative methods available to the researcher: focus groups, unstructured interviews, open-ended questionnaires, documentary data (Mintz, 2010), the decision was taken to undertake semi-structured interviews. As Smith et al note, in IPA, the aim is “to design data collection events which elicit detailed stories, thoughts and feelings from the participants. Semi structured, one-to-one interviews have tended to be the preferred means” (Smith et al., 2013, p. 57). Given the nature of this research, the face-to-face aspect was felt to be particularly important. One participant offered to be interviewed via Skype but I felt uncomfortable discussing such sensitive and potentially upsetting material in a virtual environment.



Data was collected via semi-structured interviews based on a series of open questions: the schedule can be found at appendix 11. The aim was to ensure the key issues were covered but that scope was available for participants to explore the meanings they attached to their experiences. The interview lengths varied between 55 minutes and 2 hours and 35 minutes and took place in a safe and mutually convenient location. They were recorded with a digital voice recorder and were transcribed verbatim. Participants received copies of the transcripts via email and asked to check them, if they felt comfortable doing so, and to let me know if they required any amendments. One participant responded to say she did not wish to read it, one responded with some factual corrections and the other four participants did not require any changes to be made.

### **3.4. Data Analysis**

After each interview, I made some brief notes about my own perceptions of the process: these were helpful in reminding me during the analysis of how I had experienced the engagement with the participant, what had moved me during the process and how I felt at the end of the interaction. These field notes were very useful at a later stage in allowing me to bracket off my own emotional responses in order to fully concentrate on the material the participant had shared.

Once I had completed transcribing the interviews, I listened to each interview again whilst reading the transcript. This allowed me to make notes on the tone of voice of the participant, to identify their emotional responses (laughter, tears, anger, etc). The aim was to obtain a felt sense of the participant as they engaged with their own narrative. Second, I went through the transcript noting the descriptive, linguistic and conceptual comments in different coloured pens (Smith et al., 2013). Notes were made in the right hand margin of the page (appendix 12). Once this was complete, I wrote notes to myself on the main issues which had emerged from the transcript along with page numbers (indicating where I could find the supporting evidence). I did the same with each interview transcript: notes for each participant were written on different

coloured paper so as to easily identify the participants. Once this was complete, I went back through the transcript to identify emerging themes for each of the participants: these were then noted down on coloured paper. Once the themes for each individual were chosen, I placed them all on the floor and began the challenging process of selecting the superordinate and sub-themes. Spreading the themes on the floor made it easier to identify how individual experiences could be grouped together. Gradually the themes began to emerge and I began to focus on naming the themes and sub-themes: this took a number of drafts. Once this process was complete and I had a list of themes, I cut up large pieces of paper (from lining paper) with headings of each of the themes. I then pasted quotes (all on different coloured paper) from the participants on to the paper to demonstrate the evidence of their experience (appendix 14). This was a very useful process as laying these large pieces of paper on the floor allowed me to see further overlaps in the data and to merge subthemes which had similar attributes. Further information on the challenges experienced can be found in the reflective statement (appendix one) and further notes on the analysis process (appendix 15).

### **3.5. Ethical Considerations**

The protection of participants is an absolutely critical aspect of any research project. Thus, ethical considerations should “permeate all aspects of the research process, from the formulation of the research question through to the dissemination of the findings” (Mintz, 2010, p. 6). When the issues are of a sensitive and painful nature, it is even more important to have ethical safeguards in place to ensure no harm is done to those participating in the research process. There are a number of ways in which these safeguards have been established in this study.

First, as a student member of the BACP, I am committed to the ethical framework in both my practice and research. Among the fundamental principles underlying the framework are: non-maleficence, beneficence and being trustworthy (BACP, 2010, p. 3). The onus is on the practitioner and

researcher to ensure awareness at all times of how her actions and responses impact on that of her client or participant. Bond discusses in more detail the responsibilities that researchers have particularly when working with vulnerable participants or sensitive subjects (Bond, 2004, p. 14).

Second, the research project was submitted to the departmental ethics committee of the University of Chester. Following rigorous examination, the project was approved, thus ensuring that ethical standards were in place before the process began. Initially it was agreed that only counsellors would be sought as participants as it was felt they would have likely reflected on their own personal experiences and would have sufficient support in place, either through their own therapy or supervision. When it became clear that there would not be sufficient respondents via this route, the decision was jointly taken (by my supervisor and myself) that we would broaden the call for participants. Ethical approval was re-sought for this different participant base and was granted. Accessing participants through two organisations was undertaken to ensure individuals would have access to support networks if engaging in the research was destabilising. In addition, the call for participants detailed extensively the nature of the research, the type of issues to be addressed and asked that participants were able to reflect on their experience. In this way, it was hoped that those who did not feel ready to talk would exclude themselves.

Third, participants were fully informed about the nature of the research and were given assurances of their anonymity (pseudonyms were used for the participants and others they named in their interviews) and their rights to withdraw from the process: all of this was detailed in the informed consent form.

Finally, part of ethical safeguarding is “the researcher’s responsibility to self” (Mintz, 2010, p. 6). In this regard, I was very aware before beginning the project that I needed to listen to my own emotional responses. I took the decision, when placing a call for participants, to share the fact that the project was motivated partly by my personal experience. It felt important to me that

my participants were aware I had shared aspects of their pain and that I was personally committed to breaking the silence. In doing this, I was aware that I might be asked to expand on my experience. This did occur on a number of occasions once the interview had ended. I realised throughout the interview process that whilst my commitment to breaking the silence was about providing a space for participants to share their experience, it was also providing me with an avenue to break my own silence. My awareness of this led me back to my own personal therapy which allowed me to care for myself during the process of analysis and writing up.

### **3.6. Validity**

One of the key criticisms, and a major underlying disagreement between quantitative and qualitative researchers, has been validity. The objective, numerical and repeatability of quantitative research has been contrasted to the subjective output of the qualitative researcher. This has led, as McLeod has pointed out, to a considerable amount of attention being given to how to develop measurements of validity for qualitative work (McLeod, 2011). Willig demonstrates a checklist of elements which have been developed which include: a fit between the data and categories, an integration of theory with the data, evidence of reflexivity, a clear documentation path, sensitivity to the participants' views of the outcomes and potential transferability (Willig, 2008, p. 170). As there is not space to explore all of these elements, I will concentrate here on the fit between data and categories, documentation and reflexivity.

Before and during the research process, I undertook reviews of existing material relevant to the subjects under investigation. This ensured an appropriate context was provided before the presentation of the findings and the discussion. In addition, it demonstrated how the particular findings related to previous knowledge about the subject and highlighted the place of this particular research in the wider canon: in that sense it provides the reader with an opportunity to assess the fit between the categories, data and existing knowledge. In line with this, the appendices provide an audit trail of the

documentation and analysis which demonstrate the steps taken to arrive at the superordinate and sub-themes.

Unlike quantitative research, qualitative researchers recognise their own role in the research process. IPA, in particular, “recognizes that such an exploration must necessarily implicate the researcher’s own view of the world as well as the nature of the interaction between the researcher and participant” (Willig, 2008, p. 57). Having awareness of how the self of the researcher impacts all elements of the research is a crucial aspect of the process. Being reflexive, Etherington explains, means “we need to be aware of our personal responses and to be able to make choices about how to use them” (Etherington, 2004, p. 19). Being reflexive has been a constant thread running through this research, from the development of the research question through to the writing up of the data (see appendix one). The ability to honestly reflect on my own emotional responses has been fundamental in ensuring I allow the participants’ voices to form the basis of my interpretation rather than my own experience.

### **3.7. Limitations**

Two key limitations of the study were time and space. An MA dissertation has to be completed with a specific timeframe and within a certain word limit. There is much more that could be explored based on the available literature and from the participants’ experiences. Part of the immense challenge has been to condense a vast amount of rich material into the required space and framework.

Although I am an experienced social science researcher, this is the first time I have undertaken a study using IPA. Smith et al note that it is only after having completed their first IPA study that a researcher truly understands the process of analysis (Smith et al., 2013). In addition, due to the challenge of finding participants, I was not able to conduct a pilot study of the research schedule. Although I did not alter the questions after the first interview, thereby

confirming that they were appropriate, I would have benefitted from the opportunity which a pilot study gives, to reflect more deeply.

## **Chapter 4. Findings**

### **4.1. Introduction**

In this chapter, the findings that emerged from the analysis of the lived experience of my six participants are presented. There are three superordinate themes and nine sub-themes guiding the discussion (table two). These themes approximately correspond to the chronological processes that participants have gone through: pregnancy and loss, living through grief and finding the strength to move forward. Each participant's experience is unique and the challenge of analysing these individual processes and ensuring the essence has been captured has necessarily involved excluding some of the data. This chapter focuses on their shared emotional processes. Before presenting the main findings, brief information is given about the participants (table one).

**Table 1. Brief Profiles of Participants**

Name	Age	Summary of experience
Colette	47	Colette became pregnant at 40 and miscarried at 11 weeks. She became pregnant for a second time at 41 and went through labour at 18 weeks. She took the decision at 43 to stop trying to conceive.
Maria	44	Maria conceived naturally at 35 and miscarried. She went through four cycles of assisted reproduction but did not become pregnant again.
Sarah	46	Sarah became pregnant at 40 and miscarried. She has not become pregnant again.
Sylvia	50	Sylvia had four cycles of assisted reproductive technology in her mid-thirties and became pregnant at age 36 on the final cycle. She miscarried. Following gynaecological problems she had a hysterectomy.
Tessa	56	Tessa became pregnant at age 36 and miscarried. She became pregnant a second time at 38 but had an ectopic pregnancy. Tessa has gone through the menopause.
Zaina	47	Zaina became pregnant at age 41. She miscarried at 12 weeks. She was diagnosed with endometriosis and has been taking a low dose contraceptive to help with the pain.

**Table 2. Themes and Subthemes**

1. Hope and Loss	2. Isolation and Belonging	3. Re-writing the Future
Right Time	Hidden Grief	Self
Intensity	Hard to Bear	Control
Shattered Expectations	Connection	Living with Loss



## 4.2. Superordinate Theme One: Hope and Loss

This theme emerged from the participants' experiences of deciding to become pregnant, being pregnant and experiencing pregnancy loss. Hope was connected not only to the desire for a child with their partner but also for a particular future as a mother. As well as grieving a specific pregnancy loss, therefore, participants also mourned the loss of an anticipated, expected future.

### 4.2.1. Right Time

All of the participants spoke of their decision to start trying for a family in the context of it being the right time, albeit for different reasons. For four of the participants, the issue of central concern was finding the right partner. Colette explained, *"so it was really meeting John and...him pushing the question.. and then actually thinking yeh, maybe this is something I want to do"* [87.6].

For the other participants, there had been a desire for a child prior to meeting their partner, as Sylvia explained, *"it had always just been, I was at some point going to have children and when I met my husband...he triggered in me a really strong maternal instinct. I desperately wanted a child as soon as I met him"* [35.3].

For Zaina, *"I always thought if I was ever going to have a child, it would only be with somebody I was married to...the only time I thought about having children was actually when I met my husband and by then I was in my...late thirties"* [6.1].

For Tessa and Maria respectively, the timing was connected to career and financial stability. Tessa recalled, *"towards the end of my career, things changed and I thought, well I am getting older, I would like a family and so now its time to think about what I am going to do about this"* [9.1].

For Maria, the issue was that *“we didn’t have much money...we can’t afford it”* [3.1] and so they delayed starting a family until they were financially secure.

#### **4.2.2. Intensity**

Intense emotional attachment was experienced throughout the process for all the participants. As Tessa noted, speaking of her second pregnancy: *“because I now knew what it was to imagine that thing inside you growing, the minute I knew I had conceived, I was imagining what size it was, its organs”* [261.16].

Zaina talked about *“the attachment you have right from the start when you find out...You have already started the attachment when you find out”* [568.33].

Colette spoke about the meaning of the experience for her, *“actually this isn’t just about having a baby. This is about us creating something together that would be amazing”* [80.6].

Sylvia spoke about the *“fantastic sense of possibly creating something”* [64.5]. The level of attachment at the early stage of pregnancy was felt to be significant in making sense of the huge loss, at whatever stage of the pregnancy, as Sylvia explained: *“with the miscarriage, the common thing that people say is, ‘well how far gone were you? And I wanted to say it doesn’t bloody matter. The fact is that I lost something that you will never understand what it meant to me ”* [210.13].

Powerful extremes of emotions were expressed. Tessa spoke of being *“absolutely off the planet. I mean I kept redoing the pregnancy test every five minutes. I kept retouching my boobs to make sure they were sore. I couldn’t believe it. Is it real? I was terrified something was going to go wrong”* [150.10].

For Sylvia, who had experienced successive fertility treatments before becoming pregnant, the overwhelming feeling was fear: *“I felt so precarious, everything was precarious when I was pregnant...You think it's the end of the*

*journey and its not. It's just the very beginning of the next stage of the journey and I didn't want to move anywhere or do anything. I just wanted to stay safe" [251.16].*

Zaina described her experience in stark terms: *"It was devastating because we knew, well I knew, it was our only chance, you know, getting pregnant at 40, 41....I knew that and I just felt as if I had been given a gift, a miracle, but in fact, it wasn't, it was actually a curse" [385.22].*

Maria related her feelings on finding out she was pregnant: *"It was amazing. We both felt so happy.. we were so elated" [62.4]* and on her loss as, *"the worst thing I have ever had to go through. It was absolutely awful" [67.4].*

#### **4.2.3. Shattered Expectations**

Two of the participants married later in life and had been accepting of life without children until they became pregnant. Sarah explained, *"I sort of wasn't bothered at that point whether I got pregnant or not but then I got pregnant and...it was wonderful, it was absolutely gosh that's amazing" [10.1].*

Zaina explained *"I thought, okay, you know the child thing is off the menu because I haven't met anybody...and that is when I actually met my husband...and that's when I became pregnant, you know, and lost the baby. And I think that's when I struggled" [31.2].*

Regardless of how and when the participants had come to the view that they would like a child, the expectation that it would occur became part of their imagined future. As Sarah explained, *"when you are younger and you are expecting to have children, everything you think about your future includes children, just automatically, without really recognising that is what you are doing" [168.10].*

As Zaina explained, *"its only recently that I started thinking about the thoughts I used to have as a 16 year old...that I would have liked two kids, one kid on*

*my hip coming out of the car and struggling to get into the house. It's all of that...it's not aspirations, its normality. That would have been the normal life" [679.39].*

The struggle to come to terms with the loss of that future was devastating for participants. Sylvia explained that, *"not having children was not the future I had imagined" [110.7].*

Tessa vividly recalled that she had, *"found the man, managed to get him to marry me...I had got sorted in my teaching career. I had everything perfect for a lovely family and it didn't happen" [30.3].*

Maria explained, *"All I ever wanted to do was have a family and that hasn't happened" [349.20].*

### **4.3. Superordinate Theme Two: Isolation and Belonging**

This theme emerged from a powerful sense of the participants' aloneness in the aftermath of pregnancy loss and childlessness. The feeling that nobody could understand their experience or the magnitude of their grief was overwhelming and compounded the pain of the losses. The hidden nature of the grief reinforced the sense of isolation. Many of the participants sought ways of connecting with others as a way of gaining support and validation.

#### **4.3.1. Hidden Grief**

The intense pain of grief at the losses incurred was both confusing and hidden: there was nowhere to place it and participants struggled to name it. As Maria recalled, *"its something you lost but you never had and that is difficult to explain... how can you grieve it so much" [453.26].*

For Sarah, hearing Jody Day (Gateway Women) on the radio, *"saying that its grieving and I knew it was grieving but actually having someone say, you are grieving for your children...that sort of acknowledged how difficult it was which*

*was really helpful. It didn't stop me being angry but it helped me understand you know why I was feeling the way I was feeling" [83.5].*

As well as the confusion, there seemed to be no place for the grief so it often remained hidden. As Tessa recalled, *"so this awful, awful pain I went through. I can't tell you how many times I was crying before work because I didn't want to see other people's children, oh it was awful" [757.46].*

The experience of the participants powerfully suggests they struggled to recognise or name their grief. This was heightened by the fact that they felt their feelings were not acknowledged or validated by others.

#### **4.3.2. Hard to Bear**

Whilst seeing other women pregnant was difficult participants spoke of being able to distance themselves if the friends were not particularly close: it was much harder with good friends and family. As Tessa remarked in relation to her close friend's pregnancy, *"and you know I am very happy for her but I went backwards ...because I just had a complete relapse into that uncomfortable place" [69.5].*

Zaina, whose sister-in-law was pregnant at the time of the research, explained she *"didn't want to engage in the 'oh, how is she doing? How many months is she? I don't even know how many months pregnant she is because I just didn't want to know" [355.21].*

For Maria, it was her cousin's pregnancy which helped her to become aware of the depth of her own grief: *"I kept thinking that should be me. I am 11 years older than her and that should be me and it affected me a lot, so much that I couldn't see her. It brought everything back...it actually hit me very, very hard" [302.17].*

#### **4.3.3. Connection**

The sense of *"massive isolation"* (833.46) as described by Colette was a strong element in the testimony of many of the participants. For the two

participants whose husbands had had children from a previous marriage, there was an honest recognition that they could not understand the depth of their partner's grief: as Sarah remarked *"although my husband is really supportive and lovely, he would admit I don't really understand because I have got the boys"* (104.6).

Sylvia explained that her husband *"fully admits his level of grief is not same...he says he cannot fathom what it must be like for me to have no children and not be able to have them"* (157.10).

All of the participants, with the exception of Tessa whose marriage broke down, spoke of how the experience of loss had strengthened their relationship. Colette explained, *"we drew on our love really... to get us through because...nobody else understood"*(1036.57).

Maria explained, *"it was very, very difficult and I think we have got a strong marriage anyway and I think it only strengthened it going through that...it did gel us together even more"* (412.24).

Despite the support and love of their husbands, many of the participants felt that no-one really understood what they were going through. As Sylvia poignantly recalled, *"I needed someone to hear me and I think that is the thing, that the whole way through the process, there wasn't really anybody who could understand"*(196.12).

Zaina described her experience with her family: *"but all they asked was, 'are you ok?' and I said, 'well, no, not really, its quite hard' and then it just goes quiet and the conversation starts about something else...because I think they were embarrassed. They didn't know what to say"* (406.23).

Colette described a similar experience with her family, *"just so many conversations but none of them understood and it was just awful. It was really, really awful"* (829.46).

The isolating experience with family and friends enhanced the desire among a number of participants to find a connection with others who could understand the multi-layered sense of loss. For Maria, who went through fertility treatment, Fertility Friends provided a supportive arena: *“there were hundreds of other women going through the same thing at the same time so there was all these different perspectives”* (154.9).

Colette talked about desperately seeking a place where her experience would make sense and her relief in finding it: *“it was really helpful to me to hear other people, kind of just their stories and feeling that I wasn’t alone and that other people knew how I felt”* (840.47). She also recalled how different sites were useful at different periods of her grieving: *“for a long time I was on the Miscarriage Association...and I left there...its probably about eighteen months ago now...and then I joined Gateway Women... it seemed really great because it was women who are in the same situation as me”* (1088.60).

Sarah talked about how she wished she had found the supportive online communities of women when she really needed them: *“I think I found them a bit too late...most of the people that were on there were several steps back from where I was...it would have been good if I had found something earlier to help me with the really dark stuff”* (365.20).

#### **4.4. Superordinate Theme Three: Re-writing the Future**

This theme emerged as participants reflected on how their pregnancy loss had impacted on them, how they had struggled to cope with the new reality of their lives and in some cases how they had begun to gently step into a different future. The sub-themes engage with the complex emotions felt as the past is let go and a new, unexpected future is tentatively approached.

##### **4.4.1. Self**

This sub-theme emerged in three different guises throughout the research. Participants spoke about the loss of self, how they protected themselves and how they were changed by their experience.

The loss of self was inextricably linked with a sense of failure: as Sylvia noted, *"I felt as if I had failed at the most... profound and fundamental level, at being a woman"* (147.9).

Maria echoed this, she felt *"you are not real and you can't do what you were made to do"* (382.22).

Tessa explained, *"I am still the only person I know who wanted a baby and didn't get one... because actually the few people I know who had problems, they managed it"* (62.5).

The sense of being somehow less than other women was prevalent in the participants' reflections: *"if you don't have children you are somehow a lesser being"* (Colette) (1602.89).

*"I felt I was somehow being judged as not being worthy, somehow faulty"* (Sarah) (188.11).

Sylvia movingly recalled being on a training course with a group of women who had just given birth *"I was there silenced by the fact that I was surrounded by women who had given birth and my picture of myself in that scenario is of this tiny little dot in amongst all these giants of women, these goddesses who had given birth and there I was, this shrivelled up kind of, you know, spot. I was a nobody"* (241.15).

The loss of identity, the questioning of one's purpose and role in life is encapsulated in Sarah's comment: *"if I am not a mother, why am I here?"* (310.16).

Part of the grieving process participants described related to the development of strategies (conscious or otherwise) to protect themselves. Tessa, whose job involves working with children, spoke about how she had *"anaesthetised myself to the pain"* (738.45) and developed a *"thick skin"* (80.6). In her case,



she has come to recognise what she can manage: *"I can only cope with so much. I will sort of walk away from things if I can't deal with them now but I will literally just end a conversation and walk away if something affects me too much"* (110.8).

Colette is aware that whilst she has moved on the, *"one thing I still can't do is I can't go to a baby shower...This is just too painful to contemplate"* (1056.59).

Sarah spoke about her growing relationship with children of her friends, but movingly recounted how with the children in her family, *"I can't force myself to be too involved because it just backfires...if I am sort of gentle with myself when I do see them, its okay"* (347.19).

The ability to find ways of coping with the reality of pregnancies appeared to be about survival and recognition that *"the world is going to keep getting pregnant"* (Zaina) (712.41).

For those who have emerged from the rawness of their grief, there was a sense of a changed, different self. This was most powerfully recounted by Sarah who explained, *"you go through the fire and all the extraneous bits are burnt away and you are left with the essence, you are left with you"* (417.23).

Other participants spoke about recognising that, despite their grief, they were able to take on new challenges. Sylvia explained: *"I also feel quite free. There is a part of me which feels I wouldn't be able to do the things I am doing now, um, if I had had children"* (361.22). The creative aspect of the different self was significant for three of the participants.

Several of the participants spoke about the growing and deepening level of empathy they felt had developed as a result of experiencing their losses: as Colette explained *"I know what it means to have your heartbroken...I know what it means because I had all of those physical sensations along with the emotions but it does mean I hope that I can use that to support people"* (1272.71).

Sarah commented *"I can choose to use it to help people um I don't believe that is why it happened, but equally I think you know we all go through difficult things and this is my difficult thing"* (278.15).

Using the experience of their own pain to help others was also recognised by Sylvia, *"I think it is healing and maybe it is healing for me as well knowing that maybe I can make a difference in some way"* (478.29).

#### **4.4.2. Control**

Part of moving through grief for the participants was about re-taking some control over their bodies and their future. This was related to the significant feeling of losing control engendered by the experience of pregnancy and loss.

As Sylvia recalled in relation to her cycles of fertility treatment, it was: *"as if it was lurching from one attempt to the next of treatment...I was living from one attempt to the next. It was the only hope I saw"* (143.9).

This is reiterated by Colette's experience of trying to conceive *"It was a massive big issue and it was just basically taking over the whole of our life. I look back now and I don't know what I was doing except trying to get pregnant and going to work"* (423.24).

Sarah described it as being out of control: *"And I knew it wasn't healthy but I couldn't do anything. I didn't know what to do to get it under control...it was like a sort of raging beast almost I couldn't think about anything else"* (235.14).

Feelings of powerlessness also emerged when reflecting on the loss, as Sylvia recounted: *"I remember shouting 'stop this, please stop this' and of course, there is nothing you can do"* (258.16).

In recounting her loss, Colette spoke about her disbelief, *"you felt you were in a, in a theatre play or a soap opera... You were acting something out. It wasn't*

*real and any minute the credits were going to roll and the world was going to go back to normal” (216.13).*

Regaining some control was a significant element for those participants who were in a position to make a decision.

Colette explained: *“well, we made the decision, because it had been four years of just stress and pain and torture” (955.53).* She was very clear that *“we didn’t give up trying for a baby, we made a choice to move forward” (1083.60).*

Sarah spoke in similar terms: *“I realised very strongly that I couldn’t just wait to have children and not do anything else” (147.9).*

For Sylvia, taking control freed her to accept her emotions: *“I decided to take charge of it rather than coasting and that makes me feel as if the anger that I have from time to time is okay” (368.23).*

Tessa was able to retake control through focusing on her passion for her work: *“I think where I am fortunate over many other women is that I did have a career, a vocation, something I still enjoy”.* She described it as her *“anchor”* and her *“saviour” (547.33; 687.41; 550.33)*

#### **4.4.3. Living with Loss**

Many of the participants knew they had experienced movement away from the raw stage of grief. For Sylvia, *“rather than a searing knife wound that I used to feel, I feel a kind of hmm, its like something pressing, its like a fist pressing in my, you know, inside” (319.20).*

Colette explained that when she saw pregnant women, it was *“like a burning, heating, burning sensation through me” (1070.59).*

The journey metaphor was used by two of the participants. As Sarah stated, *“I do still get upset yes, but I know that I am sort of several miles further down the road”* (175.10).

Colette talked about having reached *“landmarks”* (1051.58) in her grieving journey as she recognised her growing ability to cope with her grief.

For Sylvia there was acknowledgement that: *“the grief has changed shape but I am aware of it still being there”* (331.20).

The struggle to move forward is captured by Colette's description of *“cycling through mud”* (244.69) and Sylvia's view that it was like *“wading through treacle”* (150.10).

An additional element of living with the loss is that the participants recognised the pain of childlessness is likely to re-emerge in a different guise in the future. Anxieties were expressed around grandchildren:

*“the grandmother thing is probably going to be quite a big thing”* (Colette) (1496.83)

*“I won't have grandchildren. I don't know how that will affect me”* (Tessa) (463.28)

For Sylvia, whose husband has children from a previous marriage, there is some concern about the impact of how she will feel when *“his children start having children”* (417.25).

For Maria, there is a concern about *“what's going to happen when we get old we are not going to have anyone so it sort of rolls on, it's this constantly roll on effect because it affects everything”* (341.20).

#### **4.5. Conclusion**

Attempting to encapsulate the diverse experiences of six women who have undergone devastating pregnancy losses and who live with the pain of involuntary childlessness has proved to be extremely challenging. There are many significant processes and poignant recollections that could not be expressed due to the limited space available. The chapter has attempted to draw together the shared emotional responses through the voices of the participants.

## **Chapter 5. Discussion**

### **5.1. Introduction**

This chapter reflects on the participants' voices contained within the previous chapter. It seeks to interpret their particular experiences and relates them to existing published knowledge in the area of delayed pregnancy, pregnancy loss and involuntary childlessness. It highlights that whilst many of the feelings and processes they experienced are reflected in previous research, their voices add significantly to our understanding of how deep the existential crisis is for women who are forced to come to terms with losing their pregnancies and their future role as biological mothers. The chapter is organised around the three superordinate themes.

### **5.2. Hope and Loss**

Findings indicated that postponing pregnancy was not a conscious choice for a majority of the participants: for Zaina, Colette, Sylvia and Sarah, the desire to have a child with the right partner was the core explanation for the delay in starting a family. Having a child was not seen to be a decision that had been delayed but one which had not happened until later in life due to reasons outside of their control: in this context, there was very few regrets. These findings concur with Cooke et al whose recent qualitative study demonstrated both the lack of control women felt in their own reproductive process and the need to find the right partner (Cooke et al., 2012). Of the two respondents who had made a conscious choice to postpone pregnancy, only Maria expressed some regrets for delaying for financial reasons. However, she countered this by explaining she and her husband had wanted to be responsible and provide for their child. Tessa was the only participant who had delayed pregnancy due to her career: this was primarily for the physical impacts pregnancy could have had on her dancing. She did not express regrets but accepted the choices she had made to focus on her career at an earlier age. These findings contradict the majority of studies which suggest

education and careers are the predominant reasons why women postpone pregnancy (Bhrolchain & Beaujouan, 2012; Wu & MacNeill, 2002).

The findings also question the work of Alexander et al whose work suggested women in later life regretted their childless status (Alexander et al., 1992). The difference in outcomes may well be connected to the age of respondents, the pressures of pronatalism in the United States in the late twentieth century as opposed to UK society in the early twenty-first century and the extent to which the respondents in each of the studies felt they had made active choices not to have a child.

The intense emotions experienced by participants on finding they were pregnant and then experiencing loss is discussed in previous studies, although these have tended to focus on the shock of the loss (Maker & Ogden, 2003). Given that participants had often struggled to become pregnant the combination of joy and fear is understandable. In particular, the findings demonstrate the fear of loss expressed by the participants who were aware of the precariousness of their pregnancy, due either to age or fertility challenges. Whilst this aspect is generally not covered in the literature<sup>4</sup>, Swanson does recognise there might be additional concerns experienced by older women who are trying to become pregnant (Swanson, 2000). This study demonstrates there is an additional layer of emotional intensity for pregnant women who are childless and, due to their age, aware of their limited future chances of successful conception.

The intensity of attachment to the growing foetus was a strong factor in the level of grief experienced by the participants, expressed poignantly by Zaina, Sylvia and Colette. This is supported in the literature (Hutti, 1992; Peppers, 1989; Robinson, Baker, & Nackerud, 1999; Shreffler et al., 2011). Given the maternal age and childless status of the participants, the additional meaning inherent in, and hope for, a positive outcome suggests additional devastation is experienced when the pregnancy is lost. Whilst previous studies have noted

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<sup>4</sup> The only studies that do focus on fear in pregnancy are those that focus on pregnant women who have previously had pregnancy loss (Franche & Bulow, 1999).

the grief experienced by childless women who suffer a pregnancy loss, they have not considered the double impact of advanced maternal age and childlessness. These findings suggest an additional level of grief when women do not have the opportunity to conceive another child. As Bansen and Stevens found in their study of women who experienced a miscarriage, “several women were at least reassured by the fact that they had been pregnant and thus believed they would be able to conceive again” (Bansen & Stevens, 1992, p. 88) This option is usually not available to older women<sup>5</sup>.

Participants’ awareness that their pregnancy losses at the end of fertility signified a future childless status shattered expectations about how their lives would unfold. This was the case even for those women who had reconciled themselves to being childless until they became unexpectedly pregnant. Previous studies of involuntary childlessness have discussed the extent to which it impacts upon identity, confidence and assumptions about the world (Daniluk, 2001; Pfeffer & Woollett, 1983). In addition, these findings suggest the need to explore the impact as traumatic. This perspective could provide insight into the multi-levelled nature of the loss and consequent readjustments required to construct a meaningful future. Whilst pregnancy loss has been studied in relation to post-traumatic stress (Engelhard et al., 2001), the same lens has not been applied to the double impact of pregnancy and childlessness<sup>6</sup>. Janoff-Bulman’s work could provide insight in this regard. He argues that trauma shatters three core assumptions that the majority of people hold to be the case: the world is benevolent (generally people believe the world is a good place), the world is meaningful (there is a relationship between a person and what happens to him or her) and the self is worthy (Janoff-Bulman, 1992, p. 6). The experience of pregnancy loss and involuntary childlessness can shatter assumptions on all three levels and, in doing so, call into question issues of self, justice, order and meaning.

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<sup>5</sup> Given advances in assisted reproduction technology, it is possible for much older women to conceive using donor eggs. An interesting study of these experiences has been undertaken by Friese et al (Friese, Becker, & Nachtigall, 2006).

<sup>6</sup> Schwerdtfeger and Shreffler argue that involuntary childlessness and pregnancy loss should be understood as a potentially traumatic experience (Schwerdtfeger & Shreffler, 2009)



### 5.3. Isolation and Belonging

The findings concur with previous research that grief is an expected outcome of pregnancy loss (Lok & Neugebauer, 2007). In line with other studies, the participants' experience also demonstrates the disenfranchised nature of the grief (Anton, 1992; Cooper & Glazer, 1994; Cooper-Hilbert, 1998; Daniluk, 1996). Given the continuing taboo surrounding both pregnancy loss and childlessness, the participants experienced real challenges being able to name their grief and openly acknowledge it in an environment where it could be heard and understood. Sylvia's comment that there "was no place for it" highlights the confusion and despair arising from the experience. Whilst many of the participants could share their feelings with their partners, there was a real desire to find other women who could truly understand the depth of their pain. The sense of disappointment that those closest, particularly family members, were unable to understand, were embarrassed or made inappropriate comments, added significantly to the sense of being alone in their grief. This sense of isolation and embarrassment is recognised in previous studies (Bagchi & Friedman, 1999; Bansen & Stevens, 1992; Daniluk, 1996). The need for participants to have some acknowledgement of the intense emotional impact of their loss was a strong theme emerging from the research. Although other studies have recognised this, it appears that the taboo which continues to surround pregnancy loss and involuntary childlessness continues to silence women in their pain (Corbet-Owen, 2003).

The challenges the participants faced when a family member or close friend became pregnant have been discussed in previous studies (Cooper & Glazer, 1994; Houghton & Houghton, 1984). However, the findings demonstrate more specifically how a close friend or family pregnancy can impact on a women's grief and loss: for Maria, Colette and Tessa it acted as a trigger for them to recognise or re-access their own pain. In this sense, the findings demonstrate the lingering pain of childlessness and the difficulty of negotiating the pain within the context of family and close friends.

The desire for understanding and connection emerged very strongly from the participants' experience of isolation: these findings are supported by previous studies (Corbet-Owen, 2003; Van, 2012-2013). Forums where women could share their stories, find others who understood their pain or where they could support other women were very beneficial for Colette, Tessa and Maria. This is supported by two other studies which found internet forums to be supportive arenas for women dealing with pregnancy losses (Lafarge, Mitchell, & Fox, 2013; Sejourne, Callahan, & Chabrol, 2010). The forums seemed to provide a space where it was possible for participants to break their silence, knowing that those hearing their voice would not feel awkward or offer inappropriate and ultimately unhelpful comments. There was also a real awareness from Colette and Sarah that they knew what they needed from a particular forum and when they were ready to move on, they would seek new virtual spaces. The findings demonstrate the real sense of belonging gained via the online communities of women who understood their experience.

#### **5.4. Re-writing the Future**

These findings demonstrate how pregnancy loss and involuntary childlessness strike at the heart of how the participants perceived themselves. There was a profound sense of having failed as a woman because they were not able to give birth to their child. Terms used by the participants, such as: "not real", "not worthy", "non-identity", point to a sense of an incomplete self. For women who are used to having control over the direction of their lives, the experience of failing at what appears to be the most natural and basic role of a woman, to be a biological mother, was deeply destabilising. This sense of personal failure is inextricably connected to wider social norms: as Ireland writes, "there is an implicit assumption that motherhood is intrinsic to adult female identity. This assumption necessarily implies an 'absence' for any women who is not then not a mother" (Ireland, 1993, p. 1). The sense of personal failure is compounded by Zaina's feeling of "not belonging" in wider society or as Sylvia described it, being "on the edge".

All of the participants spoke movingly of their attempts to protect themselves from the pain of their losses and the reality of other women's pregnancies and children. Deeply aware of their vulnerability, all of the participants recalled moments when they had had to withdraw in order to emotionally survive. They were also aware that there are still situations that are too painful to contemplate. Reflecting on these participants' experiences demonstrates that even in the midst of an existential life crisis, an aspect of the self is able to access internal resources and strength as part of developing resilience and retaking some measure of control. Whilst other studies discuss coping strategies, these findings demonstrate how women intuitively know what is manageable at different moments in their grieving process and that they seek to ensure they do not push themselves beyond what they can cope with.

That growth comes from grief and pain is acknowledged in literature on bereavement and loss (Attig, 2011). What emerges from the findings is the sense that those participants who were sufficiently far enough along in their grieving processes had worked hard to find some meaning in their experience of loss: Colette's determination to ensure it was not a "waste of an experience" profoundly demonstrates this. The emotional turmoil was described as having led to the development of deeper empathy with others who were in pain, although both Colette and Sarah rejected the view that this was the 'purpose' of their experience. Being able to support other women in the midst of their suffering was important to Tessa, Colette and Sylvia to ensure other women were not so isolated in their loss. Another aspect of offering this support appeared to be connected to having an opportunity to validate their own losses and integrate the experiences into their changed self: this was openly acknowledged by Sylvia. Colette, Sarah, Sylvia and Tessa spoke about how they had been able to view their childless status as bringing some benefits to their lives, allowing them to know themselves more deeply and, on a practical level, freeing up their time and ability to explore other aspects of themselves, especially in the creative arena. Arriving at this place had clearly taken time and a great deal of reflection, whether alone, with other women or through counselling: it had been a struggle as Colette's metaphor of "cycling through mud" graphically demonstrates. These women

demonstrate the amount of grief work that is required to move out of the pain of loss into a new reality.

Studies of infertility highlight the overwhelming loss of control experienced by women who are trying to conceive naturally or through medical intervention (Houghton & Houghton, 1984). These findings support previous research and highlight the total feeling of powerlessness and helplessness the participants felt in the face of their inability to conceive or to stop the pregnancy loss. Sarah defined her lack of control as a “raging beast” within her powerfully suggesting her total inability to control what was happening to her: it is as if she was possessed. Colette’s description of her pregnancy losses suggests her sense of disorientation: these heart-breaking experiences were not part of her life script. For older women, many of who have educational or career successes behind them, the loss of control can be more disempowering than for younger women: this is particularly the case when there is an awareness that this is likely to be the final chance to be a biological mother. This came through strongly in the research confirming the challenge of dealing with a multi-layered sense of loss.

Taking control was an important aspect of the grieving process and this has been recognised in previous studies (Pfeffer & Woollett, 1983). For Colette, the decision was framed as a positive one: it was ending a process of “stress and pain and torture”. Sarah and Sylvia knew they had to regain control in order to survive and move forward. Doing so freed up their energy to contemplate a different future and, in Sylvia’s case, allows her to accept her anger when it re-emerges. Tessa had a slightly different experience: her career had always been a central aspect of her life and when she had to face the reality of a childless future, she had an alternative future already in place. She acknowledged her “luck” in having this option available.

Living with loss involves acknowledging the extent of the pain and finding ways to integrate it within the self. Whilst participants were at different stages in their grieving process, they all acknowledged that it continued to impact on them in different ways. The physicality of the pain was mentioned by Sylvia

and Colette who also acknowledged they knew their pain was diminishing because the physical sensations were less intense. Having an awareness of how the grief shaped their responses and lives was evident from all the participants as was the recognition of how hard they had had to work to move through the grieving process.

As well as integrating the loss, participants were also aware that their childlessness may re-emerge in different guises in their futures. Colette, Sylvia, Tessa and Maria all mentioned their concerns about how they would feel when their peers became grandparents. Research undertaken by Wirtberg et al with women twenty years after unsuccessful fertility treatment demonstrates the painful impact of being “grandchildless” (Wirtberg et al., 2007, p. 602). These findings confirm Letherby’s argument that infertility and involuntary childlessness is not “resolved”, but rather “adaptation” takes place (Letherby, 2002a).

## Chapter 6. Conclusion

“I am losing my baby. I am losing now my last chance at motherhood”.

Colette [675.38]

### 6.1. Introduction

Colette’s poignant comment encapsulates her own devastating losses: it also highlights the multiple levels of grieving and readjustment that women of advanced maternal age experience when undergoing pregnancy loss in the context of their childless status. This study has explored the multi-layered experiences of six women who have faced the loss of a hoped for child, a temporary loss of self and identity and the loss of a hoped for future. The struggle to come to terms with this traumatic experience has been explored in the dissertation. In this short conclusion, the main outcomes are highlighted along with suggestions for further research.

### 6.2. Outcomes

A number of significant findings emerge from this study. First, women do not consciously delay childbirth but rather they wait for the right person with whom they wish to have a child. These experiences are a departure from previous studies which assume delay is connected to conscious choices around career and education. Delaying childbirth, given it is not a conscious choice, therefore does not seem to have additional impacts on the depth and nature of the losses experienced.

Second, the experience of pregnancy is fraught with emotional turmoil for childless older women: they desire to become biological mothers, feel they might have achieved their aim when they become pregnant, only to experience the devastation of the loss. Acknowledging that childless women of advanced maternal age experience additional fears about their pregnancy is a significant finding.

Third, being childless is a life-long state. The rawness of grief usually recedes but it is replaced by a lingering sadness and an awareness of the need to self-protect: participants were aware that the pain will likely be triggered in the future. The study highlights that whilst it is possible to move from devastating loss to a place of calm, growth and healing, it is a huge struggle which takes strength, determination and time. Being able to find a renewed sense of purpose and accept the new reality of the present and the future can emerge from the disappointment and pain.

### **6.3. Further Research**

Given this is the first study of its kind there is a great deal of scope for additional research. First, there is more qualitative research required on how women feel about their decisions to delay childbirth. Most of the research is currently quantitative in nature and is unable to explore the emotional responses of women. Research in this area could also explore the issue of women's perceptions of control over their fertility. Given the growing number of women making decisions to start their families at a later stage, this would be an important avenue for further research. Second, qualitative research on the meaning of pregnancy loss for women of advanced maternal age (who have children and are childless) would shed light on the impact of pregnancy loss when it occurs towards the end of fertility. Third, the research suggests there is scope for exploring the double impact of pregnancy loss and involuntary childlessness within a traumatic framework. Thus far, this has only been undertaken in the field of pregnancy loss. Fourth, an exploration of the impact of online support would be an important area for additional research. Whilst this study found online support was significant, this is maybe not surprising given the majority of participants were recruited through adverts on social media. How widespread the use is and the value gleaned from participating would be an interesting further avenue of research, especially given the deep sense of isolation pregnancy loss and childlessness can engender. Finally, research which contributes to a growing awareness of the experience of women who are involuntary childless would be of immense value in contributing to breaking the silence which continues to exist in the

21<sup>st</sup> century. Despite one in five women over 45 in the UK being childless, the assumption that women are not complete unless they are mothers remains a dominant discourse.

#### **6.4. Implications for practice**

There are a number of implications for practice which emerge. First, it is absolutely essential that women are offered access to good counsellors, preferably who have an understanding of fertility related distress. A number of participants were not offered any form of professional support following their pregnancy loss which led to further isolation. Being able to access professional support is seen to be even more significant given the continuing social awkwardness that surrounds pregnancy loss and childlessness. Second, raising awareness of the existential pain associated with losing a pregnancy and involuntary childlessness amongst the counselling community could enhance practice: the need for women who are going through this emotional turmoil to be acknowledged and heard is vital. Facilitating women to access their grief, to recognise their feelings are valid and to hear the multiple levels upon which loss can be felt is a significant aspect in the process of being able to accept a new reality. On a final, practical note, sharing information with clients about the online support forums could facilitate the process of healing and recovery.



## **Appendix One**

### **Reflexive Statement**

Before beginning the actual research I met with my former therapist. I was aware that I might touch upon some of my pain and I wanted to reassure myself that he would be able to see me if I needed to talk through my own emotional responses to the research material. He asked me why I had chosen to investigate this topic given my own painful experiences. I recall stating that it was an important, under-researched topic and that given my experience I would be an ideal person to do it. I believed that at the time, and I still do, but what became evident throughout the process was my growing realisation that undertaking this research was part of my grieving, part of my own sense-making process and to quote Colette, my way of ensuring that my experience was not wasted.

It has been an unexpected journey. Looking back, I think there was an initial unconscious reluctance to seek participants: scared, maybe, of my own emotional fragility. At the start of the research design, I had thought briefly that I might pursue a heuristic study. This would have necessitated an immersion in my own experience and the thought of dwelling in my pain was too challenging to contemplate at the time. In addition, I was not in a therapeutic process and did not want to return to the darker periods of my own grief. I was deeply aware, however, that I was inviting others to take exactly that journey. I think I was worried about what taking that journey might do to the participants who had signed up to go there. In the end, after the first interview and thereafter, I felt a deep connection with the women who spoke to me. We have all had our own unique experience on the road to biological childlessness but, for me, there felt as if there was a common understanding that we all shared. As the participants spoke to me about the joy, loss and heartbreak, there was so much that I recognised from my own story. To hear their stories was to be validated in my own: this was an unexpected gift and one I want to thank them all for giving me.

I was aware in hearing the stories that I wanted to tell my own. Half-way through the research process I had wondered about whether I could find someone to interview me so that my experience could be included for analysis. The thought stayed with me but in the end I decided not to confuse my analytical process by trying to both place myself within it and remain outside of it. The powerful desire to be heard, however, felt like a strong indicator that I was feeling both more accepting of my own experience and the lingering sadness that remains with me. The key aim of the research was to break silence around pregnancy loss and involuntary childlessness, but in doing it, I realised I was also allowing my own voice to be heard.

The process of analysis and writing up was a difficult and pain-staking one. Smith et al comment that when implementing the IPA, “there is considerable room for manoeuvre. The route through them [strategies] will not be a linear one, and the experience will be challenging” (Smith et al., 2013, p. 80). There were two key challenges for me: first, I was very heavily and personally invested in the project. This brought benefits in that I believe it brought greater insight and sensitivity to my handling of the data, but it also made it emotionally fraught at times: being able to stand back from the narratives and analyse their content took a great deal of emotional energy. Second, it was difficult to make the decision about what should be included in the discussion and what should be removed. Part of the underlying motivation for doing this work was to make voices heard, to contribute to breaking the silence and taboo around pregnancy loss and childlessness. Removing aspects of the participants’ experiences from the discussion felt uncomfortable: almost as if I was colluding in a project of silencing. However, IPA has as its central element, interpretation, and as the researcher I realised I had to take responsibility for inclusion and exclusion of data and as long as I had a clear rationale behind this process, I was fulfilling my task.

## Appendix Two

### Search History

Initial database searches provided the original sources. Additional material was followed up from the articles found via these searches.

<u>Date</u>	<u>Database</u>	<u>Search Terms</u>
20 November 2013	University of Chester Library University of Liverpool Library	Pregnancy Loss and Maternal Age /Pregnancy Loss and Childlessness
20 November 2013	University of Chester Library University of Liverpool Library	Miscarriage and Maternal Age
29 November 2013	Psychinfo	Pregnancy Loss and Maternal Age
29 November 2013	Psychinfo	Miscarriage and Maternal Age
12 December 2013	Google Scholar	Miscarriage and Maternal Age
15 December 2013	Google Scholar	Involuntary Childlessness
14 January 2014	Google Scholar University of Chester Library University of Liverpool Library	IPA
29 January 2014	Google Scholar	Pregnancy Loss and Childlessness
11 February 2014	University of Chester Library University of Liverpool Library	Involuntary Childlessness
17 March 2014	Psychinfo / Google Scholar	Involuntary Childlessness
5 April 2014	University of Chester Library University of Liverpool Library	Delay pregnancy / postponing pregnancy
7 April 2014	Psychinfo / Google Scholar	Delay pregnancy / postponing pregnancy and pregnancy loss / involuntary childlessness

## **Appendix Three**

### **Call for participants sent to BACP and BICA**

#### ***Call for Participants***

Exploring the impact of pregnancy loss on women who delayed starting a family and remain without children.

Although there have been a number of studies exploring the impact of pregnancy loss, there has been no specific research exploring the additional factors which might impact women who have made previous choices to delay starting a family and who have not conceived a child. Motivated partly by personal experience, this MA dissertation research aims to give voice to those experiences to enrich our understanding of the complexities and impacts of the losses.

I am inviting each participant to explore their experience of pregnancy loss(es) in the context of previous life choices. Interview questions will seek to invite reflections on what factors impacted on choices to delay starting a family, motivations for deciding to become pregnant and the processes associated with making sense of losses in the context of the current reality. The audio-recorded interview will last for approximately one hour at a mutually convenient and private location.

Participants should meet the following criteria:

- Trained counsellors with access to on-going supervision
- Have experienced a pregnancy loss at a late stage of your fertility
- Made previous choices to delay starting a family
- Be in a place where you feel able to reflect on your experiences
- Not have a biological child
- Fluent in English

If you would like to participate or would like further information, please contact me at:

Many thanks

Amanda Sives

Postgraduate student, University of Chester

## **Appendix Four**

### **Correspondence from Laura Hogan, re Therapy Today**

Re: Research advert for the Therapy Today net noticeboard

Laura Hogan

Mon 16/06/2014 13:58

Hi Amanda,

Thanks for your email. Here follows the usual confirmation regarding inclusion in the online TherapyToday.net Noticeboard, which will be updated next in mid-July...

**Advert placed on the Therapy Today noticeboard, from mid-July**

Seeking trained counsellors who have experienced pregnancy loss in the later stages of fertility and remain childless. MA research exploring the impact of the losses, please contact Amanda Sives:

Thanks very much,

Amanda Sives

BACP Member:

**Appendix Five**  
Correspondence with the BACP

Stella Nichols

Tue 17/06/2014 10:4

Dear Amanda

Thank you for your email requesting a notice on our Research Notice Board. I can confirm that this has now been posted and can be viewed at: [http://www.bacp.co.uk/research/Research\\_Notice\\_Board/](http://www.bacp.co.uk/research/Research_Notice_Board/) Please can you check your notice and confirm you are happy with it.

Your notice will be posted for two months, after which time we will get in touch to see if you would like to keep the notice up for longer.

If you have any queries please get in touch.

Kind regards

Stella

Stella Nichols

Office Administrator Research Department

British Association for Counselling and Psychotherapy

BACP House, 15 St John's Business Park, Lutterworth,

Leicestershire, LE17 4HB

[www.bacp.co.uk](http://www.bacp.co.uk)

[www.itsgoodtotalk.org.uk](http://www.itsgoodtotalk.org.uk)

## Appendix Six

### Information on More to Life

More To Life members are childless by circumstance, not by choice and here we provide support and a community which understands that although children were very much wanted, it is still possible to have a fun and fulfilling future without them. Whether you have tried treatment and not been successful, or decided not to ride the rollercoaster of treatment, or perhaps even have a partner who does not want children, or has children from a previous relationship, at More To Life we understand and aim to help you as you explore new ways of life which can be joyful and satisfying. –

See more at:

[http://www.infertilitynetworkuk.com/more\\_to\\_life/about\\_us\\_mtl#sthash.5rAVta pH.dpuf](http://www.infertilitynetworkuk.com/more_to_life/about_us_mtl#sthash.5rAVta pH.dpuf)



## **Appendix Seven**

### **Information on Gateway Women**

1:5 women in the UK, Ireland, USA, Canada & Australia are now reaching their mid-forties without having had children - double what it was a generation ago. Although some women have actively chosen not to be mothers ('childfree'), many of us are 'childless-by-circumstance' and find ourselves living a life we never planned for, and for which no one's got a roadmap! I call those of us born in the 60s and 70s the 'shock absorber generation' for the sexual revolution.

I set up Gateway Women in 2011 with the aim of supporting, inspiring and empowering childless-by-circumstance women. To end our isolation and create a safe place for us to talk about our situation, work through our grief and sadness and come out the other side ready to create a 'Plan B' for a meaningful and fulfilling life without children. One that ROCKS!

My book 'Rocking the Life Unexpected: 12 Weeks to Your Plan B for a Meaningful and Fulfilling Life Without Children' was published in September 2013 and went to #1 on Amazon Kindle on day one! It's now also available in paperback and in Kobo ebook formats.

Please do join our private online community – it's only been going since December 2012 and it's already been reviewed as the best in the world. It's inclusive, non-judgmental, wise, friendly and funny. "Support for the hard stuff; enthusiasm for the good stuff" is how one member described it.

It's not just you this has happened to. There's nothing wrong with you and you didn't screw up. Welcome to Gateway Women. Welcome, finally, to YOUR tribe.

<http://gateway-women.com>

## Appendix Eight

### Amended call for participants sent to More to Life and Gateway Women

Exploring the impact of pregnancy loss on women who delayed starting a family and remain without children.

Although there have been a number of studies exploring the impact of pregnancy loss (defined in this study as miscarriage, ectopic pregnancy, termination for medical reasons, stillbirth), there has been no specific research exploring the additional factors which might impact women who have delayed starting a family and who remain childless. Motivated partly by personal experience, this MA dissertation research aims to give voice to those experiences to enrich our understanding of the complexities and impacts of the losses.

I am inviting each participant to explore their experience of pregnancy loss(es) in the context of previous life choices. Interview questions will seek to invite reflections on what factors impacted on reasons to delay starting a family, motivations for becoming pregnant and the processes associated with making sense of losses in the context of the current reality.

I would like to recruit four to six women who would be willing to share their experiences in a face-to-face interview. The interview will last 50 – 60 minutes, take place at a mutually convenient location and be audio-recorded. The research proposal has gone through the University of Chester ethical process. This requires participants to be anonymised and all data to be stored in a password protected form and destroyed once the research is completed. Whilst the work is for an MA dissertation, I would hope to publish some of the work so that it reaches a wider audience.

Participants should meet the following criteria:

- Experienced a pregnancy loss at a late stage of fertility (defined for the purposes of this study as from age 35 onwards)
- Delayed starting a family
- Be in a place to reflect on their experiences
- Not have a biological child
- Be based in the UK and be fluent in English

If you would like to participate or you would like to find out more, please contact me at:

Many thanks

Amanda Sives,

Postgraduate student, M.A. Clinical Counselling, University of Chester.

Supervised by Dr. Valda Swinton.

## Appendix Nine

### Participant Information Sheet



University of  
Chester

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### Participant Information Sheet

#### Research Title

Exploring the impact of pregnancy loss during the final stages of fertility on women without children.

#### Background

I am a third year postgraduate student studying for an MA in Clinical Counselling at Chester University. My dissertation topic aims to enhance awareness of the experiences that accompany a specific cohort of women who have undergone pregnancy loss during a particular stage of their fertility. Although there have been a number of studies exploring the impact of pregnancy loss, there has been no specific research exploring the additional factors which might impact women who have experienced pregnancy loss and made previous choices to delay starting a family.

#### Invitation

I am inviting each participant to explore their experience of pregnancy loss(es) in the context of previous life choices. Interview questions will seek to invite reflections on what factors impacted on choices to delay starting a family, motivations for deciding to become pregnant and the processes associated with making sense of losses in the context of the current reality. The interview will last for approximately one hour at a mutually convenient and private location.

#### Eligibility

Participants should meet the following criteria:

- Experienced a pregnancy loss at a late stage of fertility (defined for the purposes of this study as from age 35 onwards)
- Delayed starting a family
- Be in a place to reflect on their experiences
- Not have a biological child
- Be based in the UK and be fluent in English

#### Next Steps

If you are interested in participating in this study or you would like further information, please contact me via the email address below with a telephone number. I will then call you to discuss the research in more detail and if you would like to participate in the study we can arrange a mutually convenient time and place for an interview. You will be asked to provide your written consent before the interview begins. When we meet I will invite you to explore your experiences; this will take the form of a digitally recorded interview lasting no more than an hour. Any travel expenses will be reimbursed.

After the interview, I will transcribe the recording, and you will be offered the opportunity to check this for accuracy. Once my analysis is complete you will also be able to read the results if you wish.

### Your rights

Your participation in the study is voluntary and you are free to withdraw at any point before data analysis has begun, without giving a reason and without detriment to yourself. You will be offered the opportunity to read and agree the transcript of your interview, and at that point will be giving consent for the data to be used in the study. Once final consent has been given and the analysis begins, you will not be able to withdraw or change the material, as the data will have added into the group data set, and it will no longer be possible to isolate it.

### Potential Benefits and Risks

You may value the opportunity to tell your story. By taking part, you will be contributing to increasing awareness of this under-researched topic. There is a risk that talking about this sensitive topic may bring up painful feelings for you. I will provide you with a list of BACP accredited counsellors in your local area, should you wish to explore the subject further.

### Confidentiality

The interview will take place in an environment where privacy can be ensured. I will give you a pseudonym, which I will use throughout the research to protect your anonymity. Verbatim quotes may be used in the final dissertation but I will ensure that I only use material that will not identify participants. The transcripts and related data will be securely stored for a period of five years, by me, and then destroyed. Upon satisfactory completion of my MA in Clinical Counselling the recording will be securely destroyed.

### Results

The results of the research will be part of my dissertation which will be submitted to Chester University. The dissertation will be available in the Department of Social Studies and Counselling and also may be available electronically. The findings may be shared with relevant organisations, such as the British Infertility Counselling Association and may also be included in subsequent papers put forward for publication.

### Further information

Please feel free to contact me via email with any queries:

### Contacts in the event of concerns about the research

If you are unhappy with any aspect of the process, I would ask you to contact me in the first instance:

If the outcome is not satisfactory, you can contact my Research Supervisor, Dr Valda Swinton

If the issue still cannot be resolved, please contact the Dean of Social Sciences, David Balsamo

Thank you for your interest in this study.

Amanda Sives

April 2014

## Appendix Ten



University of  
Chester

### RESEARCH CONSENT FORM

Title of Study: Exploring the impact of pregnancy loss during the final stages of fertility on women without children.

Name of Researcher: Amanda Sives

Name of  
Participant:.....

If you are happy to participate please complete and sign the consent form below.

Please  
Initial

Box

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time before data analysis has begun, without giving a reason and without detriment to myself.
3. I understand that after reading and agreeing the transcript of my interview, and giving my written consent, that my data can be used in the analysis, and my right to withdraw from the study will cease.
4. I understand that the interviews will be audio recorded.
5. I agree to the use of anonymous quotes.
6. I agree that any data collected may be passed to other researchers.

I agree to take part in the above project

Name of participant  
Signature

Date

Name of Person taking Consent  
Signature

Date

## **Appendix Eleven**

### **Research Schedule**

1. Can you reflect on reasons why you delayed starting a family? (career, partner, lifestyle, childhood; awareness of it being a conscious decision at the time)
2. When did you decide you wanted to try and get pregnant? (age, what were the motivations, what was the context for change)
3. Can you tell me about the process of trying to become pregnant? (length of time, natural or medical intervention, how did it feel being pregnant)
4. Can you tell me what happened? (nature of the loss, at what stage of the pregnancy, how did you feel, did you feel supported or seek support during that period, reflecting back on that time of life how do you feel you managed the losses)
5. How would you describe the impact of the losses upon you? (on your sense of self, identity as a woman, your relationship with your partner, family, friends, any other aspects)
6. Can you tell me where you are now in relation to the specific loss(es) you experienced? (how have you managed the grief, how do you envisage yourself at this stage of life)
7. Can you tell me how you feel knowing you will not give birth to your own child? (do you feel reconciled to it, what adaptations have you made, what plans do you have for the future).

## Appendix Twelve

### Example of notes from an interview transcript

Interview Transcript One

		become pregnant?	
A	61	Well, I did when I started not to be able to, yes. And all these	
	62	years later <u>I am still the only person I know who wanted a</u>	<u>isolated</u>
	63	<u>baby and didn't get one</u> which is why I joined the More to Life	<u>isolation - language quite important. sense of being singled out</u>
	64	thing, just to see a few like-minded souls who actually didn't	
	65	get a child after all. Because actually the few people I know	
	66	who had problems, but <u>they managed it</u> . But anyway, you	<u>but I didn't - odd one out. sense of having failed / was of self.</u>
	67	want to know some other things.	
Q		I was just thinking that it sounds isolating	
A	68	<u>Terribly isolating, horrible and one of my best friends</u> just	<u>Empowering humble pregnancy in close circle description journey backwards / relapse</u>
	69	had an IVF baby at age 43 and you know I am very happy for	
	70	her but it was, I went backwards, that is when I joined the	
	71	More to Life and started doing things on the forum because I	
	72	just had a <u>complete relapse</u> into that really <u>uncomfortable</u>	<u>surprised / discomfort at her response: surprise that could be expected around pregnancy to manage because around children.</u>
	73	place. Very strange. I mean most of the time I manage fine	
	74	and other people's children don't bother me because I teach	
	75	children.	
Q		Ok, so you are with children all the time?	
A	76	I have had to become <u>immune</u> to it. There are a lot of people	<u>immunity - built up lead to do it,</u>

conclusion need: element of common

pregnancy self

pregnancy journey

sense of self

isolation

## Appendix Thirteen

### Example of individual themes and Sub-themes

Theme	Sub-theme	Evidence
Career	Reason for postponing pregnancy	'from the age of 10 I was determined I was going to be a ballet dancer and unlike lots of other little girls, I actually made it.' P1 'maybe I will have them but not until I have done my career'. p2 'but I had really, really focused on that career', p2
	Emotional support whilst trying	' we had a few little breaks because I couldn't cope with the stress of it and then he got made redundant so I went back to dancing for a little bit which kind of emotionally refreshed me,' P12, 'but I put my energy into my career because I just had to distract myself.... So everything was revolving around it but I couldn't, I couldn't only think about that, I had to have a plan B', p17.
	Refocus on career after multiple losses	'I think where I am fortunate over many other women is that I did have a career, a vocation, something I still enjoy so I have been lucky there.' p33, 'so that has been my anchor. And I am very, very lucky and I am lucky that I am always able to make the best of a bad situation and I am very lucky in that area.'p33 'so my work has been my absolute saviour', p41, 'It just gave me an outlet. It gave me something to bury myself in' p42, 'it kept me going. I had to put my make up on, I had to get dressed, I had to do something. p47 'you either die or you get yourself through somehow and everyone has their own way of getting through it and that was mine. And I had the good fortune that it was in my hand ready to go. So I just picked it up, I didn't have to create it. So that was lucky for me'. P48
	Had to build relationships with children due to career	'I mean most of the time I manage fine and other people's children don't bother me' p.5 There are a lot of people who say um they cannot cope seeing children, cannot cope with people talking about their children. Well, if I was like that I wouldn't eat because my marriage didn't survive this and I have to eat so I have to build a thick skin.' P6 'It was murder... and I found it wasn't the work I couldn't cope with, it was everyone else's children. And I had a couple of weeks when I managed to get people to cover my classes'. P30



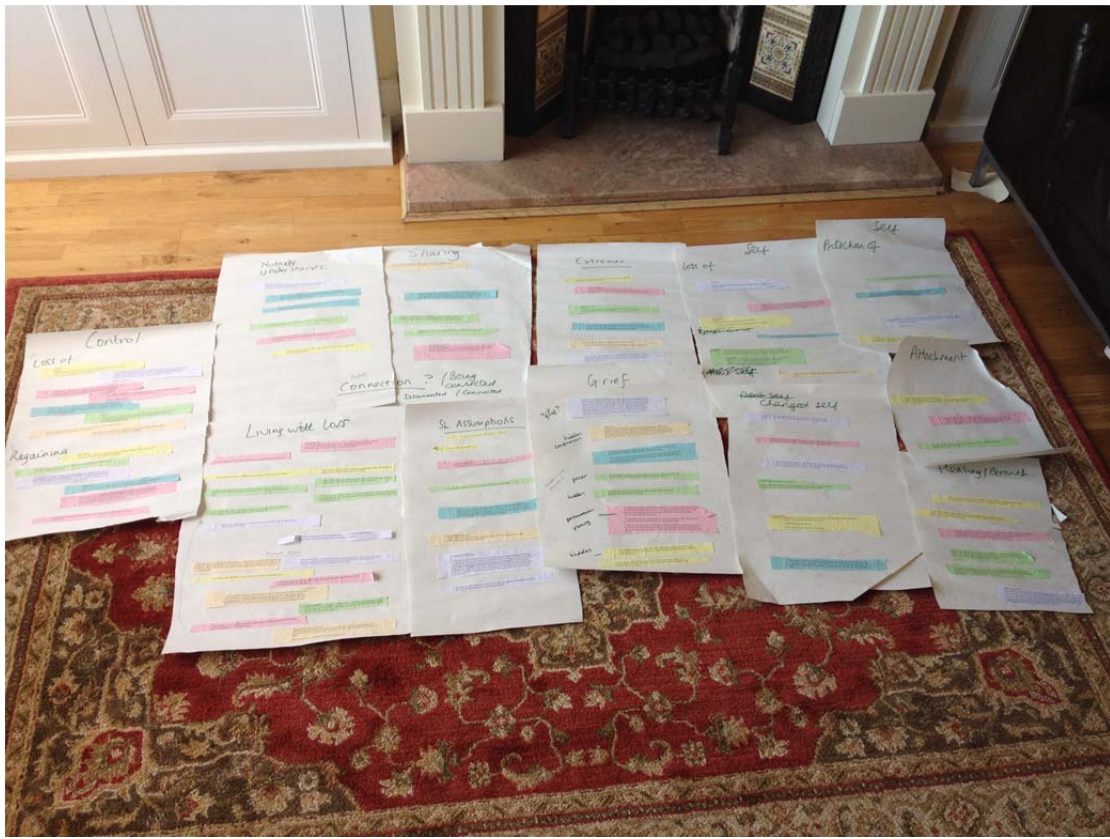
		'So this awful, awful pain I went through, I can't tell you how many times I was crying before I went to work because I didn't want to see other people's children, oh it was awful. I went through some real, real pain, but it had an up side'.p46
Relationships	Impact on marriage / partnership	'He had his own difficulties dealing with what was happening, you know, he was in his own difficult place. I was in my own difficult place'. P23
	Sense of isolation in peer group	'I am still the only person I know who wanted a baby and didn't get one... Because actually the few people I know who had problems, but they managed it,' P5 'there is still an element of how did she manage it and I didn't? What did I do wrong? P37 'And my close friends, well they forget, they forget'. P35 'terribly isolating, horrible' p5 'On the couple of occasions I have shared with clients what has happened to me, they haven't been able to handle it'. P31 'there are not many people I have shared the gory details with'. P34
	Impact on other relationships	'My way now is that I am lucky enough to know all these young people through my work and any relationship that can be nurtured, I nurture' p.29 'And I don't have problems with my young friends having children. I think that's fantastic because you know, they are almost my children, so they are also like grandchildren'. P29
Losing and Gaining Control	Planning	' and my big thing was not to get pregnant because it would get in the way of my career'. P1 'maybe I will have them but not until I have done my career', p2 'I was coming to the decision.. And I had to find a husband...I found the man, managed to get him to marry me, in three years we were married. I had everything mapped out. ... I had everything perfect for a lovely family and it didn't happen'. P3 'Where we were going on holiday and I was visualising it, yes, 'oh I will be like that next year'. P4
	Loss of control	'so when it didn't seem to be happening I started to get quite worried. Well, this isn't what I planned, what am I going to do?' p4
Ways of Coping	Sense of Self	'how do you cope with the sun rising every morning and setting every evening. It's life, it's the cycle of life and if you block yourself off to it completely, that is really hard'. P30 'Yeh, it was tough. I am a tough lady'. P47 'You have to get yourself through

		somehow and everyone has their own way of getting through it. And that was mine.' P48
	Development of 'immunity' / protecting self	'If a family member says so and so is pregnant, I can only cope with so much. I will sort of just walk away from things if I can't deal with them now but I will literally just end a conversation and walk away if something affects me too much'. P8 .. you cannot expect them to tread on eggshells all the time...So you just have to protect yourself and do what works for you without being too rude.' P36 'I think I have got tougher because I used to go, 'oh really, tell me more' and hurt, and hurt. And no, I am done with hurting like that. I am too old'. P37 'The more you talk about not having them, the more you think there is something wrong with you that you haven't got them'. P43 'I had been able to anaesthetise myself to this pain caused by other people's children ad pregnancies apart from those in my very close circle... it was only through my work and the absolute need to do that'. P45
	Nurturing	'She was coming to visit me. She had the baby. I had the cat. I have got my baby. I am not on my own, you know'. P7 'because I went on the forum out of, to answer, to try and give support to other people mostly, that was why I did it. Because I had been supporting my friend who then had the baby. I felt redundant'. P44 'My way now is that I am lucky enough to know all these young people through my work and any relationship that can be nurtured, I nurture' p.29
	Creativity	And because I had this creative thing and I wrote poetry at the time... I had to release it somehow'. P14 'I had grieved. I had written my poems. I'd grieved, that what I had done'.
	Seeking professional support	'I asked for counselling.. and that had to cover everything because there was the loss of the pregnancies, there was the potential loss of never having a child and there was the loss of the marriage, so it was very hard'. P32
	Fate/ Destiny	'And maybe that is an easier way to deal with it, to say, 'well this was my destiny and hey, I have done other things with my life'. P38
Grief work	Hope and its loss	'I had like a reason to peg up, to hang on the peg why I couldn't get pregnant which was a huge relief. That was a huge relief to me, now I have a reason. And then, ooh, hey, maybe it will happen now, I had

		<p>hope'. P9</p> <p>'Absolutely off the planet. I mean I kept redoing the pregnancy test every five minutes. I kept touching my boobs to make sure they were sore. I couldn't believe it. Is it real? I was terrified something was going to go wrong.' P10</p> <p>'Difficult, very difficult because there was a lot of hope because I had it in my hand and it had been taken away so the hope was hugely elevated on what it had been before. Because now I knew what it was to imagine that, that thing inside you growing. The minute I knew I had conceived I was imagining what size it was, its organs.' p16.</p>
	Hard work	<p>'It doesn't mean I don't have relapses, but you know, and you have to work hard at it, you have to work hard at it, oh dear'. P40</p>
	Passing of Time	<p>'But it doesn't hurt. It used to hurt. It doesn't hurt anymore'. P6</p> <p>'But at the time, every month of waiting...every month you wait you think, maybe this is it, your period is one day late you get the pregnancy test out, hmmm.' P12</p> <p>'And so for a few years, birthdays were tough. I had kind of forgotten that now, it is amazing how with time, you know, you either get through it or you don't have a life, so you have to make a choice, don't you?' p20</p> <p>'I got on with my life but I was never able to completely let go of the thing until menopause'. P26</p>
	Difficult moments	<p>'and one of my best friends just had an IVF baby at 43, and you know I am very happy for her, but it was, I went backwards...I just had a complete relapse into that really uncomfortable place,' p.5</p>
	Long term impact	<p>'I feel incomplete. I feel like I have got a limb missing'. P34</p> <p>'Menopause sorted it because all the hormones calmed down' p25</p> <p>'I won't have grandchildren. I don't know how much it will affect me.' P.28</p>

## Appendix Fourteen

In the image below, it is possible to see the process of drawing together the themes with the accompanying evidence. Each participant's information was on a different coloured paper. Laying the drafts of themes on the floor enabled me to better see overlaps: for example, sub-themes 'no-one understands' and 'sharing' were combined to form connection. A similar process occurred with the sub-theme of self which had originally been organised in three separate sub-themes.



## Appendix Fifteen

### **A further note on the data analysis process and the participant voices**

In order to respect the confidentiality assurances given to the participants, I have decided not to provide more biographical material about them in the dissertation: aside from what has already been shared in table one. However, I would like to reflect further on the process of distilling their experiences into the themes and, in doing so, I will share further information about them. This feels important as part of explaining the process of data analysis but it is also significant in highlighting the diversity of the experiences through which the participants lived.

First of all, the advert which was circulated did not specify whether women needed to have conceived naturally or through medical intervention. I did think about whether to include this but in the end, I decided to leave it unspecified and to see who responded. I was glad to have left it open as it allowed me to assess whether the emotional impact of pregnancy loss differed depending on the process of conception. What became clear from the experiences of the women who participated in this research is that the levels of grief and devastation were deeply felt regardless of how the women became pregnant.

Second, the research advert did not specify the ages of the women to take part, except to be over the age of 35. This is the age widely seen as marking an advanced maternal age. The lack of an older age parameter meant that women who responded were in different positions. In addition, I merely asked that women were able to reflect on their experiences rather than specifying where they needed to have reached in the grieving process. The participants were at different stages. Tessa had gone through the menopause whereas for Maria, there was still some hope that she might be able to conceive. Zaina and Sylvia were unable to conceive for gynaecological reasons whereas Colette and Sarah had taken the decision to stop trying to become pregnant. This diversity of experience was matched by the different stages of grieving. Four of the participants were clear that they had moved a way along their

grieving journey, whilst still recognising the existence of their pain. They were able to reflect on the process of growth and change which had occurred for them as they had emerged from the rawness towards some accommodation with the pain. For Zaina and Maria, there was recognition that there was some way to go. Zaina stated she was stuck in her grief and needed to find some coping strategies to help her move forward. Maria was aware that she had not fully come to terms with her grief as yet. Capturing the different stages of the grieving process was challenging and it is reflected in the fact that Zaina and Maria's voices are less present in the final section of the findings.

Third, different perspectives also emerged in relation to the reasons for the delay in having children: some were not captured in the analysis. First, Tessa's career was a hugely important part of her life in that it was the reason for her delay, it emotionally sustained her through the process of trying to become pregnant and through the losses, it gave her a focus following her losses and it left her with no choice but to come to terms with other people's children (given she taught them). None of the other respondents had such a powerful career drive, with the possible exception of Colette. However, Colette's experience was very different in that she had been adamant at an earlier stage that she did not want children. This was connected to her own experiences in childhood and led her to become education and career oriented.

It is not possible in any data analysis process to capture the total diversity of experience. IPA seeks the essence of the lived experience and this is achieved through a close interaction with the data. Ultimately, it is the researcher's interpretation of the data which emerges and which guides the investigation, findings and discussion. It is self-evident that not all aspects can be included in the analysis. This brief discussion has been included in order to indicate some of the diverse experiences related to me. That individuals have different experiences is not surprising as none of us live the same life. I wanted to acknowledge this here.

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