Partners and Pregnancy Loss: Perspectives From Co-Mothers In The UK

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ABSTRACT

Background

Pregnancy loss has been shown to be an emotionally distressing event, with potentially long-lasting psychological consequences (Cumming et al., 2007). Research has also found that pregnancy loss can have a significant psychological impact on partners (Due et al.,2017). However, research with partners has overwhelmingly focused on fathers in heterosexual relationships and so is limited in its application to LGBTQ+ partners. Research seeking to explore co-mothers (non-gestational female same-sex partners) experiences of pregnancy loss is limited, with only one North American empirical study focussing on this (Wojnar, 2010).

Aims

The present study aims to explore how co-mothers in the UK experience pregnancy loss. By locating this research within the UK specifically, it is hoped that this research can begin to build an understanding of how UK healthcare and social systems interact with and impact upon co-mothers' experiences of pregnancy loss.

Methodology

This qualitative study used individual, semi-structured interviews. Five co-mothers from across the UK took part in the study. The resultant data were analysed using reflexive thematic analysis.

Results

Four main themes and eleven related subthemes were developed from the data. The main themes were: The Journey Through Loss; Conception And Loss As Intertwined; The Impact Of The NHS On Pregnancy Loss; and Co-Mothers As Invisible And Unknown. The findings provide an insight into co-mothers' experiences of pregnancy loss. Co-mothers described pregnancy loss as an emotionally complex and destabilising event. The possibility of both mothers being pregnant, or trying to become pregnant at the same time, added both extra complications and benefits to their experiences of loss. The couples' journey to conception was integral to understanding the ways in which pregnancy loss impacted co-mothers. For co-mothers, pregnancy loss also encompassed a loss of carefully constructed plans, imagined futures and monetary loss, all of which added extra burdens to the already grieving couple. All co-mothers described negative experiences with the NHS, alongside some positive experiences. Co-mothers related some of these experiences to general poor-quality care, and some to direct discrimination.

Contents

TERMINOLOGY

The terminology used in this thesis to describe ideas related to gender and sexuality are also used in a way that gives consideration to the broad range of terms that have been used to describe people in the LGBTQ+ community (see appendix A for a glossary of terms). This thesis uses the term “female same-sex relationship” to refer to two cis-gendered women who consider themselves to be in a romantic and/or sexual relationship. The is used with acknowledgment that the terms participants use to describe their own relationship and sexuality may differ, for example some may prefer the term lesbian relationship, some may prefer to refer to themselves as queer. When papers or research from other authors are being discussed the terms that these researchers adopt in their work will be kept for clarity and to acknowledge the specific context in which that research was carried out.

As mentioned, the present research was focused on cis-gendered women, it therefore feels important to clarify what is meant by this. The terms “female” and “cis-gendered” are used in this thesis to refer to women who identify with the gender they were assigned at birth. It is my position as a researcher and individual that the term woman should be used in a broad and inclusive way, also encompassing people beyond the assigned female at birth population, for example trans women, or non-binary people who identify with womanhood. Therefore, it is important to be clear that in this research “female” and “cis-gendered woman” are used with this in mind and with acknowledgement that the definition of woman is not confined to sex characteristics.

The decision to focus this thesis on cis-gendered women’s experiences was made based on a number of factors. As outlined in the literature review, there is a very small body of empirical research from North America that has also focused on cis gendered co-mothers experiences of pregnancy loss, and an aim of this research was to explore similar experiences specifically within the UK. In addition, due to the constraints placed upon a doctoral thesis in terms of word count and time limitations, it was felt that focusing in a fairly narrow way on a particular group of people would allow for a more thorough and in depth analysis of their experiences. It was considered that the experiences of trans and non-binary woman are deserving of their own space and simply attempting to add in their experiences to a sample of predominantly cis-gendered women would be reductive and may result in a thinner analysis overall. Therefore this decision was made not to exclude the experience of trans or non-binary women, but to enable a detailed and thorough analysis of the experience of this specific group of co-mothers.

INTRODUCTION

1.1 Defining And Contextualising Pregnancy Loss

Pregnancy loss is currently defined in the UK as the death of a baby (or foetus or embryo) in the uterus or during birth (Tommys, 2020). Pregnancy loss is therefore a broad term that is used to encapsulate many varied and differing complications that ultimately result in the loss of a baby. It is estimated that 1 in 5 pregnancies end in loss (The Miscarriage Association, 2022), this may be through miscarriage, terminating for medical reasons, molar and ectopic pregnancies, still birth, chemical pregnancy, and neonatal death. These are all terms associated with the broad definition of pregnancy loss and each describe a type of loss characterised by shared medical factors such as gestational stage and causation of the loss.

In the UK miscarriage is deemed to be the most common form of pregnancy loss occurring around 250,000 times a year, and is defined as the spontaneous death of a baby in utero prior to 23 weeks and 6 days gestation (Tommys, 2020). Pregnancy loss that occurs after this date is most commonly referred to as a stillbirth (The Miscarriage Association, 2022). However, these terms are often used interchangeably and with a degree of ambiguity. When exploring the literature on pregnancy loss in the UK, many papers still do not differentiate between terms such as abortion, miscarriage or stillbirth (Steer, 2018; Kolte et al., 2015). Therefore, it is essential to be clear about the terminology used in this research, how pregnancy loss is defined, and the context in which the terminology was formed.

The language used to describe pregnancy loss has changed significantly over the course of history. Prior to the Abortion Act of 1967, induced termination was a criminal offence, and so women were unable to share their experience of how their pregnancy ended with medical professionals for fear of criminalisation. Therefore, in medical practice in the UK, very little distinction was ever made between induced and spontaneous pregnancy loss (Moscrop, 2013), and this is reflected in the term “abortion” being used in medical literature to refer to any premature end of a pregnancy. It can be theorised then, that as the Abortion Act 1967 eased some of the legal restrictions, it was somewhat safer for women to discuss their varying experiences of pregnancy loss and this necessitated a distinction in the clinical terms used to describe whether the end of a pregnancy was planned or unplanned. Therefore, between the early 1970s and late 1990s the most commonly used medical terms for pregnancy loss were “spontaneous abortion”, “induced abortion” and “missed abortion” (Moscrop, 2013).

However, notably, in 1985 there was another shift in terminology. A letter published in The Lancet, written by Gynaecology professionals at St. Mary’s Hospital London (Beard et al., 1985) described how patients were increasingly talking about their loss using the term miscarriage. The letter went on the describe the offence that the word “abortion” could cause to women who had not chosen to end their pregnancy. Indeed, Moscrop (2013) charted the annual incidence of the term “spontaneous abortion” published in the British Medical Journal between 1975 and 2010 and noted a steady decline in the term beginning in around 1986.

More recently however, the term miscarriage has also been questioned, particularly how it may be associated with failure e.g. a miscarriage of justice (Browne, 2018). In recent years, mostly through discourse online and on social media (Ryan, 2020), the term ‘pregnancy loss’ has been introduced as a more ‘empathic’ response to women’s experiences (Moscrop, 2013). However, the term ‘pregnancy loss’ has also been contested, similarly to miscarriage, the word ‘loss’ for some people may insinuate a failure to keep a pregnancy (Silver et al., 2011). This discursive issue highlights one of the many complicated facets that surround pregnancy loss and demonstrates how language used to describe the event both constructs and is constructed from the context in which it occurs.

The term pregnancy loss will be used in this thesis to describe any experience in which a pregnancy ends prematurely and results in the death of an embryo, foetus or baby. This term is used with acknowledgement of its historical and current context, including the possibility that it will become outdated and may not fit with the experience, or personal reality, of all those who interact with this work. Throughout this thesis the terms used in the papers being discussed will be retained, for clarity and to acknowledge the specific context of that research.

1.2 The Emotional And Psychological Impact Of Pregnancy Loss

Despite its commonality (Tommys, 2020) research suggests that various misconceptions around pregnancy loss exist both historically and currently (Bardos et al., 2015). Historically, pregnancy loss was seen by many people across Western societies such as the UK and North America as insignificant and transitory, not a ‘real loss’ (Tommys, 2020). Psychological literature prior to the 1990s reflects this, with very few papers seeking to explore the psychological impact of pregnancy loss beyond tokenistic, limited and variable definitions of ‘grief’ (Janssen et al., 1997). In more recent decades, psychological research around pregnancy loss has grown exponentially. In contrast to the ambigous nature of the pre-1990s literature, much of the recent research has attempted to understand the impact of pregnancy loss on women’s mental health through surveys and questionnaires that aim to measure clinically defined mental health conditions (Cumming et al., 2007; Engelhard et al., 2001; Neugebauer et al., 1992).

Although arguably reductive in its nature, this type of research has repeatedly shown that women appear to be at high risk of experiecing significant levels of anxiety (Farren et al., 2016; Klier et al., 2000; Prettyman et al.,1993) and depression (Athey & Spielvogel, 2000; Beutel et al., 1996; Neugebauer et al., 1992) following pregnancy loss. A narrative review of perspective cohort studies found that overall, a high level of general anxiety is the most frequent and long-lasting emotional impact of early pregnancy loss (Farren et al., 2018). Within this review it was noted that a high percentage of women whose pregnancy ended in loss experience anixety so severe that it warrants clinical attention (Prettyman et al., 1993). In addition, it was found that in general, significant levels of anxiety tend to be sustained for around 6 – 12 months post pregnancy loss (Beutel et al., 1996; Broen et al., 2005; Broen et al., 2006; Janssen et al., 1997).

Whilst many studies suggest that mental health difficulties following pregnancy loss tend to lessen with time (Brier, 2008; Farren et al., 2020) a number of studies have also demonstrated how, for many, the detrimental effects of pregnancy loss are enduring and complex, often influenced by factors such as age, gender and previous mental health needs (Cumming et al., 2007). Whether or not a pregnancy was planned or welcomed has also been found to be a key indicator of levels of psychological distress (Thapar & Thapar, 1992).This further suggest that the event of a pregnancy loss is not only likely to cause short term distress, but also is an event that can have complicated and long-term impacts on mental health (Cordle & Prettyman, 1994)

Related to this, some studies have also conceptualised pregnancy loss as a traumatic experience (Engelhard et al., 2003; Farren et al., 2016). Studies have shown that pregnancy loss at all gestations can result in women experiencing symptoms associated with Post Traumatic Stress Disorder (PTSD) such as flashbacks and dissociation (Farren et al., 2016). Perhaps most pertinent, reported rates of suicide and attempted suicide amongst people who have experienced pregnancy loss have been shown to be significantly higher than rates in the non-pregnant population (Farren et al., 2020; Weng et al., 2018).

Although literature of this kind demonstrates that pregnancy loss is likely to have a significant impact on emotional wellbeing, by focusing on narrow descriptors and diagnostic categorisation of distress, it builds a somewhat thin understanding of the experience of pregnancy loss. This can downplay what has been described by some as an experientially challenging event, which, in addition to emotional distress, can provoke long-lasting existential and psychological change (Brier, 2004; Lok & Neugebauer, 2007).

In a recent study in Scandinavia, Kukulskienė & Žemaitienė (2022) interviewed 7 women who had experienced a late pregnancy loss. Themes of being in a split state (between life and mourning, pregnancy and non-pregnancy), betrayal of the body, disconnecting and reinterpreting the concept of self and motherhood were generated. Bardos et al., (2015) found that 40% of women who had experienced a pregnancy loss felt ashamed about the experience, and 47% felt guilty. In addition, research has also described how the assumptions women may hold about the causes of their pregnancy loss can result in self-blame and feeling responsible for the loss (Frost et al., 2007; Simmons et al., 2006). Therefore, although limited, research has also begun to provide richer accounts of the ways in which pregnancy loss can influence a person’s sense of self and the difficulties individuals can have in comprehending the experience.

Overall, findings from both quantitative and qualitative research suggest that pregnancy loss is a complex and nuanced experience which can both impact upon, and be impacted by, a person's internal and external worlds.

1.3 Partners And Pregnancy Loss

Alongside the recognition of the emotional impact of pregnancy loss upon the pregnant person, there has been increasing interest in the emotional and psychological impact of pregnancy loss on partners (Due et al., 2017; Nguyen et al., 2019). Research in this area has overwhelmingly focused on the experience of fathers in heterosexual relationships, seeking to both understand the experience from the father's perspective and also compare experiences between mothers and fathers. Research in this area has reported broad and sometimes contradictory findings (Williams et al., 2020).

There is debate around the similarity and differences of the emotional experience between men and women in particular. Many studies focusing on fathers have reported that although men do seem to experience similar feelings of grief, depression and anxiety following a pregnancy loss, these feelings are less intense when compared to women (Badenhorst & Hughes, 2007; Cumming et al., 2007; Kagami et al., 2012; Kong et al., 2010;. However, other studies have suggested that men do report similarly high levels of depression and anxiety shortly after a pregnancy loss, but these feelings tend to lessen and plateau after just a few months (Due et al., 2017), suggesting that the psychological impact is similar, but men tend to recover at a quicker rate.

Although this literature presents some disagreement, a general pattern emerges suggesting that overall men tend to suffer less as a consequence of pregnancy loss compared to pregnant partners (Due et al., 2017). Importantly however, in contrast to this, a smaller number of papers have reported that in fact men do feel similar levels of distress to their partners, and their distress is also enduring. For example, Johnson & Puddifoot (1996) found that the level of grief reported by men was high and its intensity lasted for a similar length of time to their female partners. Indeed, Conway & Rusell (2000) reported that men actually scored significantly higher than their female partners on the Perinatal Grief Scale (Potvin, 1989).

This disparity in the literature leads me to consider what factors may be underlying or overlooked in how partners report and describe their experiences of pregnancy loss. Interestingly, research in this area has also found that men tend to be hesitant to disclose their feelings, as indicated by high scores on avoidance scales (Puddifoot & Johnson, 1997). This suggests that men may be under-reporting their levels of distress following a pregnancy loss, and this may begin to offer an explanation for some of the disparities seen in the literature around partners and pregnancy loss.

In addition, some studies have shown that men tend to engage in compensatory behaviours following pregnancy loss, such as increased alcohol consumption and focusing more on work (Abboud & Liamputtong 2005; O'Leary & Thorwick, 2006). Johnson & Baker (2004) found that during pregnancy, men relied more on approach-orientated coping strategies such as problem solving, and seeking support. However, after a pregnancy loss this changed to more avoidant-orientated strategies such as disconnection and withdrawal from others. This leads me to consider that the reported tendency of men to avoid their emotions through distraction and disconnection may be influencing the accuracy of research seeking to measure emotional impact. Consequently, it can be argued that the complexity and nuance of partners' experiences cannot be fully captured in research utilising questionnaires or scales to ascertain levels of emotional distress (Due et al., 2017). It must also be considered that gendered ideas of how men and women understand, describe and outwardly express their distress may be influencing differences in the reported levels of internal distress shown in research.

Qualitative studies which have interviewed men about their experience of pregnancy loss have suggested that social expectations and relationships with others, including health care practitioners, obstructed them from articulating and addressing unfamiliar emotions, uncertainties, and support requirements (Obst & Due, 2019). Within this, men have expressed that they often feel that their role is primarily as a 'supporter' to their female partner, and that this precludes recognition of their own loss. These studies also reported that men may feel overlooked and marginalised in comparison to their female partners, whose pain is typically more visible (Due et al., 2017).

Numerous studies have also sought to understand these experiences in the context of the normative social expectations placed on fathers (Abboud & Liamputtong, 2005; Johnson & Baker, 2004; Story-Chavez et al., 2019). In this research, men described being positioned by society, and consequently by themselves, as caretakers and sources of strength (Story-Chavez et al., 2019). These studies also suggest that men may feel unable to express their emotions about pregnancy loss, due to the expectation that they maintain control and be a comfort to their partner (Abboud & Liamputtong, 2005). Importantly, it was found that whilst many men described how they make the effort to appear overtly ‘strong’ and return to their regular life as a coping strategy, they nevertheless experienced internal feelings of stress and vulnerability (Story-Chavez et al., 2019).

Although individuals described their experiences differently, in research by Williams et al (2020) it was noted that overall fathers’ experiences of pregnancy loss were characterised by marginalisation of their own specific needs. Studies have identified that the overall wellbeing of fathers during pregnancy loss is mediated by the levels of social recognition they receive (Brier, 2008). Men have described feeling overlooked in comparison to their female partners, whose suffering and pain was more visible (Abboud & Liamputtong 2005; Murphy, 1998; Samuelsson et al., 2001). Studies have also compared how mothers and fathers express their grief (Volgsten et al., 2018), reporting that fathers express feelings typical of grief and bereavement, such as sadness and uncertainty, however the predominant emotions reported by men tend to be frustration and helplessness (Due et al., 2017).

Overall, the literature indicates that whilst the feelings experienced during and after pregnancy loss are often similar between men and women, the way in which these feelings manifest and are expressed tends to be different. This suggests that research focusing on partner wellbeing is important, as the lack of knowledge of these issues in society, in services and from family and friends can lead partners to feel helpless and alone in their grief (Brier, 2008; Beutal et al., 1996; Defrain et al., 1996; Serrano & Lima, 2006).

As noted earlier, it is striking that the literature around partners and pregnancy loss, has so far been overwhelmingly focused on cis-gendered fathers in heterosexual relationships (Due et al., 2017). The vast majority of research has been constructed from a heteronormative perspective of pregnancy and loss. Therefore, through this research, our current understanding of both the role of the partner in pregnancy loss and its emotional impact is completely interwoven with, and based on, male gendered understandings of grief, emotional expression and parenthood. Although this research is undeniably important, it leaves me wondering whether these findings can and should be generalised to those whose experiences fall outside of these norms of gender and sexuality. With advancements in Assistive Reproductive Technologies (ART) and Lesbian, Gay, Bisexual, Trans, Queer (LGBTQ+) rights in the UK, more LGBTQ+ people and couples are able to become pregnant and start families. LGBTQ+ people will undoubtedly also experience pregnancy loss.

1.4 Assistive Reproductive Technology And Pregnancy Loss

Whether or not a pregnancy was planned or welcomed has been described as a key influence in the levels of distress experienced by couples following a loss (Thapar & Thapar, 1992). This is perhaps most clearly illustrated in research pertaining to experiences of pregnancy in the context of difficulties with fertility (Covington & Burns, 2006; Hjelmstedt et al., 2003; Kee et al., 2000). Within this, more recent research has begun to explore the influence of Assistive Reproductive Technologies (ART) on the emotional and psychological impact of pregnancy loss (Harris & Daniluk, 2010).

ARTs comprise of treatments and methods that can aid conception without sexual intercourse (NICE, 2017). The most commonly known ART is in vitro fertilisation (IVF), whereby the eggs are fertilised outside of the body and then placed into the womb (NICE, 2017). Other methods of ART include, but are not limited to; intrauterine insemination (IUI) and the use of donor sperm or eggs (NICE, 2017). Much has been written about the experience of pregnancy and birth following the use of ART, however relatively little research has sought to understand the intersection of ART and pregnancy loss (Harris & Daniluk, 2010).

Literature has shown that attachment to a child can form very early in a pregnancy (Ranjbar et al., 2020) and attachment to the pregnancy has been shown to influence the level of distress felt following a pregnancy loss (Thapar & Thapar, 1992). The technology surrounding ART allows this attachment to begin at preconception levels when eggs are being retrieved or when sperm is donated (Harris & Daniluk, 2010). In addition, even before conception people using ART may be exposed to a range of possibly traumatising or highly distressing medical experiences such as injecting hormones, egg harvesting and embryo transfer. These experiences have been shown to increase anxiety and stress, and can have profound impacts on the mental health of both partners (Harris & Daniluk, 2010).

Research has found that couples tend to focus on becoming pregnant again as a way of managing and coping with their distress following a pregnancy loss (Meaney et al., 2017; Rowlands & Lee, 2010). However, for couples accessing ART as a means of conception, the possibility of another pregnancy is often complicated and uncertain (Harris & Daniluk, 2010). In addition, couples using ART have described the significant financial, psychological and physical burden it imposes, meaning that considering another pregnancy may not provide hope, but rather elevate their distress (Harris & Daniluk, 2010). Freda et al (2003) interviewed eight women who had lost a pregnancy after treatment for infertility and found they described themes of going back to “square one,” an inner struggle between hope and hopelessness for future fertility, and a sense that they were running out of time.

Harris & Daniluk (2010) interviewed women who had experienced pregnancy loss following the use of ART, and identified nine themes that were common amongst participants. These included: a sense of profound loss and grief; diminished control; a sense of shared loss with their partners; injustice or lack of fairness; ongoing reminders of the loss; social awkwardness; fear of re-investing in the treatment process or a subsequent pregnancy; the need to make sense of their experience; and feelings of personal responsibility for what had happened.

Women participating in this study also emphasised the importance of their partner's support in coping with medical treatment and the loss of their pregnancy, despite partners also dealing with their own feelings of disappointment and loss. The authors posited that in the context of ART, it is of utmost importance that partners be included in all aspects of medical treatment and decision making, as well as being provided with their own psychological support and validation following a pregnancy loss (Harris & Daniluk, 2010).

Similarly to the literature around pregnancy loss and partners, research considering the psychological impact of needing to use ART has thus far overwhelmingly considered only heterosexual couples' experiences. However, for many LGBTQ+ couples, ARTs are a necessary step to becoming pregnant (NHS England, 2018).

1.5 Contextualising The Process Of Conception For Female Same-Sex Couples In The UK

The majority of female same-sex couples greatly rely on ART to conceive, with the most common treatments used being Intrauterine Insemination (IUI) and Invitro Fertilisation (IVF) (NHS England, 2018). It is therefore essential to view the experience of pregnancy loss for female same sex couples in context of their journey to pregnancy, as well as the actual pregnancy loss (Black & Fields, 2014; Wojnar, 2007).

1.5.1 Pathways To Conception

The National Institute for Health and Care Excellence (NICE) guidelines around access to ART via the NHS were written from the perspective of supporting heterosexual couples (Stonewall, 2015). Related to this, Stonewall and DIVA's LGBTQ+I+ Insight Survey (2021) found that 36% of respondents experienced barriers or challenges when starting their family. One in five of those stated that the greatest barrier was the high cost of private fertility treatment. IUI costs between £350-£1,600 per cycle at a private clinic, and same-sex female couples usually have to pay for 6-12 cycles privately before they can access NHS services.

The Human Fertilisation and Embryology Authority (2020) reported that in 2018, NHS-funded IVF cycles were more common for patients in heterosexual relationships (39%) compared to patients in female same-sex relationships (14%) and this varied considerably by nation. Heterosexual couples also had the highest NHS funding for donor insemination (16%), even though they were least likely to use it. Donor insemination funding was just 13% for patients in same-sex couples, despite them being among the main users of the intervention. In addition, since local CCGs choose how to delegate NHS funding, accessing IVF has become a ‘postcode lottery’ for couples, both heterosexual or same-sex.

Due in part, to the high cost of accessing private clinics and the complexities of navigating what has been shown to be an unfair NHS system (Stonewall, 2015), many women in same-sex relationships choose pathways to pregnancy that are outside of these systems. Some couples may decide to use donor sperm from people already known to them such as friends, or members of their community. In addition to being less costly, couples choosing this method have described factors that influenced their choice, such as wanting the experience to be personal, knowing about the future child’s biological parent and for some, creating an extended family (Klien, 2022). Online platforms for this also exist, for example Pride Angel is a service based in North West UK through which recipients can connect with sperm donors.

1.5.2 LGBTQ+ Healthcare In The UK

It is important to view the disparities in access to ART via the NHS between heterosexual and same-sex couples in context of LGBTQ+ peoples’ experience of healthcare in the UK more generally. The evidence that LGBTQ+ people have disproportionately worse health outcomes and experiences of healthcare in the UK is both compelling and consistent. In 2016 the National Institute of Economic and Social Research (NIESR) published a report that summarised findings from research into LGBTQ+ peoples’ experiences of healthcare since 2008 (Hudson-Sharp & Metcalf, 2016). The report stated the LGBTQ+ peoples’ general health is worse than that of heterosexual people. In addition, the report evidenced consistently higher rates of mental health problems amongst lesbian, gay and bisexual people, compared with heterosexual people. Importantly they also noted that within this evidence base, lesbian and bisexual women are under-represented (Hudson-Sharp & Metcalf, 2016).

Although responses to surveys tend to be varied, overall dissatisfaction with health services is higher amongst LGBTQ+ people than heterosexual people (Hudson-Sharp & Metcalf, 2016). This has been linked to experiences of discrimination in healthcare, including lack of recognition of one’s partner, and negative reactions when disclosing sexual orientation (Stonewall, 2015). It has also been reported that a small number of lesbian, gay and bisexual people are reluctant to disclose their sexuality in a health context, which can exacerbate problems in access to appropriate treatment or support (Hudson-Sharp & Metcalf, 2016).

1.6 LGBTQ+ Pregnancy Loss

As discussed, pregnancy loss is a common event, that many pregnant people will experience (Tommys, 2020). Nevertheless, the event of pregnancy loss often results in significant emotional distress and psychological suffering (Cumming et al., 2007; Engelhard et al., 2001; Neugebauer et al., 1992). This impact is not only true for the pregnant person, but also for the partner (Due et al., 2017). Indeed, there is evidence to suggest that for fathers, their distress is complicated by a circular relationship between societal and personal beliefs about the role of a partner (Story-Chavez et al., 2019). In addition, partners have described having their grief ignored and marginalised by others, including healthcare professionals (Brier, 2008). Research has consistently set out that partners may require their own specific support, and space must be given to understanding the complexity and nuance of their experiences (Abboud & Liamputtong, 2005; Samuelsson & Segesten, 2001; Murphy, 1998).

However, it is important to note that, as this research has focused on fathers in heterosexual relationships, it is likely that both the fathers' experiences and indeed the research itself has been framed in the context of hegemonic conceptualisations of masculinity, which raises questions about the extent to which the findings of this research can simply be extended to same-sex couples, without seeking to hear directly from them.

When considering the impact of pregnancy loss for same-sex couples, it felt pertinent to also turn to the literature detailing the impact of pregnancy loss on couples who have used Assistive Reproductive Technologies (ART), as couples in same-sex relationships are highly likely to need the support of ART to become pregnant. The research around ART and pregnancy loss is minimal, however has begun to show that the combination of fertility difficulties, with potentially distressing medical treatments and financial costs, in context of high levels of planning and wanting to conceive are interwoven factors that can greatly increase distress following a loss. (Haris & Daniluk, 2010).

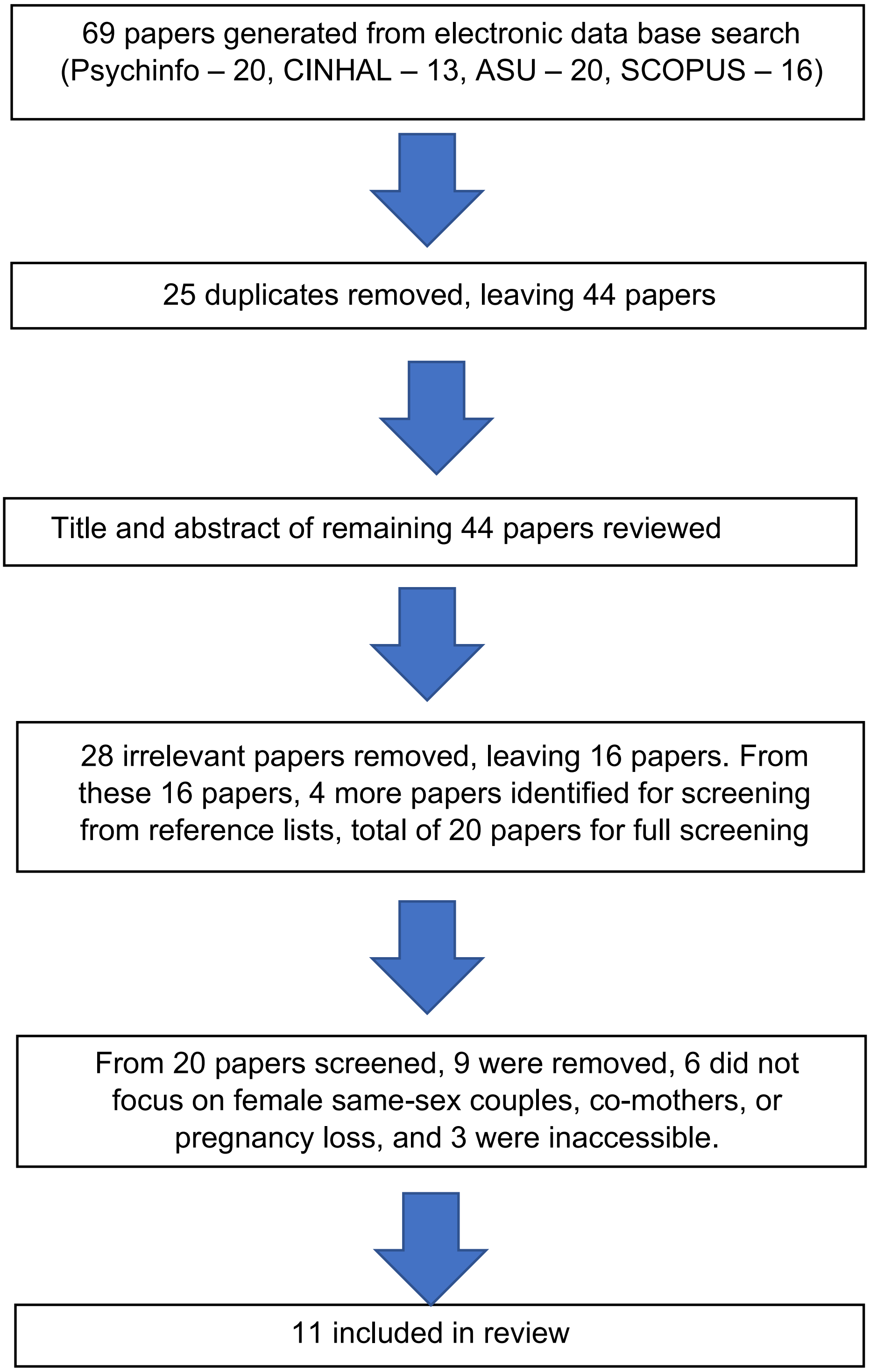
This is especially important when considering that there may be people from the LGBTQ+ community that are likely to have experiences that sit at the intersection of pregnancy loss, being a partner, and the use of ART. One such group of people is partners in female same-sex relationships.

In addition, the healthcare context within which women in same-sex relationships are conceiving and subsequently experiencing pregnancy loss has been shown to have the potential to be discriminatory, burdensome and stressful (Stonewall, 2015). LGBTQ+ physical and mental health outcomes are consistently lower than heterosexual peers (Hudson-Sharp & Metcalfe, 2016). Therefore, these demonstrated multiple levels of intersecting personal and contextual factors suggest that female partners in same-sex relationships are a group of people deserving of particular attention. Simply generalising heteronormative literature may risk losing important and nuanced understandings of non-heterosexual womens' experience of pregnancy loss.

1.7 Terminology

Previous research has shown that language often plays a central role in the validation of a person's parental role, and the terminology used to refer to this person matters (Kolte et al., 2015). Terminology that is used to identify a parent that does not carry a physical pregnancy is imperfect at best and patronising at worst (Craven, 2019, p.xxi). A broad range of labels have been used both colloquially and in research, most commonly, 'non-gestational mothers', 'co-mothers', 'non-birth mothers' and 'non-biological mothers' (Craven, 2019). Each parent should be afforded the right to choose which term fits best with their experience, and how they are constructing their parental role. However, for the purposes of this research, one term should be used consistently, to avoid possible confusion and to be clear about the definition of terms used. Careful consideration was given to each term. It was noted that through the use of ART, a non-pregnant parent may indeed be biologically related to a child, if their egg was implanted into their partner's womb. Therefore, it was felt that 'non-biological mother' would not be accurate for many women's experiences. Craven & Peel (2017) have preferred to use the term 'non-gestational' mothers in their research, as they highlight the ways in which being pregnant, the physical appearance of pregnancy, and the subsequent loss of this infused the experiences of some queer parents differently than others (Craven, 2019, p.xxi). However, as Craven & Peel (2017) themselves point out, non-gestational is still based on the absence of something for one mother. Therefore, in this research, the term ‘co-mothers’ is adopted to refer to the non-pregnant partner in female same-sex relationships, as the term does not overtly focus on the ‘lack of’ or ‘absence of’ in the partner. Instead, it makes reference to the partnership of parenting, and moves towards being inclusive of different parenting experiences. This term is used with recognition that all terminology holds deficits and may not fit with each individual.

Figure 1. Flowchart of Scoping Review



69 papers generated from electronic data base search (Psychinfo – 20, CINHAL – 13, ASU – 20, SCOPUS – 16)

25 duplicates removed, leaving 44 papers

Title and abstract of remaining 44 papers reviewed

28 irrelevant papers removed, leaving 16 papers. From these 16 papers, 4 more papers identified for screening from reference lists, total of 20 papers for full screening

From 20 papers screened, 9 were removed, 6 did not focus on female same-sex couples, co-mothers, or pregnancy loss, and 3 were inaccessible.

11 included in review

1.8 Scoping Review – Co-Mothers And Pregnancy Loss

To establish what is known about co-mothers' experiences of pregnancy loss, a scoping review of the literature was conducted to map the literature and provide an opportunity to identify key concepts, as well as gaps in the research (Munn et al., 2018). The university librarian was consulted to identify relevant data bases. Firstly, psychinfo subject index terms were searched for relevant concepts. At the time of conducting the scoping review, the only available index term related to pregnancy loss was 'spontaneous abortion', and the only available index terms related to co-mothers was 'lesbianism' or 'homosexual parents'. A search on psychinfo using the index terms 'spontaneous abortion' and 'lesbianism' yielded one paper. A search on psychoinfo using the index terms 'spontaneous abortion' and 'homosexual parents' yielded no results. Therefore, alternative search terms were used and the following search string was created for use across Academic Search Ultimate, CINAHL Plus, PsycINFO and SCOPUS. The search terms used were: (pregnancy loss OR miscarriage OR stillbirth OR perinatal loss OR intrauterine death OR perinatal death) AND (lesbians OR queer OR women who love women OR bisexual women OR sexual minority OR lgbt). Citation chaining was employed using papers returned from the data bases. Papers were included in the literature review if they involved research or discussion pertaining to women in same-sex relationships who had experienced pregnancy loss. Whis included empirical studies, conceptual papers, and summaries of work. Papers where the main or sole focus was on other communities within the LGBTQ+ umbrella (e.g. gay men or trans people) were not included. Papers that focussed on female same-sex couples experiences of pregnancy and birth, but not pregnancy loss were not included. Book chapters were also not included, with the exception of Craven (2019) who published her empirical study as a book. See Figure 1 for an overview of literature search conducted on 10/02/2022.

The scoping review revealed that research focusing specifically on co-mothers' experiences of pregnancy loss was scarce, with just one paper from North America (Wojnar, 2010) addressing co-mothers as the sole focus of the study. Additionally, two studies from North America sought to understand pregnancy loss from the perspective of female same-sex couples (Peel, 2010; Wojnar, 2007) and one from the LGBTQ+ community more broadly (Craven, 2019), including female identifying same-sex couples.

In 2006, Wojnar & Swanson published a discussion paper, entitled ‘Why shouldn't lesbian women who miscarry receive special consideration? A viewpoint’. The paper detailed how a comprehensive review of the literature around pregnancy loss revealed that, prior to this date, there had been no published work seeking to understand the experience of pregnancy loss from the perspectives of lesbian couples. Wojnar & Swanson (2006) argued that in order to develop caring-based interventions that are relevant to women in same-sex relationships who experience miscarriage, it is essential to take into account their potentially unique experiences of seeking and losing the role of expectant or new motherhood.

A year later, Wojnar (2007), interviewed 10 lesbian couples from across North America who had experienced pregnancy loss in the context of a committed relationship. This research described how the experiences of pregnancy loss and conception for lesbian couples are intertwined, with the author clearly stating that the impact of pregnancy loss cannot be fully comprehended without first understanding the difficulties surrounding conception for many women in same-sex couples. The couples that participated in the research referred to the process of becoming pregnant as “the up and down ride”, involving multiple decisions and careful planning such as deciding which partner would become pregnant first, and choosing a non-homophobic and affordable insemination provider. Linked to this, participants described feeling like they were not in control at any stage of conception, pregnancy or loss. Interestingly, the research also found that in many ways the bonding process for ‘social mothers’ was consistent with that of expectant fathers. Yet, unlike fathers, whose role is well-recognised by mainstream society, social mothers lack role models, face social biases, and have to carve out a role for themselves. In addition to this, many couples reported feeling hurt and frustrated by the lack of recognition the social mother received for their grief, and this became an additional burden for couples.

In many ways, the findings of Wojnar’s (2007) research mirror those from research seeking to understand the impact of fertility difficulties on heterosexual. For example, feelings of uncertainty or lacking control around conception have been extensively linked to heightened anxiety in literature exploring heterosexual couples' experiences of infertility (Maroufizadeh et al., 2015; Poikkeus et al., 2006; Ramezanzadeh et al., 2004), and subsequently to significant and complicated distress following pregnancy loss (Haris & Danilluk, 2010). Importantly, however, Wojnar's (2007) work emphasised the additional stress lesbian couples face in pregnancy and in loss, caused by simply existing as queer women in conservative heteronormative North American cultures.

Furthering her earlier work, Wojnar (2010) then went on to focus specifically on 'non-biological lesbian mothers whose partner miscarried'. Qualitative data was obtained from 10 participants via in-depth interviews, across North America. The research found that non-biological mothers' experiences of pregnancy loss is "complex and deeply emotional". Themes of helplessness and lack of control were reported, mirroring earlier research (Wojnar, 2007). Enduring loneliness and social isolation after the loss was also a key finding that seemed to be both related to, and exacerbated by, the personal and systemic marginalisation of the non-biological mothers' own emotions and grief.

Related to this finding, Wonjnar (2010) subsequently analysed participants' experiences using Swanson's (1991) theory of Caring Processes as a conceptual framework, in order to develop an understanding of what support non-biological mothers may need. It was found that participants' care needs were captured by the following categories:

- Yearning to be acknowledged and recognised as a parent.
- Desire to be included in the partner's care and decisions post miscarriage.
- Yearning for supportive emotional care and on-going familial and social support.
- Feeling enabled to come out from the experience emotionally intact and face future with children.

This early research begins to demonstrate the unique existential and psychological challenges that pregnancy loss may bring about for women in same-sex relationships, particularly for co-mothers whose suffering may be both characterised and amplified by a yearning to not only have their grief validated, but also to be recognised as a parent.

Through her work, Wojnar (2007;2010) made a strong case for additional research on non-heterosexual women's' experiences of pregnancy loss that pays attention to the role of heterosexist society. However, the research was preliminary in its nature, and caution needs to be exercised when broadening the findings to non-heterosexual women in other contexts, as the samples of 10 women experienced their loss(es) in the specific context of North America, which although can be assumed to share many similarities with other Western societies, has its own unique cultural, political, and healthcare systems.

In the same year, Peel (2010) collected and analysed online survey data from a much broader sample of 60 non-heterosexual, mostly lesbian, women from the UK, USA, Canada and Australia. Most women who took part in the study had experienced an early pregnancy loss (76%), with other participants reporting late pregnancy loss, stillbirth, chemical pregnancy and ectopic pregnancy. The study reported three main themes in non-heterosexual women's experiences of pregnancy loss, namely 'processes and practices for conception', 'amplification of loss' and 'health care and heterosexism'. Similarly to Wojnar (2010) the research reported that for non-heterosexual women, the experience of loss was amplified due to contextual factors such as the extensive preparation and planning required to become pregnant. However, the research from Peel (2010) further highlighted how for many respondents, their psychological, as well as financial, investment in becoming a mother was related to the severity of the distress they felt following pregnancy loss.

Most participants in the study reported that their loss(es) had made a "significant" or "very significant" impact on their lives and shared that they felt "utter devastation". Although the impact of pregnancy loss reported in this research generally corresponds to findings from the literature on heterosexual women (Brier, 2008; Geller et al., 2004), importantly, this study posited that for female same-sex couples, the impact of the loss seems to continue in its intensity for longer than heterosexual couples (Peel, 2010).

Interestingly, respondents in the study reported that overall the care they received from health professionals following pregnancy loss was 'outstanding'

(31%), with only 17% rating their care as ‘poor’, ‘very poor’ or ‘extremely poor’. Nevertheless, in response to the question ‘did you experience any heterosexism, homophobia or prejudice from health professionals?’ 26.8% indicated ‘yes’ and a further 8.6% were ‘unsure’. The experiences of heterosexism in respondents’ accounts were varied, from the more ‘diffuse’ such as general unfriendliness, to the extreme, such as partners being asked to step outside the room as they were not regarded as family. Similarly to North American research from Wojnar (2007;2010), Peel (2010) begins to draw specific attention to the role of heterosexism across the Western world, including, but not specific to the UK.

The data-set from Peel’s (2010) research has since been used in three further comparative papers. In Craven & Peel (2014), the researchers narratively compared their data-sets from Peel’s survey of lesbian and bisexual women’s experiences of pregnancy loss (2010) and Craven’s (2019), at the time unpublished, interviews with LGBTQ+ parents, as well as first-person narratives intended for public consumption through blogs. This chapter focused on the ‘othering’ of grief experienced by LGBTQ+ parents and parents to be. In both data sets, this othering was shown most starkly in the experience of non-gestational parents, the authors specifically referenced the “severely under researched experiences of non-gestational parents”.

In addition, the researchers highlighted the importance of understanding and acknowledging the ‘hidden losses’ for LGBTQ+ families, including financial concerns. For example, the cost of using ART was raised by multiple participants in Craven’s data (2019). It was explained that it is not only the financial burden that contributes to the stress following pregnancy loss for queer couples, but worry about how talking about this financial burden would be perceived, within the couple and more broadly. This meant that for some, the financial cost of pregnancy became a hidden loss within a loss.

In another comparison of their data sets, Craven & Peel (2017) focus on understanding how LGBTQ+ families memorialise the loss of a baby during pregnancy or birth. The authors re-engage with their data in context of memorialisation being an important part of LGBTQ+ history, and often as an act of resistance against societal heterosexism. The research describes how for participants in their studies, actual homophobia, or the fear of homophobia, was a barrier to accessing resources to cope with and memorialise their loss, such as local support groups. The majority of participants in both data-sets described various ways of remembering their loss. The authors concluded that for many LGBTQ+ families, creative responses to pregnancy or reproductive loss are not only an important part of coping, but can also “push the boundaries of identity, notions of family, and experiences of grief that serve an important role in queer reproductive experience.”

Craven (2019) published her research in the book ‘Reproductive losses: Challenges to LGBTQ+ family-making’, which is a broad and comprehensive qualitative study centred around in-depth analysis of over 50 interviews, conducted by the author with LGBTQ+ people who have experienced reproductive loss, including pregnancy loss, failed adoptions, infertility and sterility. Both gestational and non-gestational parents were included in the study, with participants from across the world being interviewed, offering a more cross-cultural view of reproductive loss in LGBTQ+ families. Within the participants included, 64% had experienced early pregnancy loss, 8% ‘mid’ pregnancy loss and 7% stillbirth. Out of 40 participants, 17 had experienced loss as a ‘social parent’ (non-gestational). Many participants in the study were cis-female (85%). Similarly to previous research (Peel, 2010; Wojnar, 2007; Wojnar, 2010) the author particularly highlights non-gestational female parents’ experiences of pregnancy loss, although non-gestational mothers were not the sole focus of the study. One such theme that arose in the research was the lack of existing resources on reproductive loss for LGBTQ+ parents, again, particularly for non-gestational mothers. Strikingly, many participants described how even within LGBTQ+ focused family-making literature, stories of loss were marginalised, and there seemed to be a preference for focus on ‘positive’ stories of LGBTQ+ fertility and families, suggesting that not only are non-heterosexual women’s experiences of pregnancy loss marginalised in the generic literature, but also within literature specifically made to be LGBTQ+ inclusive.

In addition, Craven’s (2019) research emphasised that diversity in LGBTQ+ reproductive loss is important and therapists need to take into account the multi-layered impacts of gender, race and culture. Related to this, the study discusses how partners can have significantly varied experiences of the same loss, in part informed by their own heritage, background, and the socio-political context they live in. Overall, the research highlights the multiple layers of invisibility for bereaved LGBTQ+ parents, as they combat the well-documented cultural silence surrounding reproductive loss and heteronormative assumptions about who should have children, as well as the political silencing of queer family-making efforts that do not always produce a “happy ending.”

In their discussion paper, Perry Black & Smith Fields (2014) summarise the intersecting contexts of loss for lesbian couples, drawing upon the work of Wojnar (2010) and Peel (2010). They offer specific consideration to the choice that female same-sex couples make around carrying the pregnancy, and highlight the complexities of this choice, including the possibilities that both partners may wish to become pregnant at the same time, the role of infertility, and the impact this decision-making process can have on the couple relationship. They discuss this as an extra layer of planning which may further contribute to the experience of pregnancy loss between the couple. They summarise findings from the above papers (Peel, 2010; Wojnar, 2007; Wojnar, 2010) and make strong reference to the issue of conceiving and subsequently losing a baby or pregnancy in a heteronormative world. They recognise the ongoing gap in the literature, particularly pertaining to the experience of ‘non-biological’ mothers.

Peel (2012) compared her data-set on pregnancy loss with data about LGBTQ+ civil partnerships, describing these events as ‘public and positive’ (civil partnership) and ‘private and painful’ (pregnancy loss). This research focused on how participants in both data-sets perceived the reactions of others to their news of pregnancy loss or civil partnership. Peel discusses two themes; muted reactions and invoking heteronormativity. It was noted that, unlike muted reactions to civil partnerships, in the pregnancy loss data reactions tended not to be muted. In fact, many participants described an outpouring of love and support from family and friends. Those that did describe experiences aligned with more ‘muted’ reactions understood this to be generic discomfort with responding to bad news, or death, rather than it being related to the couple’s same-sex relationship. However, it is important to note that the pregnancy loss data-set did not distinguish between pregnant mothers and co-mothers, and given findings from previous research showing that co-mothers’ grief is often marginalised (Craven, 2019; Wojnar, 2010) it be may hypothesised that there will likely be differences in the reactions of others towards co-mothers' grief when compared with pregnant mothers' grief.

Peel (2012) also discussed how people tend to rely on problematic heteronormative responses to the life events of LGBTQ+ people, for example female same-sex couples may experience others reminding them that they can 'try again' without an understanding of the relational and situational factors involved in 'trying again' for women who do not have easy access to sperm. Peel (2012) discusses how this cultural heteronormativity is often replicated in psychological research, and calls for LGBTQ+ specific research to be generated and valued, exploring the lives of LGBTQ+ people on their own terms.

In a paper detailing their personal experiences, Peel & Cain (2012) give accounts of their experiences of 'silent miscarriage', which is the death of a baby in utero that is only known following an ultrasound scan, as the pregnant person does not experience any (or very minimal) symptoms that might indicate a miscarriage. The personal accounts are from the perspective of a woman in a heterosexual relationship (Cain) and a woman in a same-sex relationship (Peel). The authors note similarities in their stories, the medicalised experience, treatment by the NHS, emotional reactions and grief, and joy at subsequent children. However, they also note differences, including how their relational contexts shaped their experiences. They note the invisibility of lesbian and bisexual women in generic literature around pregnancy loss, including popular pregnancy and childbirth books, literature presented to women by GPs and midwives, a finding which was still pertinent years later in the research from Craven & Peel (2014) and Craven (2019). They consider how this may contribute to the ongoing invisibility and disenfranchisement of lesbian and bisexual women's grief following pregnancy loss, and in turn maintain the heteronormative homeostasis.

Recent research from Australia (Rose & Oxlad, 2022) has focused LGBTQ+ people's experiences of workplace leave and support following pregnancy loss. The researchers interviewed 12 LGBTQ+ people who had experienced pregnancy loss, including 8 cis women in same-sex relationships. Some participants were gestational parents, some were non-gestational partners, and some had experienced pregnancy loss as both gestational and non-gestational parents. It was not clear in the paper which proportion of cis-gendered women in the sample had experienced pregnancy loss as a non-gestational partner. The research found that overall, participants described how their awareness of the pervasive nature of heteronormative models of relationships and procreation led to increased apprehension when disclosing pregnancy loss in the workplace. In most cases, the more non-normative the conception efforts, the more vulnerable people were to experiencing uncomfortable and discriminatory reactions to their disclosures. They concluded that heteronormative policies and entitlements can compound the distress of LGBTQ+ people experiencing pregnancy loss, including increasing difficulties in accessing leave, misgendering leave entitlements, and failing to understand and accommodate for high attachment to unborn babies in early gestation.

1.9 Rationale For Study And Aims

Preliminary research has shown that for women in same-sex relationships, similar to heterosexual women and their male partners, pregnancy loss can be a deeply painful and distressing event (Peel, 2010; Wojnar, 2007). Importantly however, pregnancy loss in female same-sex relationships has been shown to be an experience not only characterised by enduring distress and grief, but also by multiple, intertwined experiences of marginalisation (Peel, 2010, Peel & Cain, 2012; Perry Black & Smith Fields, 2014; Wojnar, 2007). Pregnancy loss is itself an often invisible and misunderstood experience (Bateman-Cass, 2000). It has been further demonstrated that pregnancy loss which occurs in non-normative relationships (same-sex couples), using non-normative methods (ART) is a marginalised event within marginalised contexts, adding to the possibility of couples experiencing significant, complicated and enduring distress (Craven, 2019; Rose & Oxlad, 2022).

Within this very small body of literature, the experience of co-mothers has been repeatedly discussed as particularly deserving of attention, as they can be missed out, or deliberately excluded from the care and support that is often focused on the pregnant partner following loss (Craven, 2019; Peel, 2010; Wojnar, 2007). However, with the exception of one study (Wojnar, 2010), co-mothers have thus far never been the sole focus of pregnancy loss research highlighting a possible replication of this invisibility in the research.

In addition, the research available has spoken strongly and specifically to the key role cultural, social, and political contexts play in the distress felt by co-mothers following pregnancy loss, and how women are supported in the aftermath of this event. However, no research to date has sought to place the experience of co-mothers following pregnancy loss specifically in the UK's health and social context.

Therefore, the above scoping review provides a clear rationale for the following research questions:

- How do co-mothers in the UK experience pregnancy loss?
- How does the UK specific healthcare and social landscape impact on and interact with this experience?

2. METHODS

This chapter outlines the chosen research methodology and method of analysis. The rationale for adopting a qualitative approach, my epistemological position, and the relevance of Reflexive Thematic Analysis to this research are discussed, followed by details of the method employed, including recruitment, data collection, and analysis procedures. This chapter is written in first person, to reflect the method of analysis chosen (Braun & Clarke, 2022 p.126).

2.1 Methodology

2.1.1 Ontology And Epistemology

There is a continuum of ontological (what is there to know?) and epistemological (what can we know?) positions which researchers may occupy, informed by their current frameworks of beliefs and assumptions about the world (Denzin & Lincoln, 2005). It is important for researchers to be transparent about their positions, as this will allow those engaging with the work to consider the story of the research in context of the researcher's viewpoint and evaluate its meaning accordingly (Willig, 2008).

When considering my own epistemological and ontological positions, it feels important to acknowledge the changeability of my positions as I have moved through life and have had experiences that have brought me closer or further away from a particular stance (Maynard & Barney, 2018). Both my current epistemological positioning and my journey towards this will impact upon the construction of the research, the framing of the aims and questions, and the subsequent methodology chosen (Unger et al., 1986).

Historically, psychological research has largely been conducted from a realist ontological position (Henwood & Pigeon, 1992) searching for an objective truth. This lies at the opposite end to the relativist ontological position, which argues that knowledge is socially constructed within systems of meanings and through discursive practices (Willig, 2008). Perspectives such as critical realism exist between these positions, and at the time of doing this research, my position could best be described as critical realist. Critical realism encompasses a realist ontological position, which assumes that ‘real’ phenomena exist and underlie what we can observe about the world, but that our understanding of these phenomena can only ever be partial at most (Nightingale & Cromby, 2002). Pregnancy loss in this instance is considered a real phenomenon, an unseen event that occurs inside a person’s physical body which then causes directly observable changes and consequences. Importantly however, critical realism also advocates for epistemic relativism, which acknowledges that these real phenomena occur within a particular context, and this context will influence how the event is constructed and understood (Fryer, 2020) both individually and collectively. The representations that individuals create are characterised and mediated by culture, language and political interests rooted in factors such as race, gender or social class (Pilgrim & Rogers, 1997, p.37). In turn, critical realism posits that individuals then act on these representations collectively, creating social structures. These social structures influence the actions of individuals, and individuals then collectively reproduce or transform these social structures through their actions (Fryer, 2020) and so the continual emerging and maintaining of meanings carries on. Therefore, social structures and individual agency exist together, and this must be considered in research (Fryer, 2020). As this research was concerned with exploring both individual experiences and their interactions with social structures, the critical realist position offers the ability to move between these. This position also recognises my dynamic role in attempting to make sense of participants’ experiences (Smith & Osborn, 2003).

2.1.2 Choosing An Approach

Qualitative research affords researchers the opportunity to not only develop rich understandings of how people comprehend their social realities, but also how they exist in and interact with the social world (Braun & Clarke, 2022). Qualitative methodology can make use of a variety of tools and techniques, for example analysis of transcribed interviews or content analysis of published text.

When choosing a qualitive approach it was considered that the voices and experiences of LGBTQ+ people are often marginalised and pathologised in psychological research (Clarke & Peel, 2007, p. 3). Qualitative research methods allow us to make space for the participant to express their own beliefs and understandings about their experiences, which in turn works towards ensuring that data is not limited to set, pre-determined options. Importantly, Ashworth (2003, p.24) contends that qualitative research is able to "…provide a hearing for the voices of the excluded" in a way that quantitative research cannot.

Furthermore, previous qualitative research on pregnancy loss and fathers has shown the experience to be complex, varied and nuanced (Story Chavez et al., 2019). Therefore, quantitative research might run the risk of losing some of this, or being reductive in nature. In addition, as so little is known about the experiences of female same-sex partners in the UK, it would be premature to attempt to test a specific hypothesis about this (where a qualitative approach might be best suited). What is known about these experiences comes from research based predominantly in North America (Peel, 2010; Wojnar, 2010) and so it can also be argued that the systems of health care and cultural context of North America is so different to the UK that an attempt to replicate these quantitative studies would not be justified.

2.2 Method Of Analysis

2.2.1 Reflexive Thematic Analysis

In accordance with my epistemological position, reflexive thematic analysis (TA) was chosen as the method used to analyse the data. Reflexive TA is a method that allows for inferences to be made across the data set through identifying, analysing and reporting themes (Braun & Clarke, 2022). TA is sometimes described as a foundational method of qualitative analysis (Boyatzis, 1998; Braun & Clarke, 2006).

Reflexive TA offers the opportunity for inductively-orientated analysis that focused on patterns of meaning across participants (Braun & Clarke, 2022). Arguably, the flexibility and reflexivity embedded in Reflexive TA also allows for the emergence of unanticipated findings (Barker et al., 2002) and lends itself well to complex and sensitive issues.

Braun & Clarke (2022, p.7) describe the importance of a ‘qualitative sensibility’ for reflexive TA in which the researcher grounds themself in taking a critical and questioning approach to life and knowledge. The ability to reflect on the dominant assumptions embedded in your own cultural context is essential to reflexive TA. There is no one set version of reflexive TA and Braun & Clarke (2022, p.125) set out the importance of being transparent about what type of reflexive TA approach a researcher is taking. In this research a more inductive approach is taken to the method of analysis due to the lack of existing theoretical constructs about co-mothers experiences of pregnancy loss. In addition, I considered how my position as a feminist drew me towards a more inductive approach to the date, as I believe that all systems, including healthcare are built upon patriarchal beliefs and ideals that explicitly and implicitly privilege the rights and experiences of cis-men, and in this way cause direct and systemic harm to women (and other non-male people). Therefore, I felt that taking a deductive approach and through using the existing literature around fathers’ experiences of pregnancy loss as a lens through which to analyse this data-set has the potential to be problematic.

2.2.2 Other Analysis Considered

Both grounded theory (GT) (Glaser & Strauss, 1967) and interpretative phenomenological analysis (IPA) (Smith, 1996) were also considered as possible methods of analysis for this research.

Although there are a number of versions of GT (Glaser & Strauss, 1967) there is a general consensus that as a method of analysis it aims to produce new theories which are 'grounded' in empirical data rather than testing hypotheses through the analysis of data. GT makes use of coding and the generating of broader themes within the data and tends to focus on identifying and exploring social processes (Willig, 2008). In a similar way, IPA (Smith, 1996) aims to explore the personal and social world of the individual in fine-grained detail (Smith & Osborn, 2003). IPA also encourages specific consideration to how the relationship between participant and researcher can impact on process of meaning making (Willig, 2008). IPA is closely linked to phenomenological epistemology which is concerned with an individual's experiences and not on universal truth or generalisable phenomenon (Smith and Osborn, 2003).

TA, IPA and GT all aim to represent a view of reality through the identification of patterns within qualitative data. TA is not bound to one particular epistemological position like IPA, and therefore fits more comfortably with my fluid relationship with my own epistemological and ontological positions. Importantly, TA does not attempt to develop a 'theory' (Braun and Clarke, 2006) in the same way that GT does. The attempted development of a theory is not considered meaningful or appropriate for the present research, in part due to the historical pathologisation of sexual minority people (Clarke & Peel, 2007, p.3). Importantly, TA allows the generation of potentially unanticipated insights (Braun & Clarke, 2006), as well as patterns of meaning to be developed across participants (Braun & Clarke, 2022). Therefore, TA was felt to be the best fit in terms of both my epistemological positioning and the research aims.

2.2.3 Rigour And Validity

Qualitative research has been frequently criticised for a lack of transparency around its procedure (Higginbottom, 2004), so the importance of using methods that demonstrate rigour and validity has become increasingly integral to producing high-quality qualitative research (Yardley, 2000). One way qualitative methods have sought to do this is by creating systematic methods such as coding frames (Braun & Clarke, 2006). TA has been criticised for its lack of a pre-existing coding frame and guidelines (Nowell et al, 2017, p.1), yet as Braun and Clarke (2022, p.10) point out, adhering to rigid rules about data analysis is antithetical to acknowledging that the researcher is a situated, integral component of the analysis. They make it clear that Reflexive TA offers a set of conceptual tools to facilitate a rich and robust engagement with data. Therefore, it is my responsibility to ensure that they are engaging with these tools in a way that promotes rigour and validity within the research.

With this in mind, Braun & Clarke (2022, p.8) state that in reflexive TA, researcher subjectivity is the primary tool and 'researcher bias' is not a problem to be managed but should be understood as a resource for doing analysis. In this sense, reflexive TA centralises the importance of being aware of, connected to and reflexive about our own context (Braun & Clarke, 2022 p.8). If, as a researcher, I am able to stay with the uncertainty of approaching analysis in such an open way, then I am more likely to be able to produce a rigorous and thoughtful analysis. In addition, because of TA's ontological and epistemological flexibility, its validity also comes from the level of consideration I have given to my own orientation to the data and the focus of my own meaning making (Braun & Clarke, 2022, p.10).

2.3 Ethical Approval

Ethical approval from the University of East London was obtained on the 14.05.2021 (see appendix B for ethics application and risk assessment and appendix C for approval) and was amended on 14.03.2022 (appendix D) due to a broadening of inclusion criteria.

2.4 Sample Size

Qualitative research requires fewer research participants in comparison to quantitative research as it aims for deep exploration of subjective experience and therefore (Mason, 2010). How many participants constitutes a 'good' sample however is highly contested. In a review paper for the National Centre for Research Methods, a sample size of between six and twelve was suggested for qualitative research with groups who are considered to be under accessed (Baker & Edwards, 2012). Pregnancy loss can be considered a stigmatised experience (Leith, 2009), in addition, people in same-sex relationships are often targets of homophobia and face discrimination and poor treatment in healthcare (Stonewall, 2018). Therefore, societal and systemic factors must be taken into consideration, including how these may impact upon the accessibility of research participation for 'under accessed' people belonging to these intersecting groups.

Instead of aiming for a specific number of participants, Glaser and Strauss (1967) argued for the concept of data saturation in qualitative research. However, the notion of data saturation has been widely debated (Strauss & Corbin, 1998). Braun & Clarke (2019) state that the idea of saturation is deeply problematic. They recommend actively avoiding the saturation paradigm and instead they suggest the concept of "information power" to be more useful (Malterud et al., 2016). This concept invites the researcher to reflect on the richness of their data and how that meshes with the aims of the research.

Considering all of the above, and in line with reflexive TA, I aimed to recruit between 6-8 participants, however with acknowledgment that the actual sample size may fall above or below this, and therefore to focus on the richness and quality of the data to inform what is deemed an appropriate sample size.

2.5 Approach To Recruitment

A purposive sampling strategy was used for recruitment of participants. This took place mainly via social media such as Twitter, Facebook and Instagram. I created a Twitter research account for the sole purpose of advertising the research. No personal data were made available via these media, other than those already provided on the Participant Information Sheet (PSI). The research poster (appendix E) was shared in a Facebook group with 2.4 thousand members. As well as advertising directly on social media, numerous LGBTQ+ and pregnancy focused organisations across the country were contacted for support with recruitment. Two organisations agreed to support recruitment and shared the research poster via their own social media platforms and newsletters.

Participants expressed interest by emailing me directly, I then provided the participant with the PSI (appendix F). I also offered each potential participant the opportunity to ask any questions via email or over the telephone. Once the potential participants had confirmed they had read the PSI and confirmed they were happy to move ahead, I then sent the Consent Form (appendix G) which participants signed ahead of their interviews. It was made explicit at all times that participation was voluntary. Participants were also reminded prior to and after their interview that they were free to withdraw their data up until 3 weeks post interview. Following interview participants were sent a debrief letter (appendix H).

Due to the COVID-19 pandemic, participants were offered an interview via Microsoft Teams, at a time and day that was convenient for them.

2.6 Inclusion Criteria

- Women, who identify as sexually and romantically attracted to women.
- Who, in the context of a same-sex relationship experienced a pregnancy loss (up to 37 weeks gestation) where they were the non-pregnant partner.
- The couple must have been living in the UK at the time of the loss

2.6.1 Comments And Limitations Related To Inclusion Criteria

The inclusion criteria was left deliberately broad to offer the best opportunity of engagement with the research. As discussed in the introduction, there is no agreed upon definition of the terms miscarriage, pregnancy loss or baby loss, in relation to weeks of gestation (Miller, 2015). Therefore, I considered that imposing a gestational cut off point in the inclusion criteria might unnecessarily limit the scope of the research and exclude experiences that would add valuable contribution to the data. However, one possible limitation of a broad inclusion criteria is gaining a sample of participants whose experiences were different from each other. For example, in this particular study I was mindful of how the medical interventions involved in an early loss (prior to 21 weeks) are often very different to a loss that occurs nearer to full term gestation (Tommy's, 2020).

2.7 Number of Participants

This research aimed to recruit six to eight participants. Seven people expressed interest: five people took part, one person felt unable to participate due to experiencing a pregnancy loss whilst communicating with me, one person did not respond.

2.8 Participant Demographics

Basic demographic information for each participant is provided in table 1 below. It is hoped that through linking each individuals demographic information with the pseudonym used in analysis, the readers understanding of the participants will be enriched. One participant, Rebecca requested that her son's real name be included in the research (see appendix I for anonymised consent form detailing this). This request was honoured and her son's name, Magnus, will be included throughout the rest of this thesis where appropriate.

Table 1: Basic demographic information

Katie	Katie is a White British female, living in the North West of England at the time of the pregnancy losses. The

	couple experienced four early pregnancy losses, all between 4-7 weeks gestation. The couple also have two living children.
Louise	Louise is a White British female, living in the South East of England at the time of the pregnancy loss. The couple experienced a pregnancy loss at 21 weeks, 5 days gestation. The couple also have two living children.
Rebecca	Rebecca is a White British female, living in the South East of England at the time of the pregnancy loss. Rebecca requested that her son's real name be used in this thesis. Magnus was lost at 26 weeks gestation. The couple also experienced an early pregnancy loss, less than 7 weeks gestation. The couple also have two living children who are twins.
Catherine	Catherine is a White British female, living in the East of England at the time of the pregnancy loss. The couple experienced a pregnancy loss of twins at 12 weeks gestation. The couple have one living child and at the time of interview Catherine's partner was pregnant.
Anna	Anna is a White British female, living in the East of England at the time of the pregnancy loss. The couple experienced a pregnancy loss at 7 ½ weeks gestation and 5 ½ weeks

	gestation. The couple also have one living child.

2.9 Data Collection Procedures

2.9.1 Choosing a Data Collection Method

Interviewing is arguably the most widely employed tool in qualitative research (Liamputtong, 2013; Patton, 2002). Kvale (2007) describes how, through conversation, individuals have an opportunity to know each other and if we wish to learn about each other's feelings, experiences and their world, then we need to talk with people. In this sense, interviews in qualitative research are conversations that are built specifically to facilitate this knowing. As this current research aims to know more about the experiences of co-mothers during pregnancy loss, it was felt that interviews would give the best opportunity for accessing the participants' lived world and experiences (Kvale, 2007, p.8). In addition to this, interviews position the participant as the "experiential expert on the subject" (Smith & Osborn, 2003, p.57) which felt important, given the marginalisation of LGBTQ+ women's experiences and views in healthcare (Clarke & Peel, 2007, p. 3).

Serry & Liamputtong (2013) describe how conducting good quality in-depth interviews requires preparation and skill. Smith and Osborn (2003) suggest that the development of interview schedules is one way to make researchers explicitly consider what they think and hope might be discussed, as well become aware of potential difficulties that might arise and how these might be managed. Semi-structured interviews allows for this engagement whilst also ensuring dialogue is led by the participant's answers. Therefore, one-to-one, semi-structured interviews were deemed to be the most appropriate data collection method.

2.9.2 Development of Interview Schedule

The interview schedule was sequenced to broadly follow the timeline of trying to conceive through to pregnancy loss. It was hoped that this would allow the participant to feel like they are telling their story in a way that feels more natural, whilst still covering a broad range of issues related to the topic, taking into account related research (Craven, 2019; Wojnar 2010). Open and fluid questions were developed for each area with prompts for further exploration added if required. Questions pertaining to particularly sensitive aspects of the interview, such as the event of the loss, were placed later in the schedule (Smith, 1995). Advice on constructing the interview schedule was sought from experts by experience, including women who had experienced pregnancy loss and women who had experienced assistive reproductive technologies. The development of the interview schedule was also discussed with the UEL People's Committee. This process encouraged me to spend time considering how to set up the interview in a way that acknowledged the range of ways in which people relate to their experience of pregnancy loss and is clear that I am not looking for a particular kind of account. The schedule was then submitted as part of UEL's research proposal process and was reviewed with a favourable opinion. The final schedule (appendix J) was used as a framework but was not rigidly adhered to in order to allow participants the chance to raise topics that I had not anticipated (Bannister et al., 2012).

In line with reflexive TA, after the first interview, I reflected on the richness of the data collected, and whether the questions facilitated the gathering of data aimed at answering the research question (Braun & Clarke, 2022). It was decided that more clear explanation of why the interview begins with questions about the process of conception was needed, and so this was subsequently added to the schedule (appendix J).

2.9.3 Equipment

The interviews were recorded using Microsoft Teams and were then transcribed and anonymised and made ready for coding. After transcription, all digital recordings were erased to maintain confidently.

2.10 Confidentiality

Anonymity was assured by assigning each participant a pseudonym. Each video file was downloaded and then uploaded to UEL's OneDrive for Business. These were named on the OneDrive with the relevant pseudonym and the date of the interview. Consent forms were returned to my UEL email address and were then saved in a separate location to other research data, such as video files and transcripts, on the UEL OneDrive for Business.

All of the interviews were transcribed by myself and all identifiable information was anonymised at this point. Participants were asked to give permission for anonymised quotes from their transcripts to be used. Only myself, supervisors and examiners have access to the transcriptions and there only accessible via a password on a password protected computer, the transcripts will be erased after five years.

2.11 Transcription

All interviews were around 60 minutes in length. Whilst there are no specific guidelines for transcription in TA (Braun & Clarke, 2006), a verbatim transcription of the interview is a minimum requirement and as such, conventions suggested by Banister et al. (2012) were used to ensure the transcriptions were easy to read. Basic interactional information was also transcribed, such as my questions and responses. For clarity, when preparing quotes "…" has been used to indicate the removal of surplus information or words. Details about the tone, volume or emphasis of the conversation were not included in the transcription. All participants have been given pseudonyms and any further names, places, hospitals or services were anonymised.

2.12 Keeping a reflexive journal

Braun & Clarke (2022, p.19) state that keeping a reflexive journal is one of the most important practices a researcher can take up. I spent time writing journal entries following each interview, during difficulties with recruitment, following each transcription, and throughout the data analysis process. It was felt that keeping a reflexive journal was particularly important due to my positioning as an outsider researcher (Berger, 2015) i.e. not being a part of the group that this research focuses on.

2.13 Data Analysis

Trainor & Bundon (2020) highlight the importance of describing a specific, located in the moment, first-person account of how a particular researcher approached the data analysis, rather than a more generalised description of stages and process. This is particularly important in a reflexive TA as each phase of analysis will involve deliberations and choices that are influenced by my own relationship with the data. The phases of the reflexive TA undertaken are described below.

2.13.1 Becoming Familiar With The Data

Both conducting and transcribing the interviews allowed me to begin familiarising myself with the data from a very early stage (Braun & Clarke, 2022, p.30) affording me the opportunity to achieve in-depth engagement with the data. Once transcription was complete (and had been checked against the audio recording) each interview was read and I made notes on my initial thoughts. During this process, I found it necessary to pay attention to any early interpretations of the data I was making and make use of my reflexive journal to ensure that I was relating in a tentative way to my observations at this stage (Braun & Clarke, 2022, p.198).

2.13.2 Generating Initial Codes

I then began systematically working through the dataset, in a fine-grained way to identify portions of data that appear to be meaningful, relevant and interesting to the research aims and question (Braun & Clarke, 2022, p.35). I labelled these segments with codes aimed at capturing single meaning or concepts (Tuckett, 2005). In reflexive TA, coding can occur at a range of levels from semantic (explicit and literal meaning) to latent (implicit and conceptual meaning). I found myself initially being drawn to coding at a semantic level, as I felt this allowed me to be more tentative in my approach as I was cautious about the meaning my own heteronormative perspective might bring to coding. However, as coding progressed I found myself drawn to more latent meanings, therefore, I went back to the first interviews I coded with this more latent framework in mind and re-coded (see appendix K for an example of how my coding changed). Codes were noted in the margins of the transcripts (appendix L). After each interview had been initially coded, I created an Excel spreadsheet listing the codes and their related quotes (see appendix M for an example).

2.13.3 Generating Initial Themes

This third phase moves the analysis into an interpretive level where I began considering shared meaning across the dataset. To do this I began to cluster codes together into potential themes, based on them sharing a core idea or concept (Braun & Clarke, 2022, p.35). The word ‘generating’ is used in initial theme development to draw attention to the active construction of themes. During this process, some codes were combined into potential themes, others became potential themes themselves, and some did not appear to fit within this initial analysis and so were kept aside to consider as the analysis continued.

Due to a personal preference for visual representation of information, I utilised maps for this process, writing codes on post it notes and moving these around the maps as analysis progressed (appendix N). I found that this allowed me to feel fully immersed in the data, as I was not only reading the codes, but I was able to pick up, hold and move the experiences of my participants.

2.13.4 Reviewing Themes

At this stage in the analysis I began by reviewing each theme in relation to the coded extracts of data and created an initial thematic map of six themes (appendix O). Then, moving on to the whole dataset, I checked whether each theme told a convincing story (Braun & Clarke, 2022, p.35). Themes were then either accepted, reworked, moved, discarded or in some cases a new theme was created. From this process I created a final thematic map, which can be seen in figure 2. At this point I also began considering the relationship between the themes, the existing literature and the broader context of the research.

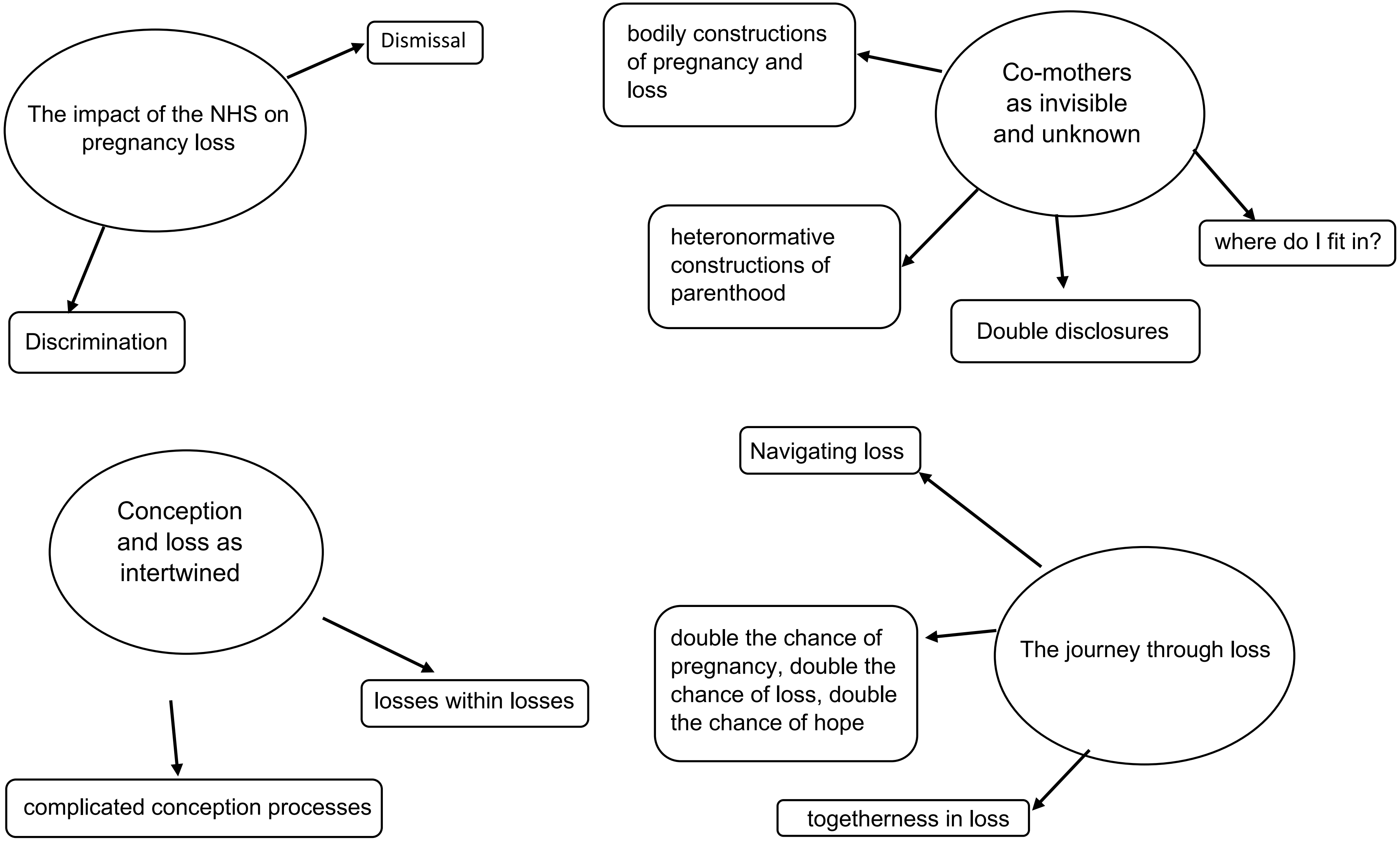
2.13.5 Refining, Defining and Naming Themes

In this penultimate stage of the analysis I focused on fine-tuning the themes, ensuring that each told a clear story and could be named succinctly (Braun & Clarke, 2022. p.36).

2.13.6 Producing The Report

This final stage of analysis is described in the following two chapters. In the results chapter themes and subthemes are both expanded and explained alongside quotations taken from the interviews with participants to help contextualise the analysis and tell the analytic story. The relevance of the report to the existing literature and current clinical practice is also outlined in the discussion chapter.

Figure 2. Final Thematic Map



3. RESULTS

The following themes have been developed reflexively, through the processes described in 2.13. In Reflexive TA, at every stage the researcher is encouraged to attend to and notice how they are bringing their own experiences and meaning to the analysis. For me this included keeping separate notes related to the themes and subthemes I was generating, including specific questions prompting myself to consider why I felt particularly drawn to understand the data in this way. Within this, I found it essential to take a critical approach to my theme development, giving myself time in between analysing to move to a different space in my house and consider what other patterns or explanations there could be, that are not immediately obvious to me.

My own intersecting identities will have ultimately influenced what themes were developed and kept and which were removed. Being an NHS psychologist I noticed myself being particularly drawn to aspects of the participants' experiences which involved contact with a professional, which is likely to have encouraged the development of the theme centred around the NHS. In addition, my heterosexuality may have constrained my ability to derive more nuanced or latent meanings from the data and likely influenced the more descriptive nature of the themes journey through loss and conception and loss as intertwined. I do feel however that my experiences and identities afforded me the opportunity to hold an open and curious stance towards the data, with perhaps fewer assumptions and expectations.

3.1 Theme 1: The Journey Through Loss

This theme focuses on how co-mothers describe their experience of pregnancy loss, and how, together with their partners, they navigated the journey through loss. For some co-mothers this meant trying to balance their own needs with a sense of responsibility for their partner's wellbeing. A number of co-mothers had the experience of being both the non-pregnant and pregnant partner, which in some ways prompted complications in their experiences of pregnancy loss and navigating this as a couple. However, this double chance of pregnancy also tended to provide hope and renewed focus for couples following loss. Importantly, some co-mothers shared the togetherness and love they felt after loss, which was felt in amongst their pain. Three subthemes were created: 1) Navigating loss, 2) double the chance of pregnancy, double the chance of loss, double the chance of hope and 3) togetherness in loss.

3.1.1 Subtheme: Navigating Loss

When asked about their experience of pregnancy loss, co-mothers who experienced early pregnancy loss described the loss as unexpected and confusing. For some, the loss occurred suddenly, catapulting them from a reality in which their baby is growing and alive to one where this is not the case.

…we went from kind of like, you know, thinking she was twelve weeks and looking forward to the scan to then like…yeah, so is it was a really bizarre, bizarre time. – CATHERINE

We lost the baby at just after seven and a half weeks. Which is just a real shock… like we were worried about it not working, like the transfer, that was a big thing, but once we got that pregnancy test, it didn't even cross my mind that miscarriage would happen. – ANNA

Co-mothers whose loss occurred at a later gestational stage described the experience as long and complicated, a sense of trying to ride waves of hope and ultimately realisation as the pregnancy progressed towards loss.

(About the loss of her son) Yeah, so that that was a really long process and obviously a lot to try and take in at the same time. – LOUISE

For most co-mothers, their description of the experience also seemed to be characterised by an overwhelming feeling of loss as being out of their control, which for some was a particularly upsetting and painful part of the event. Catherine described how not being able to fix the loss was difficult for her.

And I guess often in our like our relationship, me and [partner's name] and in the roles that we have…of those is I'm kind of a bit of a fixer. I'll sort out a lot of like you know things like the car and stuff and…so not being able to kind of fix it was really difficult for me. – CATHERINE

In navigating these complicated, confusing and unexpected events, co-mothers tended to take up the role of reassuring and looking after the pregnant mother. For some co-mothers this included trying to remain positive and hold on to hope, either for the current pregnancy (prior to the loss being confirmed) or for the future.

I'm trying to stay strong for my wife and I'm like you know it's OK. You know, it'll be positive – LOUISE

During the time at the hospital stays and things like that. I tried to be positive that it's going to continue because it's like a probability wise. It's just as likely to continue as it is to not continue so it can depend on where you go in that scale. So you kinda gotta stay positive. – REBECCA

Importantly, Anna described how for her, remaining positive also provided her with a way to deny the reality of the loss in the days after her wife's symptoms began. Anna reflected on how in this sense, her positivity served an important role for her, however it was perhaps not beneficial for her pregnant wife.

…honestly, it was the longest because I was still remaining really hopeful. I was quite delusional. I was like, no, no, no, it's fine. And [partner's name] knew and was adamant that we've lost this baby. So we were at totally different stages. I was still really hopeful. She was really down. - ANNA

In a similar way, a number of co-mothers also made reference to the difficulties associated with the balance of trying to cope with their own distress, whilst also being considerate and supportive of their partner's emotional needs and wellbeing.

how do you comfort someone when you feel that pain and stress at the same time like? – LOUISE

Within this, all co-mothers described how, to some extent, they found themselves prioritising their partner's needs over their own. For some co-mothers this meant trying as much as possible to ignore their own needs, or keep them hidden from others. It seemed that for these co-mothers, stepping into the role of being strong and holding on to some sense of normality after loss was integral to this.

yeah, so it's a lot of like. A lot of heartbreak but also, trying to stay strong and sort of mask that like I'm not a very emotional person so I can almost ignore the emotion part of it and then like be strong for everyone else. – LOUISE

Rebecca spoke about the personal cost of remaining positive in order to support others, reflecting on how pushing away her own distress meant that in the long term she will likely suffer more as a consequence of this.

...being constantly positive for everyone else's benefit 'cause it's not for your own 'cause you're gonna fall from a greater height. - REBECCA

3.1.2 Subtheme: Double The Chance Of Pregnancy, Double The Chance Of Loss, Double The Chance Of Hope

When describing their experiences of loss, many co-mothers spoke about the multiple losses they had experienced as a couple. For some co-mothers, they had experienced pregnancy loss both as a co-mother and a pregnant mother. Having two partners who are able and willing to carry a pregnancy doubled their chances of having a baby, which seemed to offer the couples hope and something to focus on after loss.

Yeah, I think I kind of thought yeah 'cause we have doubled the chance effectively compared to what a heterosexual couple would have of getting pregnant and because we didn't mind who had the baby first then. Yeah, it just sort of felt like. Well either she can get pregnant again, or I could get pregnant and so even though it was really difficult at that time. It probably wasn't, it probably wasn't particularly long lived, not in any major way anyway. – KATIE

It was it was a bit sort of bittersweet, I think, because like obviously, like the feelings that I felt about the fact that we lost [son’s name], it was...it was heartbreaking, you know, and it was all like those hopes and dreams have been *smashed. But then, being pregnant, it was like…there was erm, no replacement or anything, but it was like this little, like this, little hope in here. – LOUISE*

However, this also posed some extra challenges, such as the potential for the couple to experience cumulative losses, as for some this meant living through multiple losses in a shorter space of time.

Yeah, different aspects with being pregnant compared to being in the other role, but definitely emotionally they kind of impacted and kind of grew on each other as subsequent pregnancies. And so it felt like the fourth was the most significant. - KATIE

Louise spoke about how being pregnant whilst her partner was physically experiencing a pregnancy loss meant that as a couple, they had to navigate feelings of guilt and potential jealousy, which was an extra consideration to manage on top of an already distressing situation.

'cause like I said, like I felt almost guilty for being pregnant because I didn't want my wife to feel like, oh, why do you get to be pregnant or anything like that, but? I mean I loved being pregnant. Absolutely . - LOUISE

Katie considered how both partners having the experience of being pregnant and being a co-mother meant they were more able to support each other through the experience of pregnancy loss from a place of mutual understanding.

Some people who haven't had that experience might just feel like they have no idea about this. Well actually maybe they do have an idea 'cause they can empathise, but they do, but they kind of they hold back because they're not as sure as they would be if they'd had a similar experience. – KATIE

3.1.3 Subtheme: Togetherness In Loss

Although all co-mothers spoke about the pain of their loss, the impact it had on their hopes for the future, and their plans for conception, a number of co-mothers also spoke about feeling connected to each other in the immediate aftermath of the loss. They spoke about the dual experience of loss and love and how, for some of them, the experience brought them closer together.

It's very hard to find words for it, so it's like. Your heart is so full, but so empty at the same time. – REBECCA

Catherine also shared a sense that talking about the love or positivity that can be found within loss is perhaps something that should not be said, or spoken openly about.

cause I remember [partner's name] and I talking about a week afterwards and erm, even a week afterwards, we could kind of see like…well you probably shouldn't say this, but positivities from it. It like it brought us, you know, well I thought obviously we already really, really close, but it gave another like level to our relationship, grieving together was quite…I don't want to say a beautiful thing…but it kind of like…it kind of was. – CATHERINE

3.2 Theme 2: Conception And Loss As Intertwined

When asked about their losses in context of how the couple became pregnant, co-mothers tended to describe how these two processes, conception and loss, impacted upon each other and intertwined in a way that seemed to create additional complications for them in navigating their journey to motherhood. All co-mothers spoke about investing significantly in an imagined future with children, which included discussions and decisions with their partner around topics such as, considering different options for becoming pregnant, deciding who would carry the pregnancies, and choosing a sperm donor. A number of co-mothers described the process of conceiving as exciting, but also exhausting and requiring a lot of their personal resources such as time and money. Some co-mothers highlighted the additional stressful impact of needing to rely on others to conceive. All couples experienced losses within losses, so not only a loss (or multiple losses) of a pregnancy or baby, but also a loss of their sense of security in the process, for some a loss of their imagined future, a loss of money, and other important factors. These multiple losses impacted on how the couple approached their next attempt at conceiving. Most described the experience of trying again as stressful and anxiety provoking. In this sense, this theme encapsulates how for women in same-sex couples, understanding their journey to conception is key in understanding their experience of pregnancy loss. Two subthemes were developed, 1) conception as an emotional and complicated process, and 2) losses within losses.

3.2.1 Subtheme: Conception As An Emotional And Complicated Process

Prior to exploring options for becoming pregnant, all co-mothers and their partners spent time imagining their future families. Even during these early stages, couples began negotiating potentially complicated decisions such as who will carry the pregnancy, what methods of ART they might use, and what route of sperm donation they might want to go down. This process felt initially exciting for most couples, but also overwhelming, and the high level of planning and thought needed in this stage meant that even early on, couples seemed to invest a lot into their imagined future as mothers.

“Prior to picking the clinic, it was, it was really exciting, like it was all consuming. But you never plan for losses or things going wrong. You're only planning to create this perfect family that you dreamed of. So it was so exciting”. - ANNA

“I would have been happy to have had them both, like carried them both. But [partner’s name] felt that for equality and so we could both have the same experience and we both kind of knew what it was like to be in either position that she would like to carry one of them as well.” – KATIE

This tension between excitement and apprehension continued for a number of co-mothers throughout the process of conceiving. Some described the experience as both long and complicated, requiring a significant amount of investment in the process, particularly in terms of time, money and emotional investment.

“…it was all just really quite exciting. And then it became stressful.” – ANNA

“(About IVF) It's long, it's tiring. It's exhausting.” - REBECCA

All co-mothers described encountering what felt like hurdles and barriers in their plans. For some this centred around access to sperm. Difficulties finding suitable donors, whether through private clinics, personal acquaintances, or through online forums, were experienced.

“Uh, yeah, and the sperm bank options as well, in London and the UK really weren't good, so yeah.” – CATHERINE

“So this is quite interesting. In the UK, they give donor profiles. So it'll tell you what the hair colour is. Eye colour little bit about the background, but in America, they offer a lot more information.” - ANNA

Interestingly, Louise shared how sperm donors’ perceptions and judgements of her wife was a specific barrier to conception experienced by the couple.

“We found that like some donors would donate to me but wouldn't my wife because she wasn't like your typical girly girl, so to speak.” - LOUISE

Within this, some co-mothers also shared thoughts about the additional stress and complication of having to rely on others to conceive. For Katie, this was particularly linked to feeling like a burden to their sperm donor, which she felt added extra pressure on to the couple to conceive quickly.

“It's a bit stressful because you know that even though they’re volunteering erm…It was no payment 'cause you don’t want it to become like that kind of dynamic where you kind of, you owe them something and they want, we wanted them to be doing it because they wanted to do it. But it still felt a bit kind of erm like a burden to them because he didn't know what was going…we didn't know them.” – KATIE

For others, the extra complication of relying on others centred around clinics, counting on them to complete the treatment correctly, and waiting for news of successful egg collection, fertilisation and implementation. Rebecca shared the impact this can have on day to day life.

"Uh, you know trying to focus at work and stuff is, you know you're waiting for a phone call to see how many eggs have been collected, how many at fertilised? How many will be frozen? It's waiting, it's constantly waiting." – REBECCA

3.2.2 Subtheme: Losses Within Losses

All co-mothers spoke about the varying and multiple impacts of their losses in context of their experiences of conception, and within this a pattern was developed, in which co-mothers discussed how their pregnancy loss also encompassed other losses. For some, this was the loss of a chance to have a genetically related child, or the loss of one of their chances to have a baby altogether.

"So yeah, we did a another transfer in. When was it? Ohh, February, March, early March. And it just didn't work. So it was a another one of our…so now we're on the last embryo." – ANNA

Katie expressed worries about the potential loss of the couple's chosen sperm donor following pregnancy loss, as well as a loss in her sense of security in the process of conceiving, related to increased worries about the time it would take to become pregnant.

"The fact that if you lost one you think how long can this sperm donor keep going with this, like is he going to give up at some point? Is he going to decide he's had enough, erm I'm gonna have to phone him up again and again? And how long is it gonna take this time and those kind of things." – katie

Financial loss was also mentioned by a number of co-mothers as a factor that increased stress and pressure following pregnancy loss. Catherine also communicated a sense of guilt in allowing herself to acknowledge the loss of money.

"So, not now. Now we have our son and she's pregnant again so it's kind of like, well, you know that's…that was justified, but I suppose that it's like it's almost like gambling isn't it's like…well if I spend 20 grand and we're not actually going to have anything. And that yeah, that thought crept in." – CATHERINE

“I think, erm, I was not willing to allow myself to think that this hadn’t worked because we only had the one embryo that was mine and it’s £10,000 each time we do this, so for me it just wasn’t an option to think that I’d lost this baby.” – ANNA

Most of the co-mothers discussed how pregnancy loss tended to cause parts of their carefully constructed plans for conception and motherhood to be disrupted. Couples’ investments in process meant that changing course tended to be distressing. Anna discussed how for herself and her wife, changing plans for conception felt like a loss in itself.

“Yeah, it’s a lot. So we set out with all this confidence of having, like 4 embryos, which is a pretty good to be fair and thinking we could pick and choose who would carry and who'd have the genetics. And it just has not worked out that it's been a tough lesson really.” - ANNA

In addition to a loss in their sense of security in the process of becoming pregnant, some co-mothers shared how they lost some of their ability to fully enjoy and feel secure about any subsequent pregnancies.

“Every time, with every pregnancy we had, we would get more…I don't know, maybe yeah, maybe more vigilant around it and also just less hopeful that it was going to work out each time because the more times we had it we thought there was an issue.” – KATIE

3.3 Theme 3: The impact Of The NHS On Pregnancy Loss

All co-mothers spoke about how, for both members of the couple, their interactions with NHS systems impacted and shaped their experiences of both conception and loss. Notably, all of the co-mothers described negative, disappointing, and harmful experiences with the NHS, characterised by factors such as delays in treatment and poor communication. However, in describing these experiences, co-mothers tended to make a distinction between what they considered to be general poor quality care, and care that was underpinned by discriminatory attitudes from medical staff. This, intertwined with heteronormative systems and biases, contributed to co-mothers feeling unable to seek out psychological support from within the NHS. I have captured this in two subthemes; 1) dismissal and 2) discrimination.

3.3.1 Subtheme: Dismissal

A pattern of significant delays in treatment and waiting in silence was built, as a number of co-mothers described experiencing agonising waits to either have their loss confirmed, or to receive treatment that could potentially prevent pregnancy loss, leaving some of the couples with a sense of being suspended between life and death.

" The stitches that she needed…that was literally like life and death." – LOUISE

[About their local early pregnancy assessment unit]…"So they got us an appointment three days later, which I just thought was outrageous...so we suffered for three days." – ANNA

For Catherine and her partner, their wait for treatment was short, however Catherine conveyed a sense of being fortunate in this, suggesting rather than this being the norm, it was understood as an exception.

"…I mean, we're very fortunate because lots of people wait weeks between finding out and getting the surgery. We had it within kind of 24 hours."- CATHERINE

This waiting also tended to be characterised by poor communication from and between medical staff, which co-mothers spoke about as exacerbating the already stressful and distressing experience of pregnancy complications and ultimately loss. A number of co-mothers described how, on top of their distress, they experienced frustration and anger brought on by confusing decisions from services and a lack of information sharing, which left them in the dark about the plan for their care.

"It was very stressful and like I kept asking the nurses in the reception desk I was like you know, do you, do you know when my wife is going to be called?" - LOUISE

[About staff in Early Pregnancy Assessment Unit] "They weren't connecting with us at all, you know, so that…I was getting really angry. I was like, yeah, I could feel myself just wanting to go…can you just say something, anything to us, you know?" – ANNA

Relatedly, co-mothers described how their interactions with medical staff had a profound impact on their overall experience of pregnancy loss and how well they were able to cope or manage such a distressing event. Most co-mothers described how a general lack of warmth or empathy from staff made an already difficult situation, even more unbearable.

"….the thing is, in [Hospital B] they were very negative about the situation in itself, without even the whole gay thing on top, they wasn't very. What's the word, supportive, encouraging to the situation? It is a shitty situation to be in when your waters break at such a…like early stage, but they were quite negative from the off anyway." - REBECCA

A number of co-mothers also spoke about how within services, there were discrepancies between the quality of care given by different, individual medical staff. Louise describes how, during a distressing event such as a pregnancy loss, the impact of negative or uncaring staff can outweigh more positive experiences.

"We were pretty well looked after by the majority of like midwives and doctors and things like that. It was unfortunately just like the one or two that just completely ruined it." – LOUISE

Louise also shared how herself and her wife experienced cruel and callous remarks from the doctor treating them during their loss, which understandably caused the couple intense emotional pain.

"He was very funny about it. Really rude and like smiling while saying it and he was like, you know is it is classed as a termination, which it is. But I don't want to terminate my baby." – LOUISE

This experience seemed to fit with a general pattern of couples' losses being dismissed by hospital staff, leaving couples feeling uncared for and with a sense that, although a significant loss for them, to the system this was 'just another pregnancy loss'. For some couples this seemed to manifest through medical staff, sometimes even during treatment for the loss, telling the couples that things will hopefully be different with the next pregnancy.

"I just think services need to be more aware of the saying to somebody after they've lost a baby. Ohh well, didn't you know, on average 25 to 30% of pregnancies end in miscarriage? That's not helpful. Like I mean, great, we're not alone, but we're suffering a lot. You know what I mean? Statistics do not help." – ANNA

"…he was like, oh that's alright, on the next one, we can, you know, get you in early and she thought, but I'm still pregnant with this one. Like I don't. Not thinking about the next one…" - LOUISE

For Rebecca and her wife, dismissal of their baby's life is perhaps viscerally demonstrated through their experience of going to hospital for treatment to try and prevent pregnancy loss, and being placed in a bereavement suite despite their son still being alive.

"We…we spent like 10 days in the bereavement suite even though Magnus was still alive. Magnus wasn't dead and obviously it's still going on and it's got its own delivery suite with like…like cold cots and things like that, yeah. That was…that wasn't good." – REBECCA

Co-mothers tended to share positive experiences of NHS treatment in context of talking about discrepancies between services. Some couples described how in one service they could be provided with good quality care that made a positive difference and eased the couples distress, however in the next service they may encounter the opposite.

"We started off, we was in [Hospital A]. We spent a few days there, it is actually a very good hospital. I have good words for it and then we come back home

and then it took another turn and other things started happening. So we went into [Hospital B] which was...I have…erm…no words.” – REBECCA

All but one co-mother reported that neither pregnant mother nor co-mother were offered emotional or psychological support following their loss. However, in stark contrast, all co-mothers expressed a desire to speak to a professional about their loss. This lack of support is perhaps also indicative of the way in which the couples’ losses were dismissed by services.

“Like I think about it and it's shocking, you leave the early pregnancy unit having a scan, finding out that your baby’s not survived and they give you a leaflet. We've got a leaflet on ectopic pregnancies suspected and that was it. On your way. No follow up. No follow up call from a GP. No referral to a service.”– ANNA

3.3.2 Subtheme: Discrimination

“Really sadly, the NHS hasn't felt like a very welcome place for us.” – *CATHERINE*

As well as contending with sometimes generally poor or dismissive care related to their losses. All co-mothers described negative experiences within the NHS which they related more specifically to discrimination based on their sexuality. A number of co-mothers described feeling excluded and avoided by medical staff during both routine appointments and treatment for pregnancy loss. This was also characterised by a general sense of uncomfortableness or unease from medical staff, including lack of eye contact and having their presence ignored.

“Maybe I'm over sensitive, but even at the like antenatal clinic appointments and stuff that she's had, often I don't feel very included at all. Or, you know, I kind of like…I feel like people looking at me like what you doing here. Who are you?” – *CATHERINE*

Catherine and Katie both made specific reference to the variability of their experiences in NHS care and how this seemed to be related to a difference in levels of inclusivity and acceptance demonstrated by services and the staff within them.

“Yeah, I often just don't feel included. Uh, it is very variable. It's interesting, it seems to be more of an issue for me in in community care. So things like the GP, the antenatal clinics like definitely haven't felt like hugely. Uh involved or welcome. Whereas the hospital…much better.” - CATHERINE

“I know I've had some experiences where professionals have been great and inclusive in terms of who they're directing their attention to, and they’re asking questions. But erm, also, some where that's not been the case.” – KATIE

For some co-mothers, these discriminatory experiences were also present very early on in their journey to becoming parents. All of the co-mothers that took part, alongside their wives, used ART outside of the NHS, becoming pregnant either through treatment at private clinics or home insemination. Three co-mothers did not consider the NHS as a viable option from the beginning, and so did not try and explore possibilities for NHS treatment. However, two co-mothers did explore their options on the NHS, and found almost immediately that they were not eligible for support.

“We considered a lot of options like you know, we tried the NHS, which obviously didn’t really go anywhere.” – CATHERINE

“So we did look into the options for NHS, but it just wasn’t an option. I think you have to have maybe six failed rounds of IUI before they’ll offer you, and you can’t do reciprocally either. They just won’t allow it. It would be just IVF for one person, so yeah, just wasn’t really an option for us.” – ANNA

These systemic, heterosexist barriers to support and treatment, seemed to be carried through in some of the co-mothers’ experiences of NHS services during their pregnancy and their loss. Katie described how as a couple they tended to experience quite a tokenistic level of inclusivity from services, where, although they did not feel overtly excluded, it was clear that professionals had limited understandings of routes to pregnancy outside of what is considered the ‘norm’.

"I feel like, yeah, it the levels that they (midwives) were at was more kind of just being human, being nice to us, but not actually knowing or understanding." – KATIE

Overall co-mothers seemed to share a view of the NHS as having the potential to be unwelcoming, and ill-equipped to support their specific needs as mothers in a same-sex relationship. This, coupled with more general negative experiences of NHS services during pregnancy loss and compounded by differences in quality of care meant that for some co-mothers, approaching the NHS for psychological support following pregnancy loss did not feel like a viable option.

"In the NHS you're just a number in the system and unfortunately there's lots of barriers and hoops erm and then you add on to the fact that you're same sex and they might not even validate like that as a actual…I don't know." – Catherine

For Katie, who did approach her GP for support with anxiety following multiple losses, she found that her co-mother losses were not counted as her losses, which excluded her from receiving support. So in this sense she experienced heterosexist discrimination on a systemic level.

"So I remember, erm, so we'd had four miscarriages as a couple, and I remember going to the doctor like feeling really anxious about being pregnant and I'd check every time I went to the loo, even for about two years after just out of habit erm that there's no bleeding. And she's lovely doctor, but she said, she, I think she tried actually to refer us and they wouldn't accept it because of the fact that there wasn't three, so I guess from the medical angle they just think oh so it's two, so it's just sort of bad luck." - KATIE

3.4 Theme 4: Co-mothers As Invisible And Unknown

This theme speaks to how both bodily-focused and heteronormative constructions of pregnancy and loss can build layers of invisibility that obscure co-mothers experiences, and lead to exclusion from support and dismissal from others. These multiple invisibilities impact co-mothers in a number of ways, such as uncomfortable or burdensome interactions with others, a lack of inclusivity on official documentation, a lack of access to others with similar experiences, and a sense of not knowing where they fit in. Within this theme I have created four subthemes to speak to the intersecting but distinct elements described above; 1) bodily constructions of pregnancy and loss, 2) heteronormative constructions of parenthood, 3) double disclosures and 4) where do I fit in?

3.4.1 Subtheme: Bodily Constructions Of Pregnancy And Loss

When talking about their interactions with others around the time of pregnancy loss, I noticed a pattern of co-mothers discussing their experiences through the lens of pregnancy and loss being a primarily bodily event, and how not being the one to physically experience the loss meant that co-mothers seemed to garner little care or consideration from others and indeed, from themselves.

Rebecca poignantly illustrates this through sharing her story of being in work shortly after the loss of her son Magnus, and her colleague bringing in their newborn baby.

“INTEVIEWER - Do you think your colleagues considered what that might have been like for you?
REBECCA
No. Not at all. Probably because I didn't give birth.”

Co-mothers spoke about how their experiences as the non-pregnant partner were actively excluded or dismissed when seeking support from professionals following loss. Co-mothers related this to professionals preferring to focus their support solely on the mother who experienced the loss in her own body.

“we had a erm, midwife counselling session...but we only went to the one and I mean it didn't help me at all. She wasn't focused on like…obviously she was more focused on my wife because she birthed him and everything, but like there was no sort of. And how are you feeling or whatever I was just almost like, the spare part and I was like oh OK. – LOUISE”

In a similar way, Katie, who had experienced pregnancy loss as both the pregnant and non-pregnant partner, discussed how during a psychotherapy session, the therapist focused only on the losses she had experienced in her own body, and completely dismissed the losses she experienced as a co-mother.

“The therapist…said something about my two miscarriages or something and it was just…the way, the way it came across. That probably wasn't the same…the right language, but the way it was said, had just eradicated the other two losses from…'cause we're talking about loss rather than anything that was particularly related to my body.” – KATIE

For some co-mothers, this privileging of the bodily experience of loss left them with a sense that their parenthood went unrecognised by professionals.

“I said something and she was like, yeah, how do you feel [partner’s name] and it's like? Don't dismiss me, I'm here too, like I felt these feelings too like I didn't I didn't carry him and I didn't birth him. But he was still my son.” – LOUISE

Subsequently, this exclusion led some co-mothers to experience thoughts that seem to indicate that they themselves felt less deserving of support, due to them not being the gestational mother.

“So that was one thing is, I think because it wasn't really my loss, it hadn’t physically happened to me. I felt you know she had the operation on the Saturday and I felt very much like I needed to be at work on the Monday. And so I went back to work straight away.” - CATHERINE

“And yeah, but I suppose if she's the patient then why? Why would I be invited to a follow up?” - REBECCA

Interestingly, when considering their experiences of exclusion, a number of participants compared this to the experiences of fathers, noting possible similarities between them. This seemed to be noticed most often in discussion surrounding the tendency for professionals to focus on the pregnant mother.

"It's kind of made me feel strongly about the need to include that the parent not just for same sex couples but for any couple. If there are two parents in and all of that." – KATIE

"Even like, I suppose, if we were a generic straight couple, erm, I suppose the mum would always be the one like or how are you and whatever like, no one really asked the dad like and I suppose I was in that same position." – LOUISE

3.4.2 Subtheme: Heteronormative Constructions Of Parenthood

As well as contending with erasure through the dominance of a bodily construction of motherhood, another pattern was developed, in which co-mothers needed to, or felt as if they needed to, justify their existence and presence to others, even in the midst of distressing and upsetting situations related to pregnancy or loss. Co-mothers spoke about seeking acceptance and validation of their parenthood and connection with the pregnancy. These experiences seemed to be related more specifically to co-mothers being in a same-sex relationship that challenges the normative understanding of parents as one mother and one father.

"She got wheeled away to theatre and a nurse came in and I was in floods of tears…I said oh she's my wife and I just felt in that moment, I had to explain why I was so upset… I think that kind of goes to how it is, how it can be in a same-sex relationship and that sort of circumstance of like it's just constantly clarifying your roll and asking for validation." - CATHERINE.

"So somebody said to me that, they didn't, they didn't think that it would be such a big deal for me because…it's not like biologically, my child."– REBECCA

As well as needing to actively justify their existence in situations related to pregnancy loss, co-mothers indicated ways in which living in a heteronormative society meant that for many of them, the experience of being a co-mother in a same-sex relationship, in general, seemed quite unknown or unthought about by the majority of others in their lives. For some co-mothers this meant a lack of an established support network to turn to during difficulties.

“And I think because of the fact we were doing it in a different way. It made it particularly hard 'cause, um, we only knew each other who’d had that experience. It's good that we had each other, but we didn't…we didn't have other people that would just kind of get it, that would just kind of know what that was like.” – Katie

In a similar way, co-mothers described how much of the literature they came across following loss was geared towards either mums or dads, with no consideration to same-sex couples. None of the co-mothers had experienced themselves reflected in leaflets or documents, leading to them feeling further dismissed and excluded.

“…if you Google like bereaved parents you will find leaflets for mums and leaflets for dads now is it… I found them and the thing is you can't relate to either.” – REBECCA

“There was a document, and it said, like mother and father or something and the midwife had basically like dismissed me, and we were like, yeah but…but my wife, she’s the other parent like she's…she's the other mum like. And it was all very…dismissed almost.” – LOUISE

In addition to the heteronormative assumptions of services and documentation, co-mothers also spoke about feeling invisible to and misunderstood by their families. For some co-mothers, family members heterosexist biases meant that their parenthood was sometimes diminished or ignored. This not only further reduced their opportunities to have their experiences of loss to be seen and validated by others, but for some co-mothers also had a negative impact on their relationships with family.

My mum and dad did put a lot of pressure on us to go down the route of having a genetic grand…because they wanted to genetic grandchild…there's an element of it that's a bit of a sore subject for me and [partner’s name] and we harbour some feelings towards my mum and dad about that. – ANNA

3.4.3 Subtheme: Double Disclosures

"…we're living through it too. In the same way, there's just not a box for us." - Rebecca

The invisibility of not being the pregnant mother coupled with dominant heteronormative assumptions about parents, meant that for some co-mothers, the task of sharing the news of loss with others also required the task of 'coming out' about being in a same-sex relationship. Co-mothers described this double disclosure as burdensome, adding extra difficulty to an already painful experience. They also shared how the burden of explaining their loss in context of their relationship, prevented them from reaching out to others, indeed in some instances, actively avoiding others to get around this.

"I suppose that like added element of kind of having to say you're going through this bad thing. But also having to say oh, you know I'm in a same-sex relationship…when I was telling people that didn't know…or didn't know much about me, that coming out is really difficult on top of that, like that news." - CATHERINE

"We didn't go ahead with contact like, you know, going to a group or anything, any form of support.it was a really different situation to what a lot of people would have been going through and I think that's one of the things that really adds to the stress." – KATIE

"I think I've definitely spent four months being distant, mad, avoidant, I've avoided people left, right and centre." – REBECCA

As well as disclosing their sexuality, co-mothers described how the process for same-sex conception seemed so unknown and mysterious to others, that even in their grief, the burden was on them to disclose often quite personal, or detailed information about how women in same-sex relationships become pregnant, or answer intrusive questions from others.

"…most people I've spoken to about that they've all kind of, it's all been new, and people are so interested and they kind of like oh so what did you do then and how did that work? And did you go to a clinic or? Which you know, it's good that they're interested. But the knowledge, isn't there" - KATIE

Poignantly, four co-mothers spoke about a destabilising sense of never quite knowing if awkward reactions from people they share their loss with is because of a general uncomfortableness with death, or because of an uncomfortableness about their sexuality. For the co-mothers this seemed to add to the strain and exhaustion of being a grieving parent, and the intensity of navigating social interactions following loss.

"Again… people…kind of don't know what to say. It's, I guess it's an awkward thing anyway. The added awkwardness and people are uncomfortable because it's the same sex relationship. That's what I feel. But how accurate that is, I don't know" – CATHERINE

"I do wonder and I would like to meet heteronormative people to see if they have…the same feeling about it…because you don't know whether somebody is finding the situation difficult because the probability is you're going to lose your child…or whether it's because they didn't really know how to address the situation because of who we were, it's to know that line." - REBECCA

"I don't know whether that the a situation or whether that was the person in particular, or because we were gay. I don't know." - LOUISE

3.4.4 Subtheme: So Where Do I Fit In?

Most co-mothers spoke about feeling useless or unsure of their role during the process of pregnancy loss and it seemed that consistently encountering both heteronormative and bodily constructions of pregnancy and loss contributed to this experience.

"I just I just felt like. With a lot of it, it was all like obviously based on her more than how I felt like I said like I felt like almost like a spare part in a lot of things like." – LOUISE

In this way, finding ways to fit into or carving out a role for themselves seemed to be an important part of the process for co-mothers, some spoke about taking up a supportive role, offering both emotional and practical help to their partner during the loss.

"INTERVIEWER - Would it be OK if we just revisited what you felt your role as a partner was at that time emotionally?
REBECCA - To get them through it I suppose."

Rebecca spoke more specifically about feeling like she had to fit herself into heteronormative roles pre-designed by society, with a sense that this wasn't what she wanted, but what she had to do in order to get through the loss.

"I think because you yourself don't feel quite adequate enough…you put yourself in them boxes too, naturally, because that's what the world expects of you." – REBECCA

Louise shared how, after her loss, she began offering other partners a space to talk, or share their experiences, although did not find a similar space for herself.

"Like if I see a post or whatever and I'm like, you know, you can message me if you feel like it, I've been through the same thing sort of thing, so I'd always try and be there for people and sort of help support them erm, but I've never really found a specific thing for me." – LOUISE

Poignantly however, all co-mothers to some extent had questioned whether they had a right to their grief, wondered what they were allowed to feel or even questioned whether they had a right to feel anything at all. Some co-mothers linked this directly to not having access to others with similar experiences and not being offered a space to talk about their thoughts and feelings.

"And I suppose, yeah, it was. Yeah, yeah, it was a really bizarre kind of situation to be in really 'cause it was my loss too, but it kind of wasn't happening physically to the me, so, I suppose, like. Uh, maybe a bit of kind of confusion about like what the right or wrong way is to feel." – CATHERINE

"So then you start to question whether you should feel like that. So maybe you shouldn't. Maybe you don't have that entitlement, you know. And then you feel guilty because you feel like that because you know that you are a parent and you have the same grief stages. But it doesn't exist in the world. So should your feelings not exist or is the world wrong?" - REBECCA

When asked about what would have helped, or supported them to feel validated in their loss, co-mothers described the importance of others being open, and curious about their experiences, in a respectful way. They described a desire to both talk to other parents, co-mothers or partners, as well as a wish to talk to a professional such as a therapist.

[about professionals] "you know you wouldn't expect someone to understand your experiences completely just by meeting you. But maybe it's just about being, not having assumptions or just asking questions. Just being open minded and asking a bit around what peoples experiences where." – KATIE

4. DISCUSSION

Four main themes and eleven sub-themes were generated from the data to address the research questions:

1. How do co-mothers in the UK experience pregnancy loss?
2. How does the UK specific healthcare and social landscape impact on and interact with this experience?

This research is the second empirical study to date that focuses solely on co-mothers' experience of pregnancy loss (Wojnar, 2010), however it is the first to situate this experience specifically in the UK context. The contribution of the findings to addressing each of the two research questions will now be discussed. The themes 'conception and loss as intertwined' and 'journey through loss' are discussed in relation to the first research question. The themes 'the impact of the NHS on pregnancy loss' and 'co-mothers as invisible and unknown' are discussed in relation to the second research question.

4.1 Research Question 1: How Do Co-Mothers In The UK Experience Pregnancy Loss?

4.1.1 Conception And Loss As Intertwined

Previous research with heterosexual couples has shown that the planning of a pregnancy is a key factor in psychological distress felt following pregnancy loss (Thapar & Thapar, 1992) and in the present research it was noticed that the couples' experience of becoming pregnant impacted upon, and in some ways amplified, their loss. This was also circular in nature, as for all co-mothers, experiencing a pregnancy loss had a lasting impact on how the couple then approached 'trying again' for a baby. This relationship between conception and loss is also shown clearly in research with heterosexual couples who use ART (Harris & Daniluk, 2010).

However, the results of this research offer further evidence that same-sex couples' journeys to becoming parents are likely to be more nuanced and complicated than those of heterosexual couples, including those using ART. For example, from the start, co-mothers and their partners had to contend with making meaningful and necessary decisions around which partner would carry the pregnancy, whose eggs would be used, and options for sperm donation, meaning that for many of the co-mothers, even very early on in conversations with their partner, an emotional investment not only in having children, but the way in which the couple would have children, was formed. For some co-mothers, this comprehensive planning process led to the co-creation of a particularly detailed imagined future and was often characterised by emotions such as excitement, but also anxiety as they embarked on their journey towards motherhood. This description aligns with previous research which has also described how the emotionality and experience of conceiving a baby can be intense or more pronounced for women in same-sex relationships, and therefore has the potential to amplify the emotional experience of pregnancy loss (Peel, 2010; Wojnar, 2007). For the co-mothers in the present study, the additional stress of having to use a third party, such as a sperm donor or a clinic, was understood to be a prominent factor in the amplification of their loss. Co-mothers described feeling like their fate was in the hands of these third parties, and some described how this can add extra complication to an already complicated process. Interestingly, previous research focusing on women in same-sex relationship has not paid particular attention to the role that relying on third parties has to play in co-mothers experience of pregnancy loss. The significance of this is somewhat reflected in research focusing on heterosexual couples experience of pregnancy loss following ART (Harris & Daniluk, 2010). However this does not fully capture the additional burden of accessing sperm, or access to ART outside of the NHS, that female same-sex couples face.

In a similar way to heterosexual couples (Farren et al., 2018), co-mothers also reported that with each pregnancy loss they experienced, their anxiety about subsequent pregnancies increased. However, in addition to this, the results also show that for women in same-sex relationships, pregnancy loss can also encompass a loss of their carefully negotiated conception plans and, in this sense, a loss of their imagined future. For some this may include their planned roles in conception and parenthood of future children, including whether they had planned to be the birth mother or the co-mother. For example, co-mothers shared how they changed donors, changed clinics, changed plans for who would carry, changed plans for who would undergo IVF which in some cases also changed the genetic makeup of potential future children. Therefore, although heterosexual couples who use ART describe a similar loss of their imagined future (Harris & Daniluk, 2010), for couples who have the possibility of ‘swapping’ roles, or more conception options open to them in this sense, pregnancy loss also has the potential to mean re-engaging in emotionally complex discussions. Having to re-negotiate these decisions can not only increase exhaustion, stress and tension felt by the couple, but can also be the cause of different types of grief. As participant Anna explained, after their pregnancy loss she felt bereaved by the loss of her chance to carry another pregnancy, and the loss of her possibility of having a genetic child. Craven (2019) makes reference to this in her book about LGBTQ+ reproductive loss, stating that few have discussed the emotional complexities of lesbian couples ‘swapping’ roles following pregnancy loss or infertility difficulties. Therefore, highlighting the process of re-negotiating conception plans and the grief this can cause for co-mothers and their partners is an important and unique outcome of this research, and begins to build a picture of the ‘losses within losses’ that women in same-sex relationships may experience.

Financial loss was also mentioned frequently by co-mothers, particularly those who conceived through clinics, with some describing how the high level of financial investment needed increased the pressure for the pregnancy to result in a healthy baby. In this sense, the loss of a pregnancy or baby was also compounded by a sense of losing the money invested. This not only increased the stress and pain of the loss, but for some also engendered feelings of guilt for allowing themselves to think about the loss of their baby in financial terms. Although this is similar to the experiences of co-mothers in North America (Wojnar 2007; Wojnar, 2010) the finding led me to consider what this financial pressure and loss means in context of a country that offers free healthcare. None of the co-mothers in this sample were able to access ART though the NHS. This unequal access can be considered representative of heterosexist systems (Stonewall, 2015) that not only creates barriers to parenthood for LGBTQ+ couples, but also plays a significant role in the distress these couples experience following pregnancy loss.

4.1.2 Journey Through Loss

Previous research focusing on gestational mothers who have experienced a pregnancy loss has shown that loss at all gestational stages has the potential to impact mental health (Brier, 2008). Within the subtheme navigating loss, this finding is broadly reflected. The ways in which co-mothers described their pregnancy loss tended to fall into two descriptions based on the gestational stage of the loss. These were: shock and confusion for early loss (prior to 12 weeks), and exhaustion and uncertainty for loss at later gestational stages. However, all co-mothers spoke about their losses as being emotionally and psychologically impactful. For all co-mothers, regardless of gestational stage of loss, a sense of the event as being out of their control and feeling helpless was present. This mirrors previous research from Wojnar (2010), who reported that North American co-mothers shared a similar sense of distressing unpredictability and lack of control during pregnancy loss. Interestingly, previous research seeking to understand the experience of pregnancy loss from a father’s perspective has also noted that the predominant emotions reported by men during and shortly after pregnancy loss were frustration and helplessness (Due et al., 2017). However, it is important to note that as research into fathers’ experiences has tended to be framed through a heteronormative lens, studies in this area often attribute their findings to hegemonic concepts of masculinity, such as fathers as strong, unemotional and in control, which does not directly apply to female co-mothers. Therefore it is possible that the shared feelings of helplessness expressed by co-mothers and fathers comes more generally from the position of being the ‘other’ parent, and may be primarily linked to a lack of bodily experience rather than predominantly caused by constructions of gender roles.

However, as Wojnar (2007) discussed, unlike fathers who have roles that are well recognised and in some ways pre-ordained by society, co-mothers are more likely to feel like they need to carve out a role for themselves to manage this helplessness. This finding is also reflected in the present study through co-mothers discussing the various roles they took up during and after pregnancy loss. One such role that was spoken about by a number of co-mothers was being the one to hold on to hope, and remain positive. In her research, Wojnar (2007) also reported how lesbian couples experienced “the hope or no hope ride” of pregnancy loss. Her participants described moving between hope that the pregnancy will continue and the painful realisation that stopping the loss was beyond human control. In Wojnar’s (2007) work, this finding was presented as partners being together on this hope or no hope ride, whereas in the present study, a number of participants spoke about how they specifically took up the role of holding on to hope, whilst they described their pregnant partners as being more resigned to reality of the loss early on. This suggests that hope wasn’t something the couple always held together, and may be in some ways related to the physical experience of loss or losing a pregnancy. This particular role of holding on to hope and being positive may then also provide co-mothers with a way of coping with suspected loss by denying a reality in which this could happen.

For the co-mothers in this study, another key part of their experience was trying to balance looking after and paying attention to their own emotional needs, whilst also supporting their partner. A number of co-mothers spoke about prioritising their partner’s needs over their own, for some this included completely ignoring their own needs at times. Indeed, one participant, Rebecca, spoke directly about the personal cost of remaining positive for everybody else, whilst she herself felt hopeless. This finding generally reflects research that has discussed how fathers typically see themselves primarily as a ‘supporter’ to their female partner, and that they invest more in this than in their own needs (Due et al., 2017). Numerous studies have placed this in the context of the normative social expectations placed on fathers, suggesting that others expect men to maintain emotional control and be a comfort to the mother (Abboud & Liamputtong 2005; Johnson & Baker, 2004; Story-Chavez et al., 2019). Again, this is interesting when considering all co-mothers in this dataset are cis-female and as such have not received the same socialisation as men, yet appear to adhere to similar beliefs and roles as partners during pregnancy loss. Although different for co-mothers and fathers, it seems their tendency to deny their own needs and prioritise their partners is at least partly related to societal expectations and constructions of their role (Story-Chavez et al., 2019).

An important finding from this research is how having two mothers, who are both willing and/or able to carry a pregnancy, can impact upon the experience of pregnancy loss. Captured in the double the chance of pregnancy, double the chance of loss, double the chance of hope subtheme, co-mothers spoke primarily about how being pregnant, or having plans to become pregnant shortly after loss, was an effective coping mechanism for both themselves and their partners. Although trying again for a pregnancy has been cited by fathers as a way to cope with and move forward from loss (Due et al., 2017), the intricacies of the ‘other’ parent being pregnant, or trying to get pregnant, during pregnancy loss has not yet been explored in research seeking to understand female same-sex couples’ experiences of pregnancy loss. As well as the benefits, co-mothers also spoke about the complexities this double chance of pregnancy may bring, such as the potential for feelings like jealousy or guilt to grow between the couple. Therefore, although open and effective communication is integral for navigating loss for all couples, it may be particularly important for women in same sex relationships, who may be pregnant at the same time as their partner experiencing a pregnancy loss, or where one partner may be struggling to become pregnant. Some co-mothers did also talk about the communicative benefits of having been in both roles, expressing how shared experiences can bring about a unique confidence in knowing how to support each other through loss.

This mutual understanding of each other’s needs and experience was carried through into a number of co-mothers talking about the togetherness they felt in the immediate aftermath of loss. Some co-mothers reflected on how, in amongst their pain, the couple experienced full hearts, a deeper love for each other and a renewed sense of closeness. In Wojnar’s (2007) study, couples discussed how loss clarified what they wanted and did not want in their future. In Craven’s (2019) study, queer resiliency is discussed alongside some participants expressing what they were grateful for in loss. However, this experience of closeness following loss has not yet been discussed in this way in previous research from LGBTQ+ participants.

Co-mothers did however tend to share these experiences with some hesitancy, guilt, or with the caveat that this feeling of togetherness is difficult to describe. This gives a sense that co-mothers were worried that these more ‘positive’ aspects of grief are not acceptable to share with others. This is likely to be true to some extent for most couples regardless of sexuality, due to societal constructions and expectations of grief and loss. However this led me to consider whether for co-mothers, the guilt and worry of speaking about these more positive experiences might also relate to how their grief is often marginalised and ignored by others. Perhaps expressing feelings other than immense distress after pregnancy loss has the potential to further undermine the validity of their grief in the minds of others.

Overall, although similar in some ways to fathers, or heterosexual couples using ART, the way in which co-mothers experience pregnancy loss is nuanced and complicated in many ways, that makes them quite distinct from the experiences described in literature exploring pregnancy loss within heterosexual couples.

4.2 Research Question 2: How Does The UK Specific Healthcare And Social Landscape Impact On And Interact With This Experience?

4.2.1 The Impact Of The NHS On Pregnancy Loss

All co-mothers that took part, alongside their pregnant partners, sought support from NHS services at some point during pregnancy loss. Pertinently, all co-mothers shared that they experienced poor-quality, and in some cases harmful, care from these services. It is important to note that co-mothers also shared some more positive experiences, such as warm and inclusive midwives, and timely access to treatment. However, these more positive experiences were overwhelmingly contrasted with negative experiences, and as one participant Louise explained, negative experiences have the power to eradicate or diminish the positive. Indeed, at the time of writing this thesis, there has been increasing scrutiny of maternity services across the UK, spotlighting poor practice that has led to high rates of baby mortality (Department of Health and Social Care, 2022). Interestingly, co-mothers tended to make a distinction between experiences with the NHS that they felt related to a more generalised pattern of poor-quality care, and experiences that they felt were specifically related to their sexuality or status as the other parent. Within these more generalised experiences, co-mothers shared similar concerns to those highlighted by previous research exploring women's experiences of EPAU's (Norton & Furber, 2018; Tsartsara & Johnson, 2002), such as long waits to be seen by services and poor communication from staff. For some co-mothers, these experiences left them feeling suspended in a split state (Kukulskienė & Žemaitienė, 2022) between life and death, waiting for news or interventions which they were told would determine whether their baby was going to live or die. This understandably increased the tension and distress they felt whilst waiting for confirmation of the loss.

Within these generalised experiences, another pattern was built in which the co-mothers described how both themselves and their gestational partner experienced their loss and needs as being dismissed by NHS services. This ranged from couples being told that pregnancy loss is common, to being told to focus on the potential to become pregnant again, to Rebecca and her wife being put in a bereavement suite whilst their son Magnus was still alive. Whilst no research to date has explored the specific impact of NHS services on same-sex couples' experiences of pregnancy loss, Galeotti et al (2022) carried out a scoping review of research from across the world that focused on how hospital environments can impact upon heterosexual couples' experiences of pregnancy loss. They found that overall the studies in the review described parents' experiences as generally characterised by a perceived lack of understanding among healthcare professionals of the significance of their loss. Parents in these studies also reported that their distress was exacerbated by a lack of information, support, and feelings of isolation in the aftermath of their loss. This suggests that all parents, regardless of their sexuality and other identities, may find themselves having to contend with disappointing, distressing and in some cases harmful experiences in maternity/fertility services.

For co-mothers however, this research shows that as well as contending with these more generalised negative experiences with services, they are also vulnerable to experiences that they related more specifically to homophobia, discrimination and heterosexism. Peel (2010) described how her participants' experiences with homophobia following pregnancy loss lay on a spectrum from 'diffuse' discrimination to 'extreme'. This seems to broadly fit with the events described by co-mothers in the present study, with a number of co-mothers describing more 'diffuse' experiences such as a lack of eye contact and a general sense of unease from professionals, as well as more 'extreme' experiences such as being ignored when asked if their name would be on the baby's death certificate. As mentioned, although no previous research has specifically spoken about same-sex couples' experiences of the NHS during pregnancy loss, there has been a significant amount of survey data that has demonstrated how heterosexist and homophobic attitudes and biases are present across the NHS (Hudson-Sharp & Metcalf, 2016). Therefore it is perhaps, regretfully, not surprising that co-mothers in this study experienced similar biases in their contact with services.

Within this, most co-mothers did not feel able to explore their options for mental health support with the NHS, or had not even considered the NHS to be a place where they could access support for their mental health following pregnancy loss(es). For co-mothers and their partners then, there seems to be an insidious combined impact of general poor-quality services that is then further compounded by homophobia and discrimination. This may not only impact upon the levels of distress, confusion and pain experienced by the couple during an already difficult event, but might also create barriers to accessing support for this. As one participant, Catherine, so clearly stated, for some same-sex couples the NHS does not feel like a safe place.

4.2.2 Co-Mothers As Invisible And Unknown

Co-mothers often spoke about feeling invisible, excluded and alone in their grief, which reflects early work of Wojnar (2010) and Peel (2010). Although all co-mothers in this sample were able to find some level of comfort and support with their partner, all participants expressed that there were elements of their grief that felt specific to being the co-mother, which they struggled to have recognised or understood by others. Previous research seeking to understand the experiences of female same-sex couples during pregnancy loss has also described how the grief of 'social' parents is often othered in society (Craven & Peel, 2014). In the present study, it was noticed that co-mothers spoke about the othering they experienced in two distinct, but intertwined ways – bodily constructions of pregnancy and loss, and heteronormative constructions of pregnancy and loss. Both of these explanations for exclusion seemed to be underpinned by normative social constructions of pregnancy and loss that are dominant in the Western world.

The experiences of exclusion described by co-mothers as being related to them as the non-pregnant partner tended to be characterised by a sense that professionals, friends, and family overwhelmingly focused on the pregnant partner – their physical recovery and emotional state. Co-mothers described very few instances of being asked how they were feeling. At times, co-mothers felt actively ignored and shut down by professionals, such as medical staff or therapists. Interestingly, when talking about these specific experiences most co-mothers spontaneously linked these to that of fathers and aligned themselves with fathers in this way. Indeed, research with heterosexual fathers has evidenced similar experiences of exclusion, with an overall focus on the gestational mother (Abboud & Liamputtong, 2005; Murphy, 1998; Samuelsson & Segesten,2001). This seems to fit with the idea that a societal construction of pregnancy and loss as a primarily physical experience is pervasive and is likely to be a factor that contributes to the invisibility experienced by co-mothers, in a similar way to fathers. However, it is also important to consider how bodily constructions of loss are intimately tied into gendered notions of pregnancy. Perhaps this bodily construction might not weigh quite as heavily on fathers as it does on co-mothers, as society does not expect fathers to be pregnant. In addition, fathers are generally assumed to have a genetic (in some sense bodily) link to the pregnancy or baby, which may legitimise their relationship to the pregnancy in the eyes of others. So, although co-mothers did not speak about these particular experiences in concrete relation to heterosexist notions of pregnancy, it feels pertinent to consider how bodily constructions of pregnancy and loss are still underpinned by heterosexist assumptions. Therefore, although similar to research about fathers, to simply equate these findings with fathers' experiences in this way would be reductive.

Furthering this, co-mothers also discussed experiences that they specifically related to heterosexist beliefs from others, including their own families. Reflecting this, a number of co-mothers spoke about how the additional burden of feeling like they always need to clarify their parenthood and ask for validation, particularly in medical settings, was an exhausting complication to manage on top of the loss itself. All co-mothers spoke about how they did not see themselves reflected in supportive or official documentation, in groups for bereaved parents in person or online. In fact, some co-mothers spoke about how they actively searched for this and very rarely found what they were looking for. These findings are similar to those reported in previous research from Peel (2010) who describes how for same-sex couples this heteronormativity can be deafening and can silence co-mothers in particular. In Peel & Cain's (2014) discussion paper, the authors postulate that this systemic silencing benefits the heterosexist status quo. One co-mother in the present study, Rebecca, illustrated this clearly by explaining that as a co-mother, she felt that she needed to somehow make herself fit into the pre-ordained role of either mother or father, despite this feeling uncomfortable for her.

For some co-mothers, these intertwining layers of invisibility meant that disclosing their loss to others became additionally burdensome. This is an important finding, particularly when considering how the process for accessing psychological support often begins by contacting a professional who, as the results of this study show, is perhaps likely to have little knowledge of same-sex conception or pregnancy loss, and may also hold homophobic biases. In this way, a number of co-mothers made reference to how disclosing their loss was difficult in of itself, but was compounded by the risk of opening themselves up to intrusive questions, uncomfortable reactions, and possible homophobia from others. This is mirrored in very recent research from Australia (Rose & Oxlad, 2022) that found LGBTQ+ people felt increased apprehension when disclosing pregnancy loss in the workplace, related to their awareness of how dominant heterosexist assumptions of pregnancy and conception are in Western society. Therefore, there is also a risk of co-mothers being less able to access workplace support that they may need, or find helpful after loss such as time off, or counselling.

Peel (2010) found from her survey data, that women in same-sex relationships from across the UK, USA & Canada, tended to attribute uncomfortable reactions to others following pregnancy loss to a general unease with death, rather than to any specific feeling around their sexuality. However, interestingly in the present study, a number of co-mothers spoke about how they can never quite be sure of whether uncomfortable reactions are related to loss in general, or to their sexuality, or something else. In Peel's (2010) dataset, no distinction was made between whether it was the pregnant partner or co-mother that disclosed the loss. Therefore, contending with this uncertainty is perhaps more related to the invisibility of co-mothers through the interlinking heteronormative and bodily constructions of loss and is a burden specifically felt by them. Although not just related to co-mothers, Craven (2019) considered how a number of her non-gestational participants who had experienced reproductive loss often felt like they were left wondering whether the undercurrent of silent unease that they tended to experience was homophobia or something else.

Craven's (2019) research also highlights the multiple layers of invisibility for bereaved LGBTQ+ parents. In a similar way, the findings from this research also suggest that having to contend not only with the invisibility, but also the vulnerability that comes with existing as a co-mother in a heterosexist society, is not only likely to be exhausting, but again may incur further barriers in place of accessing support. Related to this, and a unique and poignant finding from the present research, is that all co-mothers shared some form of doubt, questioning, uncertainty or guilt around their own grief, and whether they had a right to feel anything in relation to their loss. Indeed, some co-mothers occasionally found themselves questioning whether they could even claim the loss as theirs. This in turn caused these co-mothers distress and guilt at having thoughts that conflicted with their understandings of themselves as parents, with rights to mourn the loss of their baby. This complex and insidious cultural silencing and erasure of co-mothers may be so pervasive that it has the potential to enter into co-mothers' own minds and be internalised.

Although fathers also tend to report internally denying themselves the right to grieve following disenfranchisement from others (Due et al., 2017), the societal mechanisms at the core of this process are different to the ones experienced by co-mothers. For fathers, this internal marginalisation seems more related to fulfilling the hegemonic construction of masculinity as unemotional and rational (Bonette & Broom, 2012; McCreight, 2004). For co-mothers, their silencing is multi-faceted in a different way and built on deep-rooted heterosexist assumptions about what makes a parent.

Although still underdeveloped in many ways, over the past few years there has been increasing recognition of the need to include fathers in pregnancy loss related support (Due et al., 2017). Within this, some charities are also working to expand this definition and use more inclusive language such as partners, however, co-mothers simply being included within the 'partners' support is not enough. As evidenced in this research, as well as previous research (Craven, 2019; Peel, 2010; Wojnar, 2007; Wojnar, 2010), although similar in some ways to fathers, co-mothers are a group of people with unique experiences and complex systemic and societal factors to contend with in their loss and are therefore deserving of specific, focused attention.

4.3 Future Research

This research was the first to focus specifically on co-mothers' experiences of pregnancy loss in the UK. However, as discussed, the majority of participants that took part in this study had also experienced pregnancy and sometimes loss as a gestational mother, as well as co-mother. This was a key factor that participants discussed as impacting on how the couple navigated their loss, sharing the relative benefits, as well as possible complications, that might arise as a result of this. Future research may focus on interviewing female same-sex couples, where both partners have been pregnant and where one or both have experienced pregnancy loss as a gestational mother, to understand the nuances and complexities of this in a more detailed way. Importantly, however, previous research has warned against assuming that co-mothers can simply ‘swap’ roles following pregnancy loss or difficulties conceiving (Craven, 2019). It will therefore be important for any future research to be mindful of this.

All participants in this study identified as White, which will be discussed further in section 4.6.5. However, it is well documented that women of colour, especially Black women are significantly more likely to experience poor treatment, pregnancy complications and pregnancy related mortality (Five X More, 2022), an important area for future research will be to hear specifically from women of colour who are in a same-sex relationship and have experienced pregnancy loss, with particular consideration given to the intersections of race and sexuality.

It is also recommended that future research builds upon this research and pays specific attention to, and offers analysis of, how NHS systems interact with and care for female same-sex couples during pregnancy loss. This may be through interviews with NHS staff from a variety of disciplines. Within this, a focus on a deeper understanding and analysis of the heteronormative assumptions that seem to underpin the barriers same-sex couples face in accessing ART via the NHS would be particularly timely, given the increased conversation and campaigning around health and fertility inequalities for LGBTQ+ people (BPAS, 2021). Research could also explore more specifically the relationship between this lack of access and the impact it may have on pregnancy loss for female same-sex couples, possibly on a larger scale through UK-wide survey data.

4.4 Recommendations For Clinical Practice

As discussed, the results of this study, in line with previous research (Peel, 2010), build a picture which suggests that, unfortunately, in the UK, co-mothers commonly experience being excluded and marginalised in healthcare systems. To this end, it is recommended that services that are involved in providing care to people who are experiencing pregnancy loss undertake training to specifically uncover and process implicit biases that they may hold towards same-sex couples (Stewart & O’Reilly, 2017). This should include how they currently understand and construct what it means to be a parent and expand ideas of who pregnancy loss impacts upon. With acknowledgment that maternity services are often stretched, particularly post pandemic (Department of Health and Social Care, 2022), even small improvements in clinical practice such as verbal acknowledgments of co-mothers as a grieving parent are likely to make a difference to the co-mothers' experience of pregnancy loss (Wojnar, 2010).

As discussed in Craven (2019), reproductive loss of all kinds is often framed in the Western world as an individualised experience. Re-framing pregnancy loss as being part of a collective experience, i.e. something that many LGBTQ+ couples may face on their journey to parenthood, may go some way to offer an alternative to the cultural and social silencing of co-mothers' experiences. In this way, I suggest that using a community psychology approach (Orford, 2008) that draws upon the history of queer resilience and memorialising loss (Craven & Peel, 2017) may offer a framework from which to build safe and inclusive groups, that allow co-mothers and other LGBTQ+ non-gestational parents the space to explore the meaning and complexities of their loss. There are a number of LGBTQ+ individuals and collectives that work both online and in person to offer spaces to LGBTQ+ couples and families, in which they can discuss their journey to parenthood. NHS and other charity services may wish to work with these groups either nationally or in their local area to commission a collaborative approach to creating these groups, or at least signpost to them. However, any offer of psychological or emotional support for co-mothers, from the NHS, must be done with the acknowledgment of past and current harms experienced by LGBTQ+ people in the NHS, and work on a policy level must be done alongside this.

4.5 Recommendations For Policy

In June 2021, the British Pregnancy Advisory Service (BPAS) released a comprehensive investigation report, evidencing clear disparities between heterosexual and female same-sex couples in accessing ART via the NHS (Stonewall, 2015). In November 2021, a prominent lesbian couple in the UK, alongside Stonewall and BPAS, launched a campaign to bring a judicial review against their local Clinical Commissioning Group's policy for access to ART, which they deemed to be clearly discriminatory towards LGBTQ+ couples (BPAS, 2021). This campaign is ongoing and the results of the present study are pertinent to the campaign, as all co-mothers in this research described how the financial cost of becoming pregnant is not only a burden and stress within itself, but can have significant psychological and emotional consequences in the event of a pregnancy loss. Therefore, this research offers additional evidence and incentives around the importance of equal access to fertility treatment for same-sex couples, as it shows that a lack of access to funded fertility treatment has implications that go beyond just the initial period of trying to become pregnant. The sheer financial cost of ‘trying again’ can add a significant, additional psychological burden to female same-sex couples after pregnancy loss also.

Currently, National Institute for Health Care and Excellence (NICE) guidelines for ectopic pregnancies and miscarriage (NICE, 2021) stipulate that the gestational mother is offered a follow up appointment with a professional of their choice and counselling if appropriate. However, no specific recommendations for follow-up or psychological support are made for partners, including fathers, despite there being a growing body of evidence which clearly shows that pregnancy loss can have a significant psychological and emotional impact on partners (Due et al., 2017). This included the current research, where all co-mothers expressed a desire to speak to an inclusive and informed professional about their loss. Research has shown consistently that asking for psychological support is not straightforward for partners. This research and previous research has shown this to be particularly true for co-mothers, as they risk having to ‘double disclose’ their loss and sexuality, risk facing homophobic reactions from others, and having their loss invalidated. Whilst a change in NICE guidelines to include partners (of all genders and sexualities) will not protect co-mothers from these potentially discriminatory experiences, it may go some way to building a more inclusive and compassionate approach to partner loss and remove some barriers to accessing support. In addition, policy changes may in turn work towards deconstructing and expanding the individualised, bodily construction of pregnancy loss that is dominant in UK healthcare systems.

4.6 Assessment Of Research Quality

Alongside recommendations to ensure quality by Braun & Clarke (2022), the key principles presented by Yardley (2000) were followed.

4.6.1 Sensitivity To Context

Throughout the conceptualisation, development and realisation of this research, it felt important to ensure that the work itself was sensitive to its broader context. This was particularly important given that women in same-sex relationships are likely to experience societal marginalisation and oppression. As illustrated in the Introduction, this led me to explore UK LGBTQ+ healthcare experiences in the UK more generally as one way to ground the study in its context. Indeed, one of the research's aims was to situate co-mothers' experiences within a UK specific health and social landscape.

4.6.2 Commitment And Rigour

The concept of commitment encompasses prolonged engagement with the topic, the development of competence and skill in the methods used, and immersion in the relevant data (Yardley, 2000). As I myself am not a mother, nor am I in a same-sex relationship, it felt particularly important that from an early stage I engaged with a range of perspectives from people with lived experience of the topic. This was sought out primarily through social media and reading blogs from women in same-sex relationships talking about their journey of becoming pregnant and their experiences of pregnancy loss. This also included keeping up to date of current campaigns around unequal access to fertility treatment for LGBTQ+ people, and investigations and reports into NHS maternity services (BPAS, 2021).

Transcribing my own data also allowed for deeper absorption of participants' stories, and the process of converting audio to written text supported me to feel more connected and immersed in the data. Competence and skill in Thematic Analysis was gained through attending teaching related specifically to the method and attending an additional seminar ran online by Braun & Clarke. Although the sample size of the study could be considered low, each interview contains a multitude of rich data and so was deemed to supply enough information for a detailed and comprehensive analysis (Braun & Clarke, 2022).

4.6.3 Coherence And Transparency

The criteria of transparency and coherence relate to the clarity and cogency – and hence the rhetorical power or persuasiveness of the description and argumentation (Yardley, 2000).

For many qualitative researchers, the function of any story, including the story of a research project, is not to describe but to construct a version of reality (Bruner, 1991; Freeman, 1993). This was true for me, as one of my reasons for conducting this research was to explore constructions of pregnancy loss that exist outside of heteronormative understandings of pregnancy and parental roles. To this end, I aimed to provide a coherent yet analytic story through taking an interpretive approach to the data that considered latent meanings contained within co-mothers' stories and generate themes around this. This way of approaching the data was also coherent with my critical realist epistemology. Attendance to coherence was also supported by my supervisor reviewing different stages of analysis, including the final thematic map.

An audit trail detailing the generation of initial codes, initial themes and reviewing of the thematic map are provided with an aim to offer transparency to the reader about the methodological process. Data extracts were also provided to allow the reader to judge for themselves the patterns identified through analysis. I have also provided a reflective section to allow the reader insight into my internal world during the research (section 4.7). Finally, the 'Methods' chapter ensures transparency through outlining the research methodology.

4.6.4 Impact And Importance

Impact and importance are discussed further in sections 4.4 and 4.5. Briefly, this is the first study to date which focuses solely on co-mothers' experiences of pregnancy loss in the UK. It is hoped that this research will offer co-mothers in the UK an opportunity to see some of their experiences reflected back to them. In addition, this research makes a strong and clear case for disaggregating co-mothers' experiences from the more generalised but dominant 'partners and pregnancy loss' discourse that services tend to lean towards (Peel, 2010).

It is hoped that the research can contribute to improving genuine awareness and understandings among health professionals of how they themselves may contribute to the erasure and exclusion of co-mothers, as well as the profound, positive difference they can make in their experience of pregnancy loss.

4.6.5 Study Limitations

Whilst significant efforts were made to recruit participants from across the UK, through contact with a range of organisations and online groups, recruitment proved challenging and therefore the sample size might be considered problematic. Although data collected were deemed sufficiently rich for a thorough thematic analysis to take place (Braun & Clarke, 2022), a larger sample size would have likely provided the opportunity for more nuanced and unique aspects of co-mothers' experiences to be understood. This is perhaps particularly pertinent given the many different ways female same-sex couples can become pregnant. These routes to pregnancy can have an impact on the experience of loss (Peel, 2010; Wojnar 2010). A broader sample size may have allowed for a more equal distribution of different types of ART used and therefore a more detailed understanding of co-mothers needs following pregnancy loss.

All co-mothers in the sample identified as White. This is a particularly important limitation to consider, given that woman of colour in the UK, Black women in particular, are more likely to experience loss and poor treatment in the NHS (Five X More, 2022). A recent paper published in The Lancet evidenced that miscarriage rates are over 40% higher in Black women when compared with their White peers (Quenby et al, 2021). In addition, the recent Black Maternity Experience report (Five X More, 2022) found that Black women often have negative experiences of maternity services, which include racist attitudes and assumptions from staff, as well as a lack of clinical knowledge related to the anatomy and physiology of Black parents and babies. Craven (2019) found that for LGBTQ+ people of colour who experienced reproductive loss, homophobia was often impossible to disentangle from racism. Therefore, for Black women who are also in a same-sex relationships, it is likely that these experiences will intersect with experiences of homophobia and discrimination in a way that is not captured in this study.

4.7 Researcher Reflexivity

Reflexive TA involves routinely reflecting on one’s choices, assumptions, expectations and actions throughout the research process (Braun & Clarke, 2022). Locating ourselves within our research supports us to explicitly consider how our choices and views of the world may enable, exclude, or close us off to aspects of our participants’ experiences (Wilkinson, 1988). As an outsider researcher, it felt important to me right from the developmental stage of this research to reflect upon what drew me to this topic, having never been pregnant myself and therefore having never experienced a pregnancy loss, and also having been in a heterosexual relationship for the past 9 years. Please see appendix P for an extract of my reflexive diary.

Braun & Clarke (2022, p.14) discuss the political history of qualitative research. Reading and considering their summary of this helped me to reflect on why I particularly wished to hear from women in same-sex relationships. They described how qualitative research is deeply enmeshed with left, liberal or radical political positioning. This includes feminist research that allows for the deconstruction of dominant and taken for granted meanings that legitimise and continue oppressive social arrangements. In this way I found myself quite instinctually drawn to considering how fertility and pregnancy are spoken about in society and the impact this can have upon a person. I think the topic lies at the intersection of my interest in matters of women's health, psychological well-being and identities. For so many people, being a parent is an integral part of how they wish to live their life. This is the same for me. I myself am approaching a time in my life where I wish to try and become pregnant, and so perhaps my commitment to this research topic is also influenced by this.

During the second year of my doctorate I experienced a profound loss, in context of the pandemic. This earth-shattering event plunged me into a more existential headspace and I lost my sense of security in the world. As I attempted to wade through my grief and allow myself to acknowledge that I now must live without one of my most prominent maternal figures, I also listened to the stories of my participants' maternal grief. During this time I noticed a pull inside me to deny myself access to the similarities between my pain and that of my participants, a worry perhaps that this might in some way interfere with my ability to conduct a thorough analysis. I considered how I could connect back to my belief that we must bring our full selves to the work we do, and within this we must accept that sometimes this includes feelings and experiences that we wish didn't belong to us. I considered how this may be the case for my participants, and how they had sat with me for an hour, talking about experiences that they perhaps wish didn't belong to them. I considered how thoughtfully and mindfully integrating my own personal experiences with academic and clinical work might allow me to listen, not just with my mind but with my heart as well, as so much of grief is felt rather than thought. I held on to this throughout the analysis, and ultimately I feel that this gave me the confidence to move towards a more interpretive approach to the data.

4.8 Conclusion

The findings from this research both corroborate and build upon previous qualitative research from North America (Wojnar, 2010) and across the world

(Craven, 2019), as well as survey data from North America and the UK (Peel, 2010). This study is the first to empirically explore co-mothers' experiences of pregnancy loss in a UK specific context, and found that from conception through to loss, co-mothers may have to contend with multiple, intersecting experiences of discrimination that not only forms and maintains barriers to them accessing support from services, but also exacerbates the emotional and psychological impact of their loss. Co-mothers' experiences of pregnancy loss are frequently silenced and excluded by others, and this is present in their every day, individual experiences, through to systemic and policy level erasure. This study illuminates the complexities of pregnancy loss for co-mothers, and it is hoped that dissemination of this research will go some way to increasing the visibility of co-mothers and their needs within the UK.

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Appendix A - Glossary of terms (https://www.stonewall.org.uk/help-advice/faqs-and-glossary/list-lgbtq-terms)

Cisgender or Cis

Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.

Gender

Often expressed in terms of masculinity and femininity, gender is largely culturally determined and is assumed from the sex assigned at birth.

Gender identity

A person's innate sense of their own gender, whether male, female or something else (see non-binary below), which may or may not correspond to the sex assigned at birth.

Heterosexual/straight

Refers to a man who has a romantic and/or sexual orientation towards women or to a woman who has a romantic and/or sexual orientation towards men.

Homophobia

The fear or dislike of someone, based on prejudice or negative attitudes, beliefs or views about lesbian, gay or bi people. Homophobic bullying may be targeted at people who are, or who are perceived to be, lesbian, gay or bi.

Lesbian

Refers to a woman who has a romantic and/or sexual orientation towards women. Some non-binary people may also identify with this term.

LGBTQ+

The acronym for lesbian, gay, bi, trans, queer, questioning and ace.

Queer

Queer is a term used by those wanting to reject specific labels of romantic orientation, sexual orientation and/or gender identity. It can also be a way of rejecting the perceived norms of the LGBT community (racism, sizeism, ableism etc). Although some LGBT people view the word as a slur, it was reclaimed in the late 80s by the queer community who have embraced it.

Sex

Assigned to a person on the basis of primary sex characteristics (genitalia) and reproductive functions. Sometimes the terms 'sex' and 'gender' are interchanged to mean 'male' or 'female'.

Appendix B – Ethics application and risk assessment form

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood thes ☒ les:

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☒

☒

- The participant consent form
- The participant debrief letter ☒

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

  Included ☒ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☒ or

  Not required (because the research takes place solely on campus or online) ☐

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☒

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☒

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research) ☒

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included ☐ or

  Not required (because you are not using pre-existing questionnaires or tests) ☒

- Interview questions for qualitative studies.
  Included ☒ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.
  Included ☐ or

  Not required (because you are not using any visual materials) ☒

2. Your details

2.1 Your name: Elizabeth Hampson

2.2 Your supervisor's name: Dr Kenneth Gannon

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2022. There is no resit date for this work.

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: Partners and Pregnancy Loss: Perspectives From Co-Mothers in the UK.

3.2 Your research question: Pregnancy loss (also called miscarriage) is defined in the UK as the death of a baby (or fetus or embryo) in the uterus up to a gestation of 24 weeks. This form of early pregnancy loss is common, with estimates of around 1 in 4 pregnancies being affected (Miscarriage Association, n.d.) In recent years psychological literature around pregnancy loss has sought to understand the loss from the partner's perspective. Overall, the literature suggests that within a couple's experience of pregnancy loss, there are complex psychological and emotional factors that are specific to partners in terms of their experience, how they understand their role within the relationship and relate to the systems around them. However, this research has primarily focused on male partners where the loss occurred within a heterosexual relationship. There is minimal literature exploring the psychological impact of pregnancy loss upon female same sex couples and with even less focusing on the partner's perspective. Therefore, my research questions are;

- In the UK, how do co-mothers, in female same gender (lesbian) relationships understand and cope with the loss of a pregnancy?
- What was the impact of the loss on decision making for future pregnancies?
- What was the co-mother's experience of interactions with the systems around them (family, friends, healthcare)?

3.3 Design of the research: A qualitative approach employing individual interviews is planned. Transcripts will be analysed using thematic analysis following the guidance of Braun and Clarke (2006).

3.4 Participants: Cis-gendered woman who self-identify as being sexually and romantically attracted to women. The inclusion criteria are:

  - Was or is still in a relationship with a woman who experienced a pregnancy loss prior to 24 weeks , within the last 2 years.
  - Was born and continues to live in the UK, was living in the UK at the time of the pregnancy loss.
  - Able to speak, read and write English.

3.5 Recruitment: Purposive sampling will be used to recruit 10-12 co-mothers via social media and snowball recruitment.

3.6 Measures, materials or equipment: Participants will need access to a private computer with a camera, microphone and access to the internet.

3.7 Data collection: Semi-structured interviews will last for 45-60 minutes; they will take place on Microsoft Teams at a date and time convenient for the participant. Demographic data, specifically, age, gender identity and ethnicity will be collected. Data will also be collected on the duration of the relationship within which the pregnancy loss occurred. Where the participant or couple have gone on to have further pregnancies, data will be collected on time between loss and future pregnancies and whether subsequent pregnancies were carried to term. All data will be anonymised and stored securely.

3.8 Data analysis: Transcripts will be analysed using thematic analysis following the stages outlined by Braun and Clarke (2006).

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously? No, due to qualitative interviews.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

- The final thesis and subsequent dissemination will only include anonymised/non-identifiable data and quotes. Names and identifying information will be removed from transcripts at transcription. Only the researcher, supervisor and examiners will have access to the transcripts. The researcher will access transcripts by inputting a password and will close and lock the files when finished with them, and will also then lock the password-protected computer. Demographic data will be stored separately to the transcripts and will not be linked with quotes.

4.3 How will you ensure participants details will be kept confidential?

Recordings will be transcribed and then deleted. Until transcription is completed the recordings will be password protected and stored on a secure UEL OneDrive. All demographic data and transcripts will also be anonymised, password protected and stored securely on a UEL OneDrive separately from the transcripts, only the researcher and supervisor will have access to these files. These files will be stored for two years until deletion

4.4 How will the data be securely stored?

The anonymised data will be stored securely using UEL cloud storage (OneDrive).

4.5 Who will have access to the data?

Only the researcher and research supervisor will have access to the data.

4.6 How long will data be retained for?

Five years after completion of the research.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ☒

5.2 Your research question: ☒

5.3 The purpose of the research: ☒

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. invo ☒

5.5 That participation is strictly voluntary: ☒

5.6 What are the potential risks to taking part: ☒

5.7 What are the potential advantages to taking part: ☒

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked ☒

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation ☒

5.10 How long their data will be retained for: ☒

5.11 How their information will be kept confidential: ☒

5.12 How their data will be securely stored: ☒

5.13 What will happen to the results/analysis: ☒

5.14 Your UEL contact details: ☒

5.15 The UEL contact details of your supervisor: ☒

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature. NO

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

NO. Recordings will be transcribed and then deleted. Until transcription is completed the recordings will be password protected and stored on a secure UEL OneDrive. All demographic data and transcripts will then be anonymised, password protected and stored securely on a UEL OneDrive, only the researcher and supervisor will have access to these files. These files will be stored for two years until deletion.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth? NO

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

There are no physical risks to participants. Participants may become distressed or upset when discussing topics that are sensitive. The researcher will monitor signs of this and offer breaks in the interview and ask how the participant would like to proceed. The debrief sheet will contain the contact details of organisations that can offer support for participants.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

Yes, due to the nature of the research, it may be distressing or upsetting to hear the accounts of participants. My clinical work and skills mean that I am practiced in managing my own emotions when hearing another's difficult or traumatic experiences. If I feel that I need further support to manage this at any time during the data collection process, I am able to contact my DoS or Individual Tutor.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

YES, the following organisations offer bereavement support to people who have experienced pregnancy loss:
The Miscarriage Association – the miscarriage helpline.
SANDS.ORG.UK
petalscharity.org.uk

6.4 Does the research take place outside the UEL campus? If so, where? YES – online data collection employing Microsoft Teams.

If so, a 'general risk assessment form' must be completed. This is included below as appendix D. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this ☐ been completed:

6.5 Does the research take place outside the UK? If so, where? NO

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a 'country-specific risk assessment form' *is* needed, please tick to confirm that this has been in☐d:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

NO If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.

- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NO

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.
NO

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written per☐ion as an appendix:

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Elizabeth Hampson

Student's number: U1945456 Date: 20/04/2021

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

UEL Risk Assessment Form

Name of Assessor:	Elizabeth Hampson	**Date of Assessment**	22/04/21
Activity title:	Online data collection	**Location of activity:**	Online
Signed off by Manager (Print Name)		**Date and time (if applicable)**	N/A

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The proposed research will explore how 'co-mothers' (the non-pregnant partner in female same sex relationships) make sense of and cope with pregnancy loss. Participants will be recruited primarily through LGBTQ+ organisations and websites that focus on fertility and reproduction, as well as through social media (Twitter and Facebook). Purposive sampling will be used to recruit 10-12 co-mothers via social media and snowball recruitment. Consent shall be obtained from each participant.

Using Microsoft Teams, participants will be asked to attend an interview lasting approximately 45-60 minutes. They will be invited to discuss their journey to their partners pregnancy, their experience of the loss, subsequent interactions with support systems (family, friends and healthcare, charities and organisations) and how the loss may have influenced future family planning. The interviews will be analysed using Thematic Analysis. The research will be written up as a thesis for submission at UEL and a journal article will also be prepared.

Overview of FIELD TRIP or EVENT:

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating
Psychological distress due to sensitive topic of research.	Participants	The researcher will monitor signs of this and offer breaks in the interview and ask how the participant would like to proceed. The debrief sheet will contain the contact details of organisations that can offer support for participants.	2	1	2	If participants have any questions or concerns about how the research has been conducted they can contact the research supervisor using the details on either the PiS or the debrief sheet.	2
Psychological distress due to sensitive topic of research.	Researcher	My clinical work and skills mean that I am practiced in managing my own emotions when hearing another’s difficult or traumatic experiences.	1	1	1	If I feel that I need further support to manage this at any time during the data collection process, I am able to contact my DoS or Individual Tutor.	1

Appendix C – Ethical approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

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

REVIEWER: Christian Van Nieuwerburgh

SUPERVISOR: Kenneth Gannon

STUDENT: Elizabeth Hampson

Course: Prof Doc in Clinical Psychology

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application

will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

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

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

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

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

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

Student number:

Date:

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

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

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

YES / NO

Please request resubmission with an adequate risk assessment

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

☐ HIGH

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

☐ MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

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

Reviewer *(Typed name to act as signature)*: *Christian van Nieuwerburgh*

Date: 14 May 2021

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

RESEARCHER PLEASE NOTE:

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

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

Appendix D – Ethics amendment approval

University of
East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Elizabeth Hampson**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Partners and Pregnancy Loss: Perspectives From Co-Mothers in the UK.**
Name of supervisor:	**Dr. Kenneth Gannon**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Change in inclusion criteria from loss occurring before 24 weeks gestation to loss occurring before 37 weeks (full term) gestation.	There are people who has shown interest in participating who have experienced a pregnancy loss after 24 weeks gestation and on further discussion with my supervisor and consideration of the available literature, the difference in experience of those who miscarry prior to or after 24 weeks does not seem justifiably different enough to exclude participants based on this.
Change in inclusion criteria from loss occurring less than 2 years ago, to no time limit on when loss occurred.	Similar to the above, upon further consideration, a person's ability to recall important details of their loss, does not seem to be significantly impacted by time. Particularly due to the impactful nature of the experience.
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Elizabeth Hampson**
Date:	**11/03/2022**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**14/03/2022**	

Appendix E – Research poster

RESEARCH STUDY: CO-MOTHERS' EXPERIENCES OF PREGNANCY LOSS

Pregnancy loss can be an emotionally difficult and upsetting time for both the person carrying the pregnancy and their partner. Research in this area has tended to focus on heteronormative experiences of pregnancy loss. Therefore, this study would like to hear from co-mothers (the non-pregnant partner) in same-sex relationships (WLW - Women who Love Women) who have experienced pregnancy loss.

I am hoping to speak with:

- Women, who identify as being sexually and romantically attracted to women.
- Who, in the context of a WLW relationship, experienced a pregnancy loss where they were the partner/co-mother (i.e. the non-pregnant partner).
- You will be interviewed in conversation via Microsoft Teams for 45-60 minutes.
- I will ask you about your thoughts, feelings and experiences of being a partner during a pregnancy loss. I will also ask you about your interactions with others during this time, such as friends, family and healthcare providers.
- All information will be kept confidential and your comfort will be prioritized throughout.

This study forms part of my Doctorate in Clinical Psychology. If you are interested in taking part, or would like more information, please email Lizzie Hampson: U1945456@uel.ac.uk

University of East London

This study has been approved by the University of East London School of Psychology Research and Ethics Committee, Department of Professional Psychology, University of East London, Water Lane, E15 4LZ

Appendix F – Participant information sheet

PARTICIPANT INFORMATION SHEET

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

Who am I?

I am a Trainee Clinical Psychologist in the School of Psychology at the University of East London and am studying for a Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into how “co-mothers” (non-pregnant mothers) in female same sex relationships experience the loss of a pregnancy (miscarriage).

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee’s evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am hoping to hear from women who identify as sexually and romantically attracted to women, who were or still are in relationship where their partner was carrying a pregnancy that was lost to miscarriage. You must have been the non-pregnant partner in that relationship. You have been invited to participate in my research as somebody who meets the above criteria.

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

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to attend an interview with myself on Microsoft Teams, the interview will last between 45-60 minutes and will take place at a pre agreed time that is convenient for you. The interview will be recorded on Microsoft Teams and then moved immediately to a secure UEL OneDrive where it will be stored (please see section below for more information on how your interview will be stored and kept confidential.)

The interview will be like having an informal chat, where there are no right or wrong answers. At the start of the interview we will think about what will help you to feel comfortable, for example if there are particular terms or names you would like me to use when referring to yourself, your partner and your experience of the loss.

I will ask you to tell me, in your own words, about your experiences, thoughts and feelings during the process of your partner conceiving. I will then ask you to share with me your experience of the pregnancy loss, again including your thoughts, feelings and reactions. Following this I will ask you about how others around you reacted, whether you received support from friends, family and other services such as the NHS, charities or organisations. I will be interested to hear about your experience of any support you did receive, what was helpful and what was less helpful.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of how co-mothers experience pregnancy loss and what support is helpful.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

You do not have to answer all questions asked in the interview and you can stop your participation at any time. The interview will be recorded on Microsoft Teams so that I can listen to you fully without having to take notes. I will transcribe the recording of our interview and then delete the recording. The transcription will be anonymised and will be stored on a secure server.

The research has been reviewed by an independent group of people called a Research Ethics Committee in order to protect your safety, rights, wellbeing and dignity. The research has been given a favourable opinion. It has also been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

In line with good clinical practice, if I were to become concerned about anything we discussed together, i.e. if I felt there was a risk to yourself or others, I may need to break confidentiality. I would do my best to speak to you about this first.

What will happen to the information that you provide?

The transcript of your interview will only be seen by me and the research supervisor. Your anonymised data will be stored securely using UEL cloud storage. All information collected from you will be kept confidential and stored securely for two years after the study ends and then it will be deleted.

Your name and any other identifiable details will be changed so that anyone who reads the research will not be able to tell who you are. A report of the research will be publicly available and disseminated to relevant charities and NHS services.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

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

Lizzie Hampson

Email: u1945456@uel.ac.uk

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

Email: k.n.gannon@uel.ac.uk

or

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

(Email: t.patel@uel.ac.uk)

Appendix G – Consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Co-mothers experiences of pregnancy loss in the UK

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

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

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

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………

Participant's Signature

……………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

……………………………………………………………………………………………..

Researcher’s Signature

………………………………………………………………………………………………

Date: …………………………..…….

Appendix H – Participant debrief letter

Participant Debrief Letter

Thank you for participating in my research, your contributions are so valuable and by talking to me you have helped me to understand your experience of pregnancy loss from your perspective as a partner. I was interested in your emotional experiences and your thoughts about being a partner during this time. I was also interested in what kind of support (if any) you felt that you needed during this time, and what was helpful or unhelpful about that support. The questions I asked you were centred around these ideas.

We talked about a sensitive topic today, you may notice yourself feeling upset following our interview, this is an understandable reaction to talking about an sensitive topic. However, if you find that these feelings are persisting or you would like to speak to somebody about this, then you may find the following resources and charities helpful in relation to information and support:

- https://www.parentingqueer.co.uk/support-groups
- Miscarriage Association: https://www.miscarriageassociation.org.uk/
  Phone: 01924 200799
- SANDS: https://www.sands.org.uk/support-you Phone: 080 164 3332
- Petals: https://petalscharity.org/ Phone: 0300 688 0068
- Tommy's: https://www.tommys.org/our-partnership-lgbt-mummies-tribe

You are also welcome to contact myself or my supervisor via our emails at the end of this letter. If you feel unsure or uncomfortable about anything that we discussed, please also feel free to contact myself or my supervisor on the contact details below.

I would like to remind you that your data will be stored securely and any information you shared will be written up anonymously, this includes removal of your name and any identifiable information for example your age, ethnicity and geographic location.

If, after talking together, you decide you would like to withdraw your data from the research, please contact me within three weeks' from the date of our interview. After 3 weeks we will be unable to remove your data from the research, as it will have been fully anonymised at this point and data analysis will have begun.

If you have given verbal consent for me to do so, once I have written up the research, I will get back in touch with you and give you a summary of the outcomes.

Contact Details

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

Lizzie Hampson

U1945456@uel.ac.uk

Kenneth Gannon (supervisor)

K.N.Gannon@uel.ac.uk

Thank you once again for your valuable input and insight.

Appendix I – Rebecca personalised consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Co-mothers experiences of pregnancy loss in the UK

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

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

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

Upon my request, I give consent for the researcher to use my son's actual name in the write up of the research, including any possible quotes that may be used throughout the final thesis.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher’s Signature

…………………………………………………………………………………………

Date: ……………………..…….

Appendix J – Final interview schedule

CO-MOTHERS EXPERIENCE OF PREGNANCY LOSS

Interview Schedule

Demographic Data

Gender:

Ethnicity:

Location in UK:

Introduction and preamble

Ascertain participants preferred way of referring to the pregnancy loss.

- "There are many different ways to refer to the loss of a pregnancy, some people prefer the word miscarriage, some people prefer to talk about the loss of a baby, or you may have a name that you wish for me to use. What would feel most comfortable for you when we are talking about your loss (or losses)?"
- Tell me about was is in your family at the time of the loss e.g. partners name, any children? Any further pregnancies? Timeline of pregnancies?

1. The process of conception for the couple

I think it is important that I hear about your experience of loss in context of your experience as a couple, of conceiving. So, if it's ok with you, we will start by talking about how you and your partner decided to try for a baby, and what that was like.

Can you tell me about your experience of the decision-making process that led to your partner becoming pregnant (the first time, if multiple losses)?

- How long had you been considering becoming parents?
- How did you decide who would carry the baby?
- Did you seek advice and support from others?
- What was the process like, what were you thinking and feeling at the time?

2. The pregnancy loss

Now I want to ask you some questions about the pregnancy loss(es). Can you tell me, in your own words, what happened and how you would describe that experience?

- How did the loss impact on you emotionally?

- What was it like trying to cope with those feelings? What helped and what made it harder?
- Can you tell me about the loss in context of the process of becoming pregnant…

3. Their role as a partner

What was it like being a partner during this time?

- Do you feel that your own needs were recognised during this time?
- How did you understand and cope with the loss as a couple?
- Do you think the loss had an impact on your relationship?

4. Interactions with others

How did others around you come to learn about the loss?

- How did those around you react to your news?
- Did you feel supported by anybody close to you, such as friends or family?
- What was helpful? Less helpful?
- Did you meet with, speak to or seek support from other couples who have experienced pregnancy loss?

5. Interactions with healthcare services

Did you come into contact with any healthcare services during the loss? For example your GP, A&E etc?

- What was that experience like?
- As the non-pregnant partner, did you feel like your own needs and experiences were recognised?
- What was helpful? Less helpful?
- Were your decisions to seek help or not seek help in any way related to previous experiences of healthcare?

6. Future pregnancies

Depending on whether participant has shared that since the loss they have gone on to have children or pregnancies.

- Do you think your experience of pregnancy loss impacted on your decision making about future pregnancies?

If couple did become pregnant again…

- What were you thinking and feeling during the pregnancy?
- What was it like telling others?

(questions to be tailored depending on who carried the subsequent pregnancy)

Ending

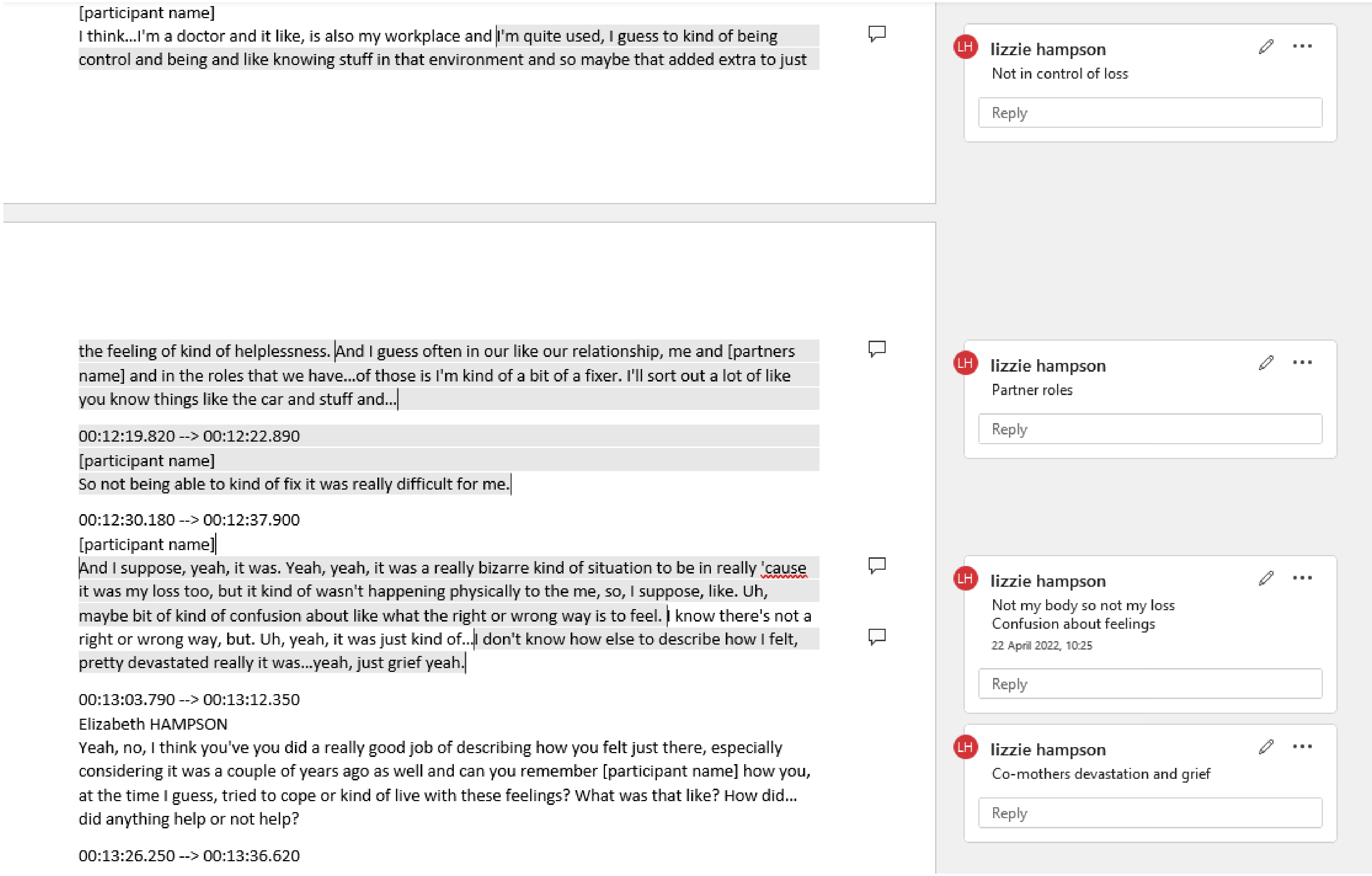
Thank you for giving your time and for sharing your story.

1. Is there anything that I have not asked today that you were hoping I'd ask, or anything you would like to say that you haven't had the chance to?

2. Do you have any questions for me?

- Then re-confirm consent, give debrief sheet and remind about three week cut-off for withdrawal of data.

Appendix K – Semantic to latent coding of Catherine's interview



[participant name]
I think...I'm a doctor and it like, is also my workplace and I'm quite used, I guess to kind of being control and being and like knowing stuff in that environment and so maybe that added extra to just

lizzie hampson
Not in control of loss

the feeling of kind of helplessness. And I guess often in our like our relationship, me and [partners name] and in the roles that we have...of those is I'm kind of a bit of a fixer. I'll sort out a lot of like you know things like the car and stuff and...

lizzie hampson
Partner roles

00:12:19.820 --> 00:12:22.890
[participant name]
So not being able to kind of fix it was really difficult for me.

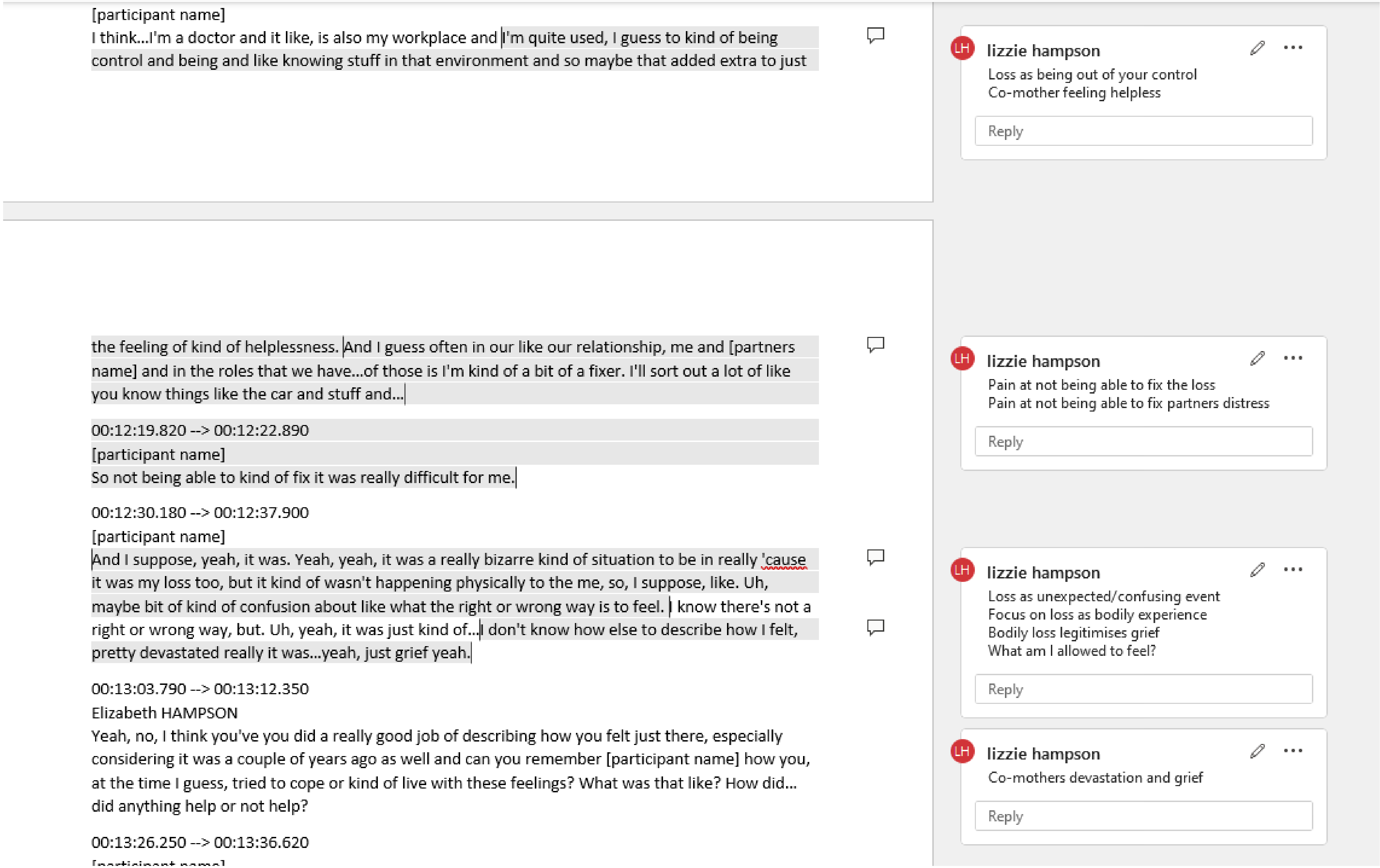
00:12:30.180 --> 00:12:37.900
[participant name]
And I suppose, yeah, it was. Yeah, yeah, it was a really bizarre kind of situation to be in really 'cause it was my loss too, but it kind of wasn't happening physically to the me, so, I suppose, like. Uh, maybe bit of kind of confusion about like what the right or wrong way is to feel. I know there's not a right or wrong way, but. Uh, yeah, it was just kind of...I don't know how else to describe how I felt, pretty devastated really it was...yeah, just grief yeah.

lizzie hampson
Not my body so not my loss
Confusion about feelings
22 April 2022, 10:25

lizzie hampson
Co-mothers devastation and grief

00:13:03.790 --> 00:13:12.350
Elizabeth HAMPSON
Yeah, no, I think you've you did a really good job of describing how you felt just there, especially considering it was a couple of years ago as well and can you remember [participant name] how you, at the time I guess, tried to cope or kind of live with these feelings? What was that like? How did... did anything help or not help?

00:13:26.250 --> 00:13:36.620



[participant name]
I think...I'm a doctor and it like, is also my workplace and I'm quite used, I guess to kind of being control and being and like knowing stuff in that environment and so maybe that added extra to just

lizzie hampson
Loss as being out of your control
Co-mother feeling helpless

Reply

the feeling of kind of helplessness. And I guess often in our like our relationship, me and [partners name] and in the roles that we have...of those is I'm kind of a bit of a fixer. I'll sort out a lot of like you know things like the car and stuff and...

lizzie hampson
Pain at not being able to fix the loss
Pain at not being able to fix partners distress

Reply

00:12:19.820 --> 00:12:22.890
[participant name]
So not being able to kind of fix it was really difficult for me.

00:12:30.180 --> 00:12:37.900
[participant name]
And I suppose, yeah, it was. Yeah, yeah, it was a really bizarre kind of situation to be in really 'cause it was my loss too, but it kind of wasn't happening physically to the me, so, I suppose, like. Uh, maybe bit of kind of confusion about like what the right or wrong way is to feel. I know there's not a right or wrong way, but. Uh, yeah, it was just kind of... I don't know how else to describe how I felt, pretty devastated really it was...yeah, just grief yeah.

lizzie hampson
Loss as unexpected/confusing event
Focus on loss as bodily experience
Bodily loss legitimises grief
What am I allowed to feel?

Reply

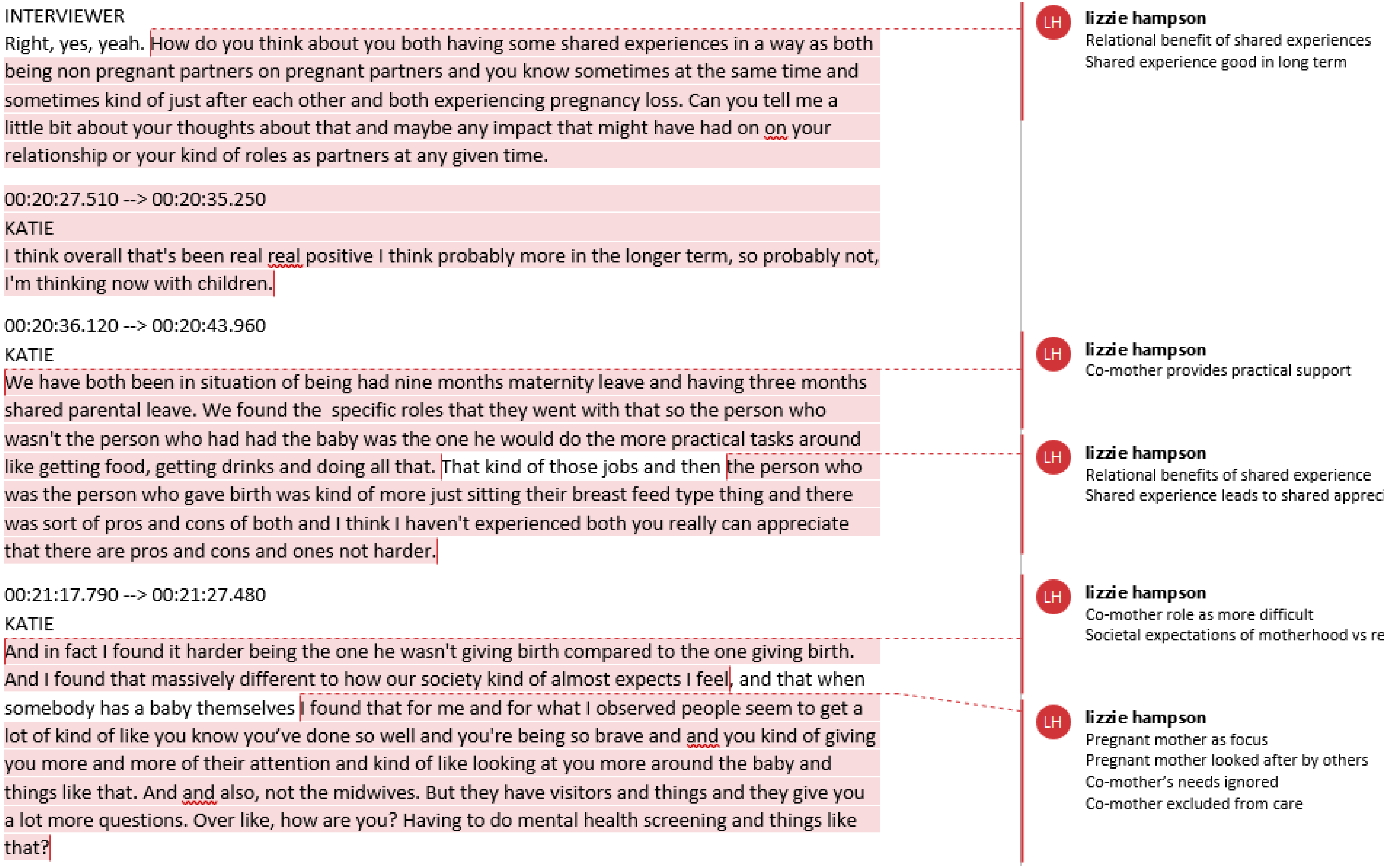
lizzie hampson
Co-mothers devastation and grief

Reply

00:13:03.790 --> 00:13:12.350
Elizabeth HAMPSON
Yeah, no, I think you've you did a really good job of describing how you felt just there, especially considering it was a couple of years ago as well and can you remember [participant name] how you, at the time I guess, tried to cope or kind of live with these feelings? What was that like? How did... did anything help or not help?

00:13:26.250 --> 00:13:36.620

Appendix L – Coding sample



INTERVIEWER
Right, yes, yeah. How do you think about you both having some shared experiences in a way as both being non pregnant partners on pregnant partners and you know sometimes at the same time and sometimes kind of just after each other and both experiencing pregnancy loss. Can you tell me a little bit about your thoughts about that and maybe any impact that might have had on on your relationship or your kind of roles as partners at any given time.

00:20:27.510 --> 00:20:35.250
KATIE
I think overall that's been real real positive I think probably more in the longer term, so probably not, I'm thinking now with children.

00:20:36.120 --> 00:20:43.960
KATIE
We have both been in situation of being had nine months maternity leave and having three months shared parental leave. We found the specific roles that they went with that so the person who wasn't the person who had had the baby was the one he would do the more practical tasks around like getting food, getting drinks and doing all that. That kind of those jobs and then the person who was the person who gave birth was kind of more just sitting their breast feed type thing and there was sort of pros and cons of both and I think I haven't experienced both you really can appreciate that there are pros and cons and ones not harder.

00:21:17.790 --> 00:21:27.480
KATIE
And in fact I found it harder being the one he wasn't giving birth compared to the one giving birth. And I found that massively different to how our society kind of almost expects I feel, and that when somebody has a baby themselves I found that for me and for what I observed people seem to get a lot of kind of like you know you've done so well and you're being so brave and and you kind of giving you more and more of their attention and kind of like looking at you more around the baby and things like that. And and also, not the midwives. But they have visitors and things and they give you a lot more questions. Over like, how are you? Having to do mental health screening and things like that?

LH **lizzie hampson**
Relational benefit of shared experiences
Shared experience good in long term

LH **lizzie hampson**
Co-mother provides practical support

LH **lizzie hampson**
Relational benefits of shared experience
Shared experience leads to shared appreci

LH **lizzie hampson**
Co-mother role as more difficult
Societal expectations of motherhood vs re

LH **lizzie hampson**
Pregnant mother as focus
Pregnant mother looked after by others
Co-mother's needs ignored
Co-mother excluded from care

And to just kind of recognize, you know, recognize some of what the other person is going through I suppose, and it kind of. What [partners name redacted] was going through.

lizzie hampson
Co-mother excluded
Co-mother's needs ignored
Co-mother's role as unrecognised by others

00:22:54.990 --> 00:23:01.570
KATIE
And I mean when she was pregnant, I wasn't. So I can't kind of say that I really understood at that point, but I guess. And when she was the person who wasn't pregnant, then I'd already kind of been there so.

lizzie hampson
Shared experiences increase partner understanding

00:23:08.100 --> 00:23:28.290
INTERVIEWER
Yes, yeah, and it sounds like that kind of and is applicable on both a practical but also emotional level as well. Maybe in being able to connect to what your partner might need or might want during a pregnancy loss or even giving given birth as you said.

lizzie hampson
Shared experiences helpful in practical support
Shared experiences helpful in emotional support
Differences in experiences of loss
Shared experience gives partner confidence

00:23:28.810 --> 00:23:42.700
KATIE
Yeah, definitely. I mean, I think it can be really different as well, like even between women like the experience that people have. It kind of you know what it's like to have a miscarriage. I think [partners name redacted]'s two are very different from one another. And my two were different. There are differences, but. And but yeah, definitely. I think having some sort of maybe it's more like a confidence that you kind of you at least know what you're talking about a bit [laughs]

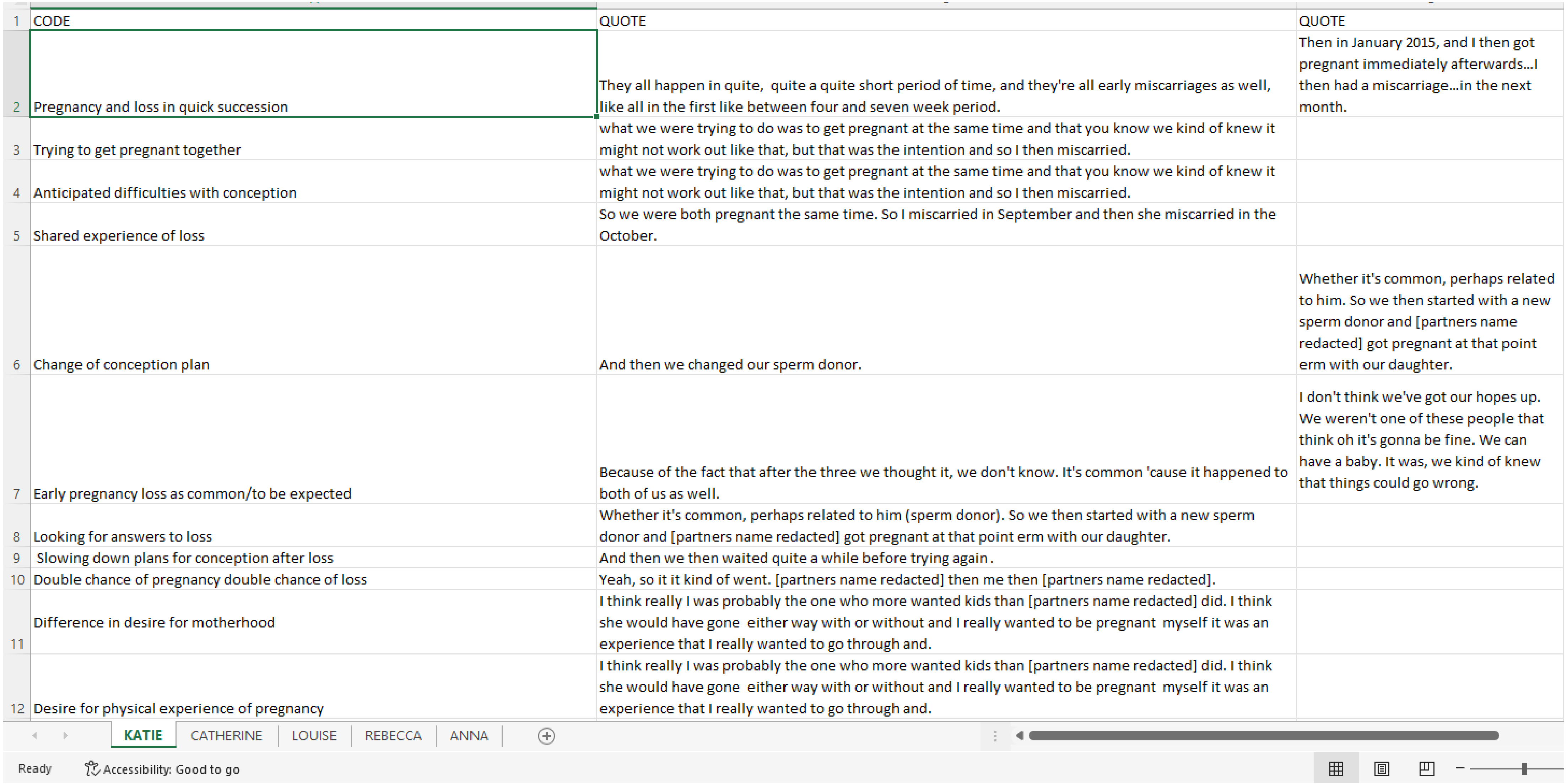
00:23:58.000 --> 00:23:59.240
INTERVIEWER
Yes, yeah.

00:24:00.170 --> 00:24:03.040
KATIE
Some people who haven't had that experience might just feel like they have no idea about this. Well actually maybe they do have an idea 'cause they can empathize, but they do, but they kind of they hold back because they're not as sure as they would be if they'd had a similar experience.

lizzie hampson
Shared experience gives partner confidence
Empathy isn't enough by itself

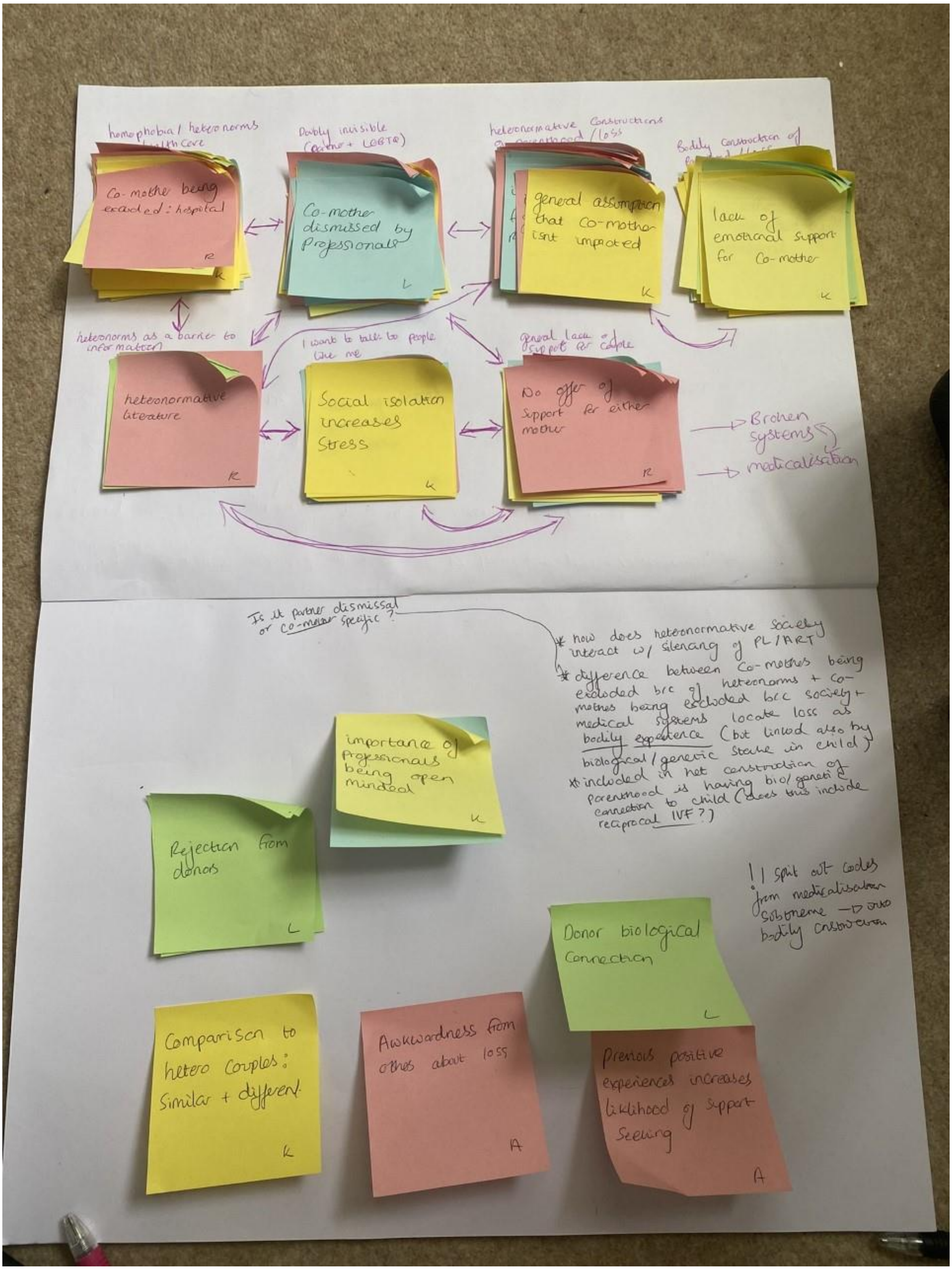
00:24:11.480 --> 00:24:11.920
INTERVIEWER
Yeah.

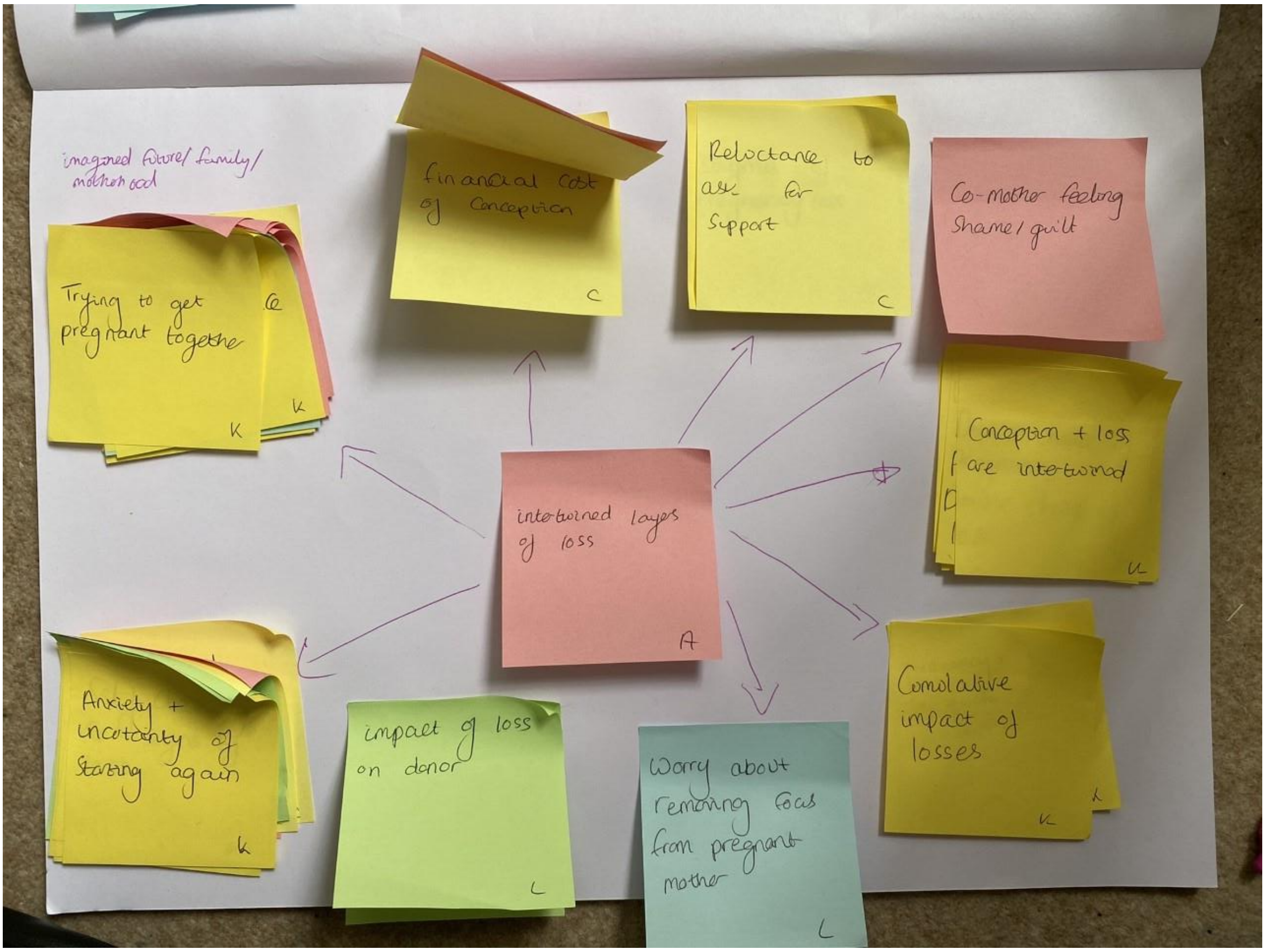
Appendix M – Example codebook



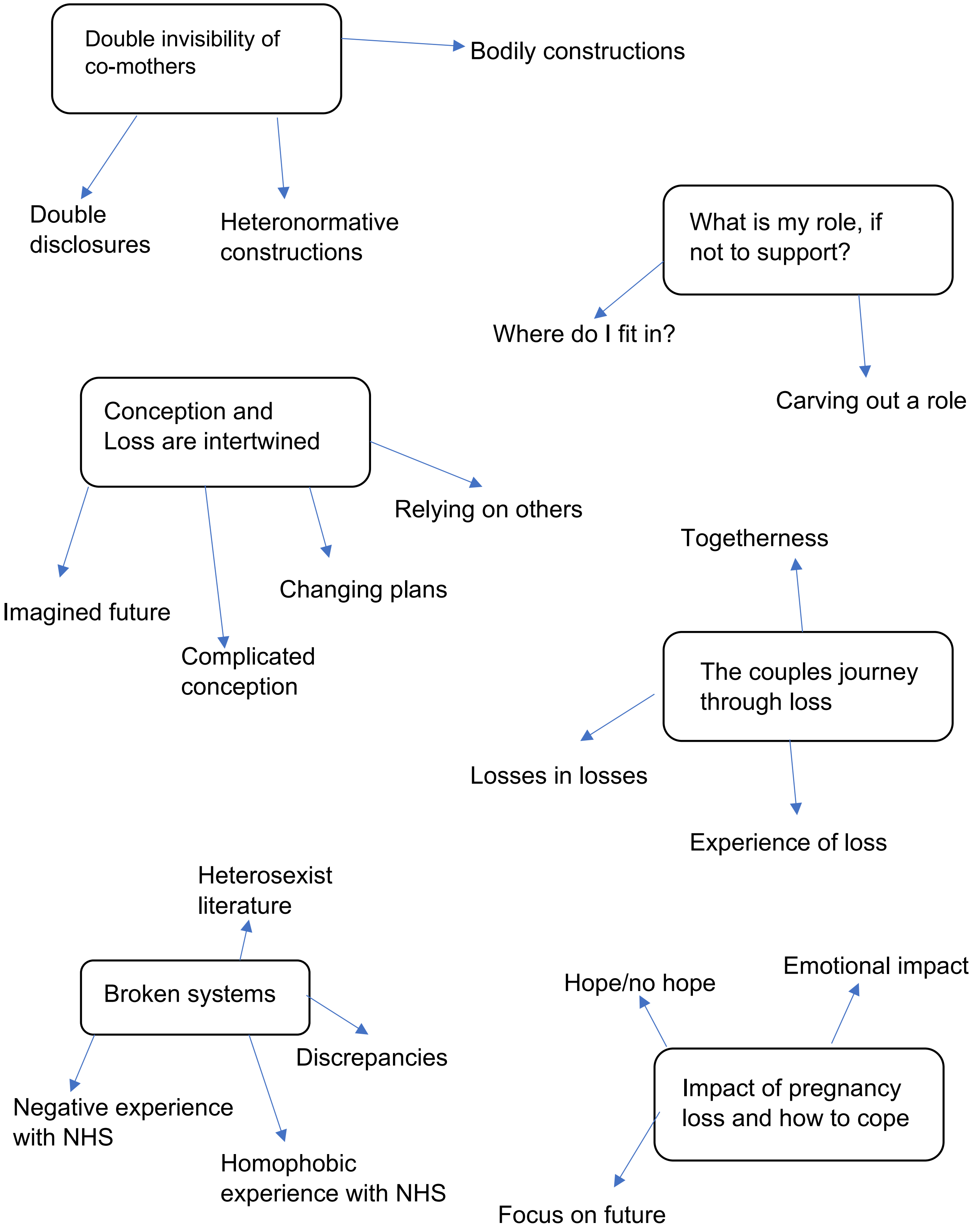
	CODE	QUOTE	QUOTE
2	Pregnancy and loss in quick succession	They all happen in quite, quite a quite short period of time, and they're all early miscarriages as well, like all in the first like between four and seven week period.	Then in January 2015, and I then got pregnant immediately afterwards…I then had a miscarriage…in the next month.
3	Trying to get pregnant together	what we were trying to do was to get pregnant at the same time and that you know we kind of knew it might not work out like that, but that was the intention and so I then miscarried.	
4	Anticipated difficulties with conception	what we were trying to do was to get pregnant at the same time and that you know we kind of knew it might not work out like that, but that was the intention and so I then miscarried.	
5	Shared experience of loss	So we were both pregnant the same time. So I miscarried in September and then she miscarried in the October.	
6	Change of conception plan	And then we changed our sperm donor.	Whether it's common, perhaps related to him. So we then started with a new sperm donor and [partners name redacted] got pregnant at that point erm with our daughter.
7	Early pregnancy loss as common/to be expected	Because of the fact that after the three we thought it, we don't know. It's common 'cause it happened to both of us as well.	I don't think we've got our hopes up. We weren't one of these people that think oh it's gonna be fine. We can have a baby. It was, we kind of knew that things could go wrong.
8	Looking for answers to loss	Whether it's common, perhaps related to him (sperm donor). So we then started with a new sperm donor and [partners name redacted] got pregnant at that point erm with our daughter.	
9	Slowing down plans for conception after loss	And then we then waited quite a while before trying again .	
10	Double chance of pregnancy double chance of loss	Yeah, so it it kind of went. [partners name redacted] then me then [partners name redacted].	
11	Difference in desire for motherhood	I think really I was probably the one who more wanted kids than [partners name redacted] did. I think she would have gone either way with or without and I really wanted to be pregnant myself it was an experience that I really wanted to go through and.	
12	Desire for physical experience of pregnancy	I think really I was probably the one who more wanted kids than [partners name redacted] did. I think she would have gone either way with or without and I really wanted to be pregnant myself it was an experience that I really wanted to go through and.	

Appendix N – Post it notes (generating initial themes)




imagined future/ family/ motherhood
Trying to get pregnant together
K
financial cost of conception
C
Reluctance to ask for support
C
Co-mother feeling shame/ guilt
Conception + loss are intertwined
K
intertwined layers of loss
A
Anxiety + uncertainty of starting again
K
impact of loss on donor
L
Worry about removing focus from pregnant mother
L
Cumulative impact of losses
K

Appendix O – Initial thematic map



Appendix P – Extract of reflexive diary

16.11.2021

I've found myself thinking particularly about recruiting participants and the difficulties I've had with this a lot recently. It's made me wonder about what we assume we know and don't know about each other, and how connections are made and how this might have changed over the past year with COVID and our increasing disconnection from each other. Been thinking about the role of a research poster/advert and how I'd always thought of it as an advert for the research but really it's one of our only opportunities to advertise ourselves, who we are and what we stand for, what our motivations are for doing this research. I wonder what questions might cross potential participants minds, do they wonder if I am gay, or if I have children or if I have experienced pregnancy loss. In some ways I fit the stereotype of a psychologist/researcher in that I'm white and young but not too young. I wonder what advantage this has given me, and what it means then that I am still struggling to recruit, is it because of some of the unseen aspects of me e.g. my sexuality, political beliefs and history of pregnancy/child birth, people don't know this without being given the chance to ask me. I think in some ways my outsider position has really helped me hold a very tentative and critical approach to my own assumptions, particularly the words I use. However, historically, being in an outsider position has been an unthought about given for researchers I think, participants might assume that's who we are (often rightfully so), because for researchers the fantasy is that being on the outside gives us some sort of scientific objectivity. Which I absolutely disagree with. So perhaps it's a mix of research as being a risk for people from marginalised communities, as a lot of harm has come from researchers seeking to unthoughtfully take up this outsider scientific position. In addition to the difficulties in communicating via research posters and information sheets my own position which seeks to be opposite to this and use my outsider status as a reason to be more careful and more curious/open. Maybe in the future I can consider this more explicitly from the start.