Governors State University
OPUS Open Portal to University Scholarship

All Student Theses Student Theses

Spring 2020

Utilizing Relational Dialectics Theory to Identify Dominant and Marginalized Discourses in Women's Miscarriage Podcast Stories

Cherinicole Lardino

Follow this and additional works at: https://opus.govst.edu/theses

For more information about the academic degree, extended learning, and certificate programs of Governors State University, go to http://www.govst.edu/Academics/Degree_Programs_and_Certifications/

Visit the Governors State Communication and Training Department
This Thesis is brought to you for free and open access by the Student Theses at OPUS Open Portal to University Scholarship. It has been accepted for inclusion in All Student Theses by an authorized administrator of OPUS Open Portal to University Scholarship. For more information, please contact opus@govst.edu.

UTILIZING RELATIONAL DIALECTICS THEORY TO IDENTIFY DOMINANT AND MARGAINALIZED DISCOURSES IN WOMEN'S MISCARRAIGE PODCAST STORIES

By

Cherinicole Lardino

B.A., Governors State University, 2020

THESIS

Submitted in partial fulfillment of the requirements

For the Degree of Master of Communication

Governors State University

University Park, IL 60484

2020

© 2020

Cherinicole Lardino

ALL RIGHTS RESERVED

To

Sam and Ella Grace & the little guy coming soon

Thank you for motivating me and giving me a million reasons to push forward in this journey.

To my family and in-laws thank you for supporting me through this process I would not have been able to get through this without you guys.

&

To that soul that helped guide me to this research project and future research interests.

Thank you.

ACKNOWLEDGMENTS

I would like to first and foremost like to pay special regards to my advisor throughout this project and mentor through most of my time in this program, Dr. Cronin-Fisher. Without your academic, mental, and emotional support I would never have gotten through this experience. Your unending commitment to not only get the best out of me academically, push me to think critically every step of the way, but also remind me of my potential has made this process more rewarding than I could have imagined.

I would also like to thank my committee members on this project for taking the time out of their schedule to guide me in the right direction, and make this project what it is. I have truly been blessed with great advisors, professors, and mentors throughout my time here at GSU, and I am forever grateful for that.

TABLE OF CONTENTS

Abstract 1

I. Introduction 2

II. Literature Review 4

Miscarriage 4

Women's Experiences of Miscarriage 7

Social Support During Miscarriage 9

Culture of Motherhood 12

Relational Dialectics Theory 14

III. Method 17

Participants.................... 17

Life After Miscarriage Podcast.................... 17

Data and Procedure 19

Theoretical Consideration.................... 20

IV. Findings 21

Dominant Discourse of Miscarriage as One of Silence (DDMS).................... 21

Marginalized Discourse of Open and Honest (MDOH).................... 35

Marginalized Discourse of Fear and Anxiety (MDFA).................... 41

Other Findings....................48

V. Discussion 54

Theoretical and Practical Implications 63

Limitations and Future Directions....................66

References 70

ABSTRACT

UTILIZING RELATIONAL DIALECTICS THEORY TO IDENTIFY DOMINANT AND MARGAINALIZED DISCOURSES IN WOMEN'S MISCARRAIGE PODCAST STORIES

by

Cherinicole Lardino

Governors State University, 2020
Under the Supervision of Dr. Valerie Cronin-Fisher

This study examined the discourses of miscarriage from the podcast narratives of women who have experienced miscarriage by utilizing Relational Dialectic Theory (RDT). The process of contrapuntal analysis identified the discourse of silence as the dominant miscarriage discourse in which the marginalized miscarriage discourses of open and honest and fear and anxiety were a counterpoint to. There were four interrelated themes of shame, lack of supportive and encouraging messages, lack of readily available information, and a communicated feeling that their circumstances could be worse that revealed the silence discourse within the women's stories. The marginalized discourse of open and honest was supported by the two interrelated themes of community and advocacy, and validation. The marginalized discourse of fear and anxiety was supported by the themes doubt and insecurity and the triggers women experienced after having had a miscarriage. These competing discourses revealed many different nuances and avenues for future miscarriage and reproductive health communication in RDT research.

Keywords. *miscarriage, communication, relational dialectics theory, silence, open, fear, anxiety*

I. Introduction

Research showed that anywhere from 10-25% of all clinically diagnosed pregnancies will end in miscarriage (American Pregnancy.org, 2019). That number does not include miscarriages that happen to women who do not yet realize they were pregnant. A staggering number, and yet a topic of conversation that is still shrouded in secrecy for many women. Miscarriage (i.e. natural termination of pregnancy before 20 weeks) places a myriad of stressors on the women who have experienced it. Some of those stressors could be relational, physical, emotional, and psychological, which could lead to increased anxiety and depression (Brier, 2008). Miscarriage is a life changing experience and yet women were often met with inadequate comforting messages from close others in quality and/or quantity (MacGeorge & Wilkum, 2012). For example, MacGeorge and Wilkum (2012) found that individuals who have experienced miscarriage do not want their experience minimized, or to be told that they "could always try again." Focusing on the timeline of a future pregnancy, and not allowing individuals to grieve their loss have proven to be inadequate forms of supportive communication. The two extremes of completely ignoring a woman's experience of a miscarriage and providing quality comfort messages to the women who have experienced a miscarriage is a common theme in miscarriage research (MacGeorge & Wilkum, 2012). It is important to shed light on miscarriage culture as well as individual experiences in order to gain a better understanding of the ways in which women view and experience miscarriage, as well as identify ways to improve supportive communication throughout this difficult process and time of grief.

This study examined the dominant and marginalized cultural discourses of miscarriage from women's miscarriage stories.The purpose of this study is to add to the research on miscarriage communication and cultural discourse. Specifically, this study utilizes Relational

Dialectics Theory to explicate the dominant and marginalized discourses of miscarriage from the unique perspective of twenty women who relayed their stories on *The Life After Miscarriage Podcast*. On the *Life after Miscarriage* podcast women tell their personal stories of miscarriage and their struggle to make sense of their own miscarriage experience.

While there has been both qualitative and quantitative research conducted in miscarriage communication there has yet to be a study conducted that utilizes RDT. Also, because RDT's main goal is to extract and showcase the marginalized voice of a phenomena it is the ideal choice to use as a lens into the phenomena. This study highlights why the topic of miscarriage communication should further be examined, how it will contribute to, and push forward reproductive health communication specifically miscarriage communication. It also adds to the growing field of RDT research, and revealed various understudied fields of communication to further study.

Previous research on miscarriage has sought to examine the comfort quality of messages in the context of miscarriage (MacGeorge & Wilkum, 2012). The study examined what messages were deemed highly comforting or not comforting at all from the perspective of couples who have experienced miscarriage. While that study is helpful to having a better understanding of what makes a quality support message, having a better understanding of women's experiences of miscarriage could also enhance the quality of the comfort message, and understanding the needs of that person at such a difficult time. One of the goals of the current study is to find concrete examples of quality supportive messages for women who have experienced a miscarriage that could be utilized by close others. In this study "close others" is defined as someone who would be viewed as part of the woman's support system, whether it be a physical or psychological closeness, from the perspective of that woman, whether that be romantic relationships, familial

relationships, friendships or otherwise.

Further research has looked at spousal sensemaking and perspective taking of miscarriage (Horstman & Holman, 2017). This particular study is helpful in gaining a better understanding on how couples made sense of their miscarriage, and how coping with their miscarriage together determined relational satisfaction. It also previewed and supported a finding within the current study that men cope with miscarriage differently than their female counterparts, and overall that can determine relational satisfaction. The current study analyzed a women's perspective of miscarriage, but with that came additional findings on their perspective of their husband's reaction to the miscarriage.

The current study sought to both interpretively and critically examine the discourses that animate the way women construct meaning from their miscarriage experience. The women's experiences with communicating about and the various messages relayed to them about their loss helps to further inform miscarriage communication. It is necessary to have a better understanding of how women who actually experience miscarriage communicate about it (or not) and what ways that communication is influenced by what they perceive is the dominant culture of miscarrriage. The unique utilization of Relational Dialectics Theory within the context of miscarriage talk will prove to be a significant addition to research about women, family, and health communication. RDT paired with the data set of personal podcast narratives of miscarriages from a women's perspective, I was able to gain a unique perspective on how some women communicate about the topic of miscarriage as compared to their perspecption of what the dominant cultural communication about miscarriage is which they perceive as one of silence.

II. Literature Review

Miscarriage

Miscarriage is the term used to refer to a pregnancy that ends "naturally" within the first 20 weeks of pregnancy (American Pregnancy.org, 2019). As stated previously miscarriage occurs in 10-25% of all recognized pregnancies, and that does not include the miscarriages women have before they even realize they have conceived (American Pregnancy.org, 2019). Chemical pregnancy is a type of miscarriage that accounts for 50-75% percent of all miscarriages, and occurs when a pregnancy has ended shortly after the egg has implanted (American Pregnancy.org, 2019). A chemical pregnancy often results in bleeding around the time a woman would have had their menstrual cycle, and could very well be misinterpreted as a period (American Pregnancy.org, 2019). Most miscarriages happen in the first thirteen weeks of pregnancy (American Pregnancy.org, 2019), but this study examined miscarriages that occurred in all stages of miscarriage (i.e. within 20 weeks of gestation). It was important not to exclude the narratives of women who had a miscarriage after 13 weeks just because it was not as common. This study utilized podcast interviews from women who have had one or more miscarriages. Podcasts were utilized in order to get the number of stories needed for the data set in the time restraints for the thesis. Recurrent miscarriages were often referenced within the podcast's stories, and are defined as "the spontaneous loss of three or more consecutive pregnancies with the same biological father in the first trimester, and affects 1% to 2% of women, half of whom have no identifiable cause for why the miscarriages occur" by American Pregnancy.org (2019).

It is important to note that miscarriage on a national level is no longer such a taboo or secretive topic of discussion. Over the years many celebrities, politicians, and the media have brought the miscarriage experience to the forefront of national discussion. For example, Ronald Reagan proclaimed in 1988 the month of October as the Pregnancy and Infant Loss Awareness

month (Reagan, 1988). In his proclamation he detailed the need for such a month because it "offers us the opportunity to increase our understanding of the great tragedy involved in the deaths of unborn and newborn babies. It also enables us to consider how, as individuals and communities, we can meet the needs of bereaved parents and family members and work to prevent causes of these problems" (para. 1). This excerpt from the proclamation worked to push forward the national dialogue of reproductive and infant loss, and bring awareness to how we support individuals who have experienced reproductive loss such as miscarriage. It is essential to note that this proclamation was created in 1988, and from the perspective of many women specifically the women included in my data set there is still a stigma of silence that surrounds the topic of reproductive loss. It is my responsibility to note that although not all women feel as though there miscarriage experience has been "silenced" there is still a large enough group of women as shown in my study that do feel as though their miscarriage experience has been silenced by society particularly their close others.

Additionally, there have been numerous pregnancy loss organizations created to aide in the continued discussion and awareness about pregnancy loss. Some of these organizations include the Star Legacy Foundation which focused its research and support for those who have experienced perinatal loss or a still birth (Star Legacy Foundation, 2020). While the Star Legacy Foundation (2020) does not focus their research on all types of reproductive loss such as miscarriage this foundation has become a platform to inform society about some types of reproductive loss, and adds to the national dialogue. Another organization that works to support individuals who have experienced reproductive (i.e miscarriage or still birth) and/or early infant loss (first few months of life) with various grief resources, educate individuals on reproductive and infant loss, and advocate for those who have experienced that type of loss was National

Share. Pregnancy and Infant Loss Support. When looking at the topic of miscarriage on a national level there has been some progression to making miscarriage a less secretive topic of discussion due in large part to the various organizations developed to recognize reproductive loss, and many well known public figures opening up about their struggles with reproductive loss. The current study reveals from the viewpoint of a small group of women that there is still some work to be done in order to make miscarriage a more common topic of discussion when communicating about miscarriage with close others and relationally. Although, there are many more resources available to women who have experienced a reproductive loss the relational stigma surrounding the topic of miscarriage communication as revealed in the current study often stopped women from seeking help/support when they needed it. The national organizations and media coverage while helpful resources lack the intimacy and bond that many women search for after having experienced a miscarriage.

As this study shows many of the women feel most comfortable with seeking out miscarriage information from resources/individuals on social media (i.e. Instagram, Miscarriage/ Reproductive Loss Podcasts, and Facebook) because they felt a deeper connection with those who openly discussed their miscarriage experience. This allowed the women in the data set who felt alone and silenced within their miscarriage experience an opportunity to connect with others who may share a similar experience. In fact, researchers Kuchinskaya and Parker (2018) studied how women who experienced reoccurring pregnancy loss (RPL) utilized social media platforms to not only share their personal experiences of RPL, but to also share their research on a phenomona they feel is understudied and often socially invisible. Through the collective sharing of personal experiences and active research in RPL these women have become what Kuchinskay and Parker (2018) define as evidence-based activist for their condition which is when individuals

challenge the way diagnoisis/conditions are understood, treated and communicated both culturally and medically. The women in the data set of the current study have utilized social media in a very similar ways, and it is further explained within the findings of this study.

Additionally, as previously mentioned women who have experienced reproductive loss or simply had struggles reproductively search for support and solace from others who shared a similar experience. When Betts et al. (2014), studied threatened miscarriage social media forums they found that women sought out hope which provided much needed therepautic help, and often challenged medical advice. This finding showed that medical practitioners should be aware of the power that social media paltforms hold for their patients. While social media forums can be beneficial to women who need support it can also be dangerous if they are given advice that could do more harm than good. It is essential that practitioners become proactive in their patients solicitation of support on social media forums by educating them on the misgivings they may encounter, but they must also give them alternative places to seek the support they are searching for. Social media platforms may be a new frontier for indviduals to come together to not only share their experiences in order to find comfort and solace, but also to find knowledge and resources in order to be more active participants in their medical care. This current study is one depiction of how women came together on a social media platform (*Life After Miscarriage Podcast*) in order to find a community and gain more knowledge about miscarriage.

Women's Experiences of Miscarriage

Women's experiences of miscarriage are often complicated as they are emotionally and physically taxing. Paired with the silence that often surrounds the topic of miscarriage, it is difficult to locate research articles and stories from women who were willing to share the intimate details of their experience. Researchers Adolfsson, Larsson, and Wijma (2004), made it

their research goal to identify and describe as authentically as possible the experiences of women who have had miscarriages. Adolfsson et al. (2004), interviewed fifteen women about their miscarriage experience and the common thread that linked those women and their experiences of miscarriage together were their intense feelings of guilt and emptiness following their miscarriage. The women in the study spoke about the multiple losses they experienced when dealing with their miscarriages. They detailed not only the loss of the child itself, but of the future that child could have had, and their role as that child's mother (Adolfsson et al., 2004). The women also detailed the physical and emotional toll the miscarriage placed on their bodies and mental health (Adolfsson et al, 2004). Women anguished over the bleeding that made them feel out of control of their own body, and the emotional pain of feeling both physically and mentally empty after miscarrying (Adolfsson et al., 2004). In order to feel some control over the situation the women often searched for a reason why they miscarried and if they could not find one, they would assign their own reasons for miscarrying (i.e. stress, anxiety, poor diet, smoking) (Adolfsson et al., 2004). The women who were interviewed all referenced their losses as a "child" and not an "embryo" or a "fetus" (Adolfsson et al., 2004). This notion supports the current study as many of the women referenced their loss as child which was a specific frame to view miscarriage. Many of the themes of guilt, emptiness, loss of control, mental and emotional anguish relayed in Adolfsson et al.'s (2004), study were very similar if not identical to the themes relayed by the women in the data set being utilized for the study. To be clear, not all women who have experienced a miscarriage frame their loss in the way that the women in this data set for this study do. It is likely that the women in the data set view their loss in a very similar way (loss of a child and not embryo/fetus or pregnancy) while there are many women who may not define their miscarriage experience as a loss of a child or for that matter a loss at

all. It is not uncommon for indviduals with a similar frame of mind regarding a phenomena find a community to share their similar perspective of an experence in the case of this study that community is the, *Life After Miscarriage Podcast*. The utilization of this podcast sheds light on a subset of women who struggled communicating through their miscarriage experience and provide a valuable cite to identify miscarriage discourses.

In regards to grief, Brier (2008) found that after a miscarriage woman often grieved more intensely and for a longer period of time than their male partner. Further, Adolfsson (2006) interviewed 13 women four months after their miscarriage, and found that they had wished others around them would have given them more time to grieve. Many women referenced the societal tradition of waiting until after the first trimester to reveal a pregnancy as having contributed to the overall stigma that surrounds miscarriage, because miscarriage often occurs before the end of the 'first trimester' leaving the women isolated in their grief because they have yet to reveal they were expecting (Bellhouse et al, 2018). Following their miscarriage experiences the women in Bellhouse et al.'s (2018) study felt that if there were more open communication about miscarriage within their communities, they would have felt less isolated and alone, and overall more prepared about the prospect of a miscarriage even occurring. The lack of conversation about a topic such as miscarriage leads to a lack of understanding, knowledge, and awareness about it. Overall, women who have experienced miscarriage often advocate for the topic of miscarriage to be a normal topic of discussion, in order to foster better support for women (Bellhouse et al., 2018; Kranstuber & Holman, 2018).

There were complicated and often conflicting cultural forces at work that shape the way in which women experience pregnancy loss (Laney, 2006). In the 20th century, the second wave of feminism came about and influenced women to take control of their pregnancies, combined

with low infant mortality rate, earlier medical intervention, and more advanced medical technology, women felt a push to become more informed about their pregnancy (Laney, 2006). All of those factors made women feel more secure in their pregnancies and women were able to invest more, emotionally and physically, earlier in their pregnancies. In confluence to that, society presents grief, loss, and women's biology as taboo topics of conversation that limits the emotional support and acknowledgment of pregnancy loss culturally (Laney, 2006). These contradictory forces complicate the way women may experience their pregnancy loss, because they become invested early on and have little knowledge of the possibilities of pregnancy loss. When women have experienced miscarriage, they were faced with the stark reality of lack of overall knowledge about miscarriage and emotional support from close others and medical staff.

Social Support During Miscarriage

Social networks play a vital role in softening the level of grief and loss experienced by women who have miscarried by simply relaying positive support messages following the miscarriage (Bellhouse et al., 2018). After a comprehensive look into miscarriage grief, Brier (2008) found that women who have experienced miscarriage would like the social support/comfort of their close others following the traumatic event of a miscarriage. The lack of social support during that time following a miscarriage can lead to a downfall in mental health (Kranstuber & Holman, 2018). Furthermore, the paradox of both wanting social support following a miscarriage (Brier, 2008), but not getting adequate social support messages lead women to not disclose or talk about their miscarriage (Meyer, 2016). That paradox may have influenced the silence that surrounds the topic of miscarriage. Communicating social support at its very basis could be defined as informal help from an individual's social network (i.e. friends and family) and in the specific case of miscarriage, from medical professionals. Social support

can be defined as emotional assistance (a place to vent frustration and grief, a judgment free zone, and to receive comforting messages), instrumental support including but not limited to (advice, and next step problem solving), and tangible support (bringing meals and just physically being of assistance for whatever they may need) (Burleson & MacGeorge, 2002). These social support messages can be modified in order to fit a specific situation and the specific individual who experienced the miscarriage. The findings section of this research provides specific examples of adequate and inadequate comforting messages following miscarriage.

Studies also show that women who have a support system were more open to sharing their miscarriage experience(s) and were able to adjust to that loss better than individuals who feel they do not have that support (Bute & Brann, 2015). A social support system was a group of close others (i.e friends and family) that provide appropriate social support messages for the individual and situation as previously noted. MacGeorge and Wilkum (2012) studied what factors make up a quality comforting message to women who have experienced miscarriage. They also found that women who have experienced miscarriage(s) were able to produce a more empathetic comforting message. Women who have experienced a miscarriage can give a first hand account of their experience and how they coped with it. Which can be very comforting to women who recently experienced a miscarriage. They also noted that women in general were able to develop a more quality comforting message because they were more cognitively complex, and were able to truly empathize greater with pregnancy loss, because there may be a chance they could experience one (MacGeorge and Wilkum, 2012). An example, of a high-quality support message communicated to someone who experienced a miscarriage could be something like:

Hey, I know you must be really hurting right now. I know you were probably really excited

for the baby. I can't imagine what you must be going through. You may not feel like talking, but if you ever want to, you know I'm here for you any time if you need it. (MacGeorge & Wilkum, 2012, pg. 67)

MacGeorge and Wilkum (2012) found that person centered messages were deemed the most sensitive and supportive when looking at the quality of the comforting messages. Another aspect of their research was how time influenced the quality of comforting messages and they found that the further time had passed since the miscarriage, the lower the comfort quality (MacGeorge and Wilkum, 2012). This may suggest that there were limitations placed on the duration women were expected to grieve their miscarriage loss.

Overall, although social support can be very helpful to women who have experienced miscarriage the right social support messages were key to the healing and overall wellbeing of these women. Women who were bombarded with negative or less then helpful social support messages that limit their grief or moderate their experience may in fact cause women dealing with miscarriage to feel disregarded and make the grieving process that much harder. Some examples of less then helpful social support messages that were given by MacGeorge and Wilkum (2012) were, "That was a month ago get over it already," and "Just learn from the experience and try again." That experience of being disregarded often lead women to stay silent about their miscarriage experience all together, which perpetuates the idea that miscarriage was a taboo topic of conversation.

Culture of Motherhood

Motherhood in the 21st century has become convoluted, complicated and, often times, contradictory in American culture. It was no secret that the socially constructed ideals of what it means to be a mother have put pressures on mothers to make sense of their own individual

identities and experience of motherhood. Despite years of work towards researching and understanding women's perspectives of motherhood the ideals of motherhood were still firmly rooted in the gendered discourses of how society perceives a woman's role, and the unrealistic expectations of what it means to be a mother (Miller, 2007). The "old wives" tales and various expectations of motherhood, such as, women were naturally and instinctively nurturers of children, that were handed down generation to generation promote unrealistic beliefs about what motherhood should look like, and when women actually experience it themselves, they struggle to create their own meaning of what motherhood was to them (Miller, 2007).

Intensive mothering as coined by Hays (1996) was constructed by three tenets. The first was the demand that all mothers should be the primary nurturer of their child (Hays, 1996). Second Hays (1996) positions intensive mothering as emotionally, financially, and physically all consuming, because all the mother's energy was focused on the child. Lastly, intensive mothering situates being a mother as self-sacrificing and having little value in the public sphere (Hays, 1996). Scharp and Thomas (2017) found that intensive mothering highlighted the dominant societal discourse of what it means to be a "good mother" often situated mothers as the nurturers, caregivers, and someone who must sacrifice everything for their children including their own physical and psychological wellbeing. Further, Gross (1998) suggested that mothers who attempt to engage in intensive mothering often struggle with the unrealistic expectations to be "super mom," while also trying to enjoy their personal or work successes outside of being a mother. Mothers often struggled with the decision to have others watch their children, and harbor intense guilt for having to or choosing to work outside of the home (Gross, 1998). That guilt was a product of the socially constructed ideals of motherhood passed down throughout history, and enforced by the expectations placed on women to sacrifice all of their dreams in order to care for

their children and husband (Gross, 1998). The idea that children were priceless and worth far more than the women caring for them, and that emotionally and physically depleting oneself to care for them was the only way to successfully raise children have conflicted with the real-life experiences of motherhood. Gross'(1998) article was twenty-one years old, but those same expectations were what fuel the way women construct their meaning of motherhood, and how their individual identities have become less important. The ideals of intensive mothering were so ingrained into the psyche of women they struggle to make sense of their own feelings and manage their own needs when they actually become mother's themselves. It essential to note that the culture of motherhood for this current study is based in the U.S context, and the perspective of motherhood and miscarriage may be very different in other countries.

In fact, Scharp and Taylor (2017), found that some women who suffered from prenatal and post-partum depression would often sacrifice taking their antidepressant medication needed to manage their depression in order to breastfeed for fear of harming the baby. The expectations to be a "good mother" means sacrificing in ways that could make a woman suffer tremendously physically and psychologically. Yet, as a society, we believe it was the only way to raise and care for a child successfully. It may in fact just perpetuate a cycle of girls turning into women who do not prioritize their wants and needs before motherhood. These intensive pressures to become a mother may lead to a feeling of inadequacy when confronted with a pregnancy loss such as miscarriage. Society has placed a high value on motherhood and when the pregnancy was not successful it can lead women to question their value and place within society.

Relational Dialectics Theory

Relational dialectics theory (RDT) was inspired by the work of Russian theorist Mikhail Bakhtin whose life work was focused on culture, language, and literature and would go on to be

labeled dialogism (Baxter, 2011). RDT was formalized by researchers Baxter and Montgomery (1996), and later advanced by Baxter (2011) to encompass the cultural effects on discourses and the way those discourses interplay to effect culture. Baxter (2011) argued individuals then construct meaning of a phenomenon through that interplay. The foundation of RDT was the idea that meanings were born from conflicting and competing discourses within phenomena (Baxter, 2011). More importantly RDT closely examined the dominant cultural discourses that influence the way individuals make meaning about any given phenomena (Baxter, 2011). In the current study, RDT was used to locate the dominant and marginalized discourses surrounding miscarriage in women's talk about their miscarriage experience. Future research, will expand on the interplay involved within the dominant and marginalized discourses that inform cultural and relational discourses on the topic of miscarriage.

RDT is not utilized to predict or explain the cause and effect of an objective phenomena; instead it is utilized as a heuristic tool to better understand that phenomena (Baxter, 2011). RDT does not rely on falsifiability that was often associated with postpositivist theories (Baxter, 2011). RDT truly is a tool utilized to help researchers see the nuances in the different discourses of a phenomenon that help individuals create meaning around that phenomenon (Baxter, 2011). RDT takes the position that individuals and their relationships were established through the interplay of communicative discourses (Braithwaite & Schrodt, 2015, p. 287). Further, RDT stands firm in the thought that phenomena's were given meaning through the communication that surrounds it, and communication does not just simply mirror whatever was happing in the phenomena (Braithwaite & Schrodt, 2015, p. 287). Instead, communication was both influenced by the phenomena and influences the way individuals construct meaning about the phenomena.

Baxter argued that RDT was a theory that was not individually centered, but instead

focuses on the interplay of utterances that an individual experience to create their utterance about a particular phenomenon (Baxter, 2011). This utterance chain begins with the notion that every utterance was a byproduct of a larger chain of utterances (Braithwaite & Schrodt, 2015, p. 281). Utterances were shaped by the greater cultural discourses that were circulated about any phenomena the utterance was about. There were four links to the utterance chain, distal already spoken, proximal already spoken, proximal not yet spoken, and distal not yet spoken (Baxter, 2011, pg. 50). Baxter argued that the flow of these utterance chain links represents the varying discourses about a phenomenon that come together to form that utterance and to construct its meaning (Baxter. 2011, pg. 50). Distal already-spoken links of an utterance chain were the utterances that were already being circulated by the culture at large about any given phenomenon (Baxter, 2011). These distal already-spoken utterances will be a particular focus in this research as the dominant (already spoken) discourses about miscarriage were going to be examined alongside discourses that were distal not yet spoken discourses The already spoken discourses from the perspective of the women in the data set is that miscarriage is a topic shrouded in silence with various themes that will be explained further in the study. While the distal not yet spoken discourses are that of the marginalized perspective of the women in the data set, and the various themes that are attached to it.

Second, Baxter (2011) argued that often times, one discourse has greater power over the other and that struggle was one of the central focuses of RDT. The interplay of these competing and often times conflicting discourses leave meaning making in a constant state of flux with no concrete and final meaning having been created (Braithwaite & Schrodt, 2015, p. 283). The goal of this research was to utilize RDT as a lens to explicate the centripetal forces (dominant) and centrifugal (marginalized discourses) of miscarriage (Baxter, 2011), and understand how they

interplay to form meaning for the women who have experienced miscarriage. Centripetal forces were discourses that work to unify and centralize the meaning of a phenomena or process (Braithwaite & Schrodt, 2015, p. 282). While centrifugal forces were discourses that work to decentralize and diversify the meaning of a phenomena or process (Braithwaite & Schrodt, 2015, pg. 282).

Most research utilizing RDT have focused on explicating the competing discourses in relationship types, processes and phenomena. More work needs to be done to utilize RDT to examine how culture influences the utterances and utterances were influenced by culture in order to help individuals construct meaning (Braithwaite & Short, 2015, p. 287). Some previous research into familial relationships employed RDT theory in order to examine the different discourses that interplay in those relationships. For example, Scharp & Thomas (2016), examined the narratives of adult children estranged from their parents in order to understand how they construct meaning about their estranged relationship. The Discourses of Relationship Endurance and the Discourses of Temporal Contingency competed to create the participants meaning of the parent-child relationship (Scharp & Thomas, 2016). The goal of the current study was to utilize RDT to critically examine the discourses around miscarriage, and from the interplaying discourses explicate a dialogue that was more supportive of individuals who have experienced miscarriage.

A true strength of RDT was that it was rooted in communication and was not a theory that was adapted from a different discipline (Baxter & Braithwaite, 2008). RDT’s main focus was to examine the various struggles with communication in our interpersonal relationships (Baxter & Braithwaite, 2008). RDT strategically situates itself as a theory that helps individuals understand the discursive nuances of competing discourses and the construction of meaning that

was born from the interplay among discourses (Baxter & Braithwaite, 2008). Surely, being able to better understand how individuals construct meaning about a phenomenon gives RDT merit. Based on existing miscarriage communication research the following research question is posed:

What discourses were present in women's talk about miscarriage experiences?

III. Method

Participants

This project aimed to identify various discourses of miscarriage, and how the dominant and marginalized discourses compete to create meaning for individuals who have experienced miscarriage. In order to efficiently and unobtrusively analyze those discourses a podcast that features stories of miscarriage have been utilized. Twenty podcast stories from women who have experienced miscarriage(s) were analyzed to get a better understanding of the various competing and sometimes conflicting discourses that surround the topic of miscarriage. The criteria for my data set was simple. I chose podcast stories that first were strictly about miscarriages. The women's miscarriage stories had to be detailed in order to explicate as much information as possible, and to truly be able to decipher competing/conflicting discourses. The women in the data set did not provide any demogrophic information such as race or class. The following sections further explain the use of the podcast *Life After Miscarriage* for the data set of this study.

Life After Miscarriage Podcast

The *Life After Miscarriage* podcast was a forum that podcast moderator Shelly Mettling created in order to share her story and the stories of women who have experienced pregnancy loss. After experiencing four miscarriages herself, Mettling felt that she could not communicate with those around her about the grief and loss she felt after her miscarriage. Mettling realized

that many women who have experienced miscarriage may feel the same way, and created a platform for women to connect and communicate about miscarriage in whatever way they felt comforted them. *Life After Miscarriage* podcast was a relatively small podcast with a little over 100,000 downloads as of this writing, and has a five out of five-star rating on iTunes. The podcast at the time of writing is currently only available on iTunes. *Life After Miscarriage* has an Instagram page with 782 followers and Mettling also developed a YouTube page called Miscarriage to Motherhood, which has 4.9 thousand subscribers.

The main goals of the *Life After Miscarriage Podcast* were to connect with women who have experienced miscarriage and get their unfiltered perspective of all facets of their miscarriage. Women were both recruited via social media to participate in the podcast from others in the Life After Miscarriage community, and some have reached out to the podcast moderator Shelly Mettling in hopes of sharing their story with the community. The podcast stories take a raw look into the emotional, physical and relational tolls that a miscarriage takes on women and from their perspective, their close others. The women's stories shed light on the communication they wished they would have received from their close others, and their medical providers. It also enlightens the listener on the internal dialogue the women had while experiencing their miscarriage and the aftermath of that experience. The women were able to share their unique perspective of motherhood after carrying a child and losing it before it was born. That unique perspective of motherhood often conflicts with the traditional discourse of motherhood which views a mother as a woman who gave birth to a living child, and a woman who was sacrificing herself for her child both mentally and physically. One can argue that although these women who have miscarried have not given birth to a living child from that pregnancy, they still sacrificed mentally and physically. The stories being shared on the *Life after*

Miscarriage podcast were a part of the discourses of miscarriage and motherhood, and the *Life after Miscarriage* podcast was meant to be a platform to authentically share miscarriage stories.

Data & Procedure

In order to gain access to discourses of miscarriage and motherhood that were needed for this research study, the public forum *Life After Miscarriage* podcast was utilized. Twenty stories from women who have experienced miscarriages were explicated and transcribed from the *Life After Miscarriage* podcast. This podcast serves as a platform for women who have experienced all stages of pregnancy loss to share their stories. For the purpose of this research study, only stories from women who experienced a miscarriage (i.e. a loss before 20 weeks) were analyzed. Some women shared their experiences of stillbirth on the podcast, but these were not included as they were outside the scope of this study.

Many of the women who have been featured on the *Life After Miscarriage* podcast reached out to the moderator Shelly Mettling with their pregnancy loss story in hopes of sharing their stories and connecting with others. Shelly Mettling also connected with individuals through her YouTube channel “Miscarriage to Motherhood,” where she shared her experiences with miscarriage and motherhood. “Miscarriage to Motherhood” was where she was able to build a community and enlist people to share their stories on her podcast. While the podcast was not a representation of every women’s experience of miscarriage, Mettling’s podcast has become a community for women most of whom view their loss as a “child,” and not that of an embryo or fetus. That particular view of their miscarriage has situated them in a specific frame within culture, but one that was still every important to the overall understanding of miscarriage communication.

When the podcast “interviews” begin, the women were prompted to tell the listeners

about themselves with basic demographics like age, relationship status, and then they dive straight into their miscarriage(s) stories. The women were able to tell their stories in whatever way they feel was best with little prompting or interjection from the moderator. The moderator may ask a few clarifying questions, but other than that, remains unobtrusive throughout the time women were sharing their experience with miscarriage. At the very end of the podcast the moderator ends with a variation of the same question to the guest; "Do you have any advice for someone who has gone through/or is currently going through pregnancy loss to help them get through this?" Overall, the podcast interviews were perfectly unobtrusive and leave the stories to be analyzed without much input or guidance from the moderator, which works out well for this study. When the moderator does make comments or communicates with her guests, she adds to the very complicated and complex discourses of miscarriage and motherhood, which enhances the explication process of this study, and as a woman who has experienced four miscarriages herself, her perspective only adds to the research not detracts.

Theoretical Considerations

The twenty *Life After Miscarriage* podcasts have been analyzed using contrapuntal analysis (Baxter, 2011). Contrapuntal analysis was utilized when employing the theoretical framework of Relational Dialectics Theory. This analysis method helped to identify conflicting cultural discourses within a phenomenon in this study (miscarriage and motherhood discourses), and how they interplayed in order to construct meaning about the phenomena.

I first identified the different discourses within the phenomena miscarriage in the podcasts that met my criteria, then I looked for the dominant and marginalized competing discourses, and lastly, I recognized where those conflicting discourses worked together and the women in the podcast created meaning about their miscarriage experience. I utilized the *in vivo*

coding method for my first cycle of coding. In vivo coding has been utilized in many different qualitative studies, and in particular studies that look to highlight the individuals/participants voice within the study (Saldana, 2015). In vivo coding worked well with this study, because it helped highlight and give power to the participants actual words they utilized when constructing meaning of their experience with miscarriage(s). After the initial coding (in vivo coding) second cycle coding helped to narrow down the codes into categories and my overall themes. To clarify and make concise there were three main steps being utilized to analyze the data set; (1) initial coding (in vivo), (2) identifying themes (3) identifying discourses

IV. Findings

Through the framing of RDT, contrapuntal analysis was used to explicate competing discourses in order to identify features of their communication about their miscarriage experiences. Through contrapuntal analysis one dominant discourse as well as two marginalized discourses were identified: the dominant discourse of miscarriage as silence (DDMS), the marginalized discourse of miscarriage as open and honest (MDOH), and the marginalized discourse of fear and anxiety (MDFA). First, the dominant discourses and their corresponding themes have been unpacked, and then the marginalized discourses and their corresponding themes were unpacked.

Dominant Discourse of Miscarriage as one of Silence (DDMS)

The DDMS was one culturally related to taboo, uncomfortable, and shameful topics of discussion. Through the DDMS four themes emerged from the data: lack of supportive messages, lack of readily available information and knowledge, feelings of shame, guilt and loneliness, and the belief that it could always be worse. The themes within the discourse of silence that emerged from the data encompassed the various ways in which women stay silent

about their miscarriage.

Lack of supportive messages from close others and medical professionals. One way the DDMS was reinforced was by the lack of supportive messages women receive who were experiencing or have experienced a miscarriage. The definition of lack of supportive messages as it related to this study were messages of judgment, messages that lack encouragement empathy, sympathy, and understanding. The theme of lack of supportive messages were prevalent in the stories of the women in the data set as noted in the following example.

Chaney recalled a time in her miscarriage journey when she was experiencing depression, and a feeling of her pain not being understood or seen by those around her. Chaney spoke about feeling judgement and unwanted questions that made her feel lonely in her experience.

> I faced judgment at times about depression and, and taking anti-depressants. I faced questions about my miscarriage that made me feel so isolated, like no one could see the pain I felt again. (T8, 2281-2283)

Chaney's feeling of her pain being overlooked was a common theme amongst the women in the data set. Many of them had similar experiences with their close others when it came to the acknowledgement of their miscarriage, and the pain and sadness that often can comes with it.

Another example of this theme represented within the women stories was when Erika relayed her perception of her husband's reaction and experience of the miscarriage. Erika was frustrated by her husband's statistical way of understanding the miscarriage rather than the more emotional way she experienced the miscarriage. She had hoped her husband would relate to her feelings of seeing the miscarriage as a loss of their baby rather than just another percentage.

> Zac though, it was frustrating for me because I felt like he wasn't… I felt like he wasn't feeling it, and I think you touched on this in your book a little bit. I felt like he wasn't feeling

> it and for him he was like “well 30% of pregnancies end in miscarriage.” He was like number, number, number, textbook, textbook, and I’m like wanting to ring his neck because I was like this was a baby this was a human. (T2, 683-692)

Erika was not alone in her experience of male partners dealing with miscarriage very differently than the women experiencing it physically. Often times the women in the data set referenced how they wished that their husbands/partners could physically feel what they went through in order to relate on a deeper level. That feeling of not being understood by others outside of the miscarriage community or the community created through the *Life After Miscarriage* podcast helped to perpetuate the silence discourse for these women.

Lissa explained how some of the questions she received from other’s left her feeling hurt, and called for more sensitivity when talking to and asking questions of women who have experienced miscarriage.

> I think some of the most hurtful things that people said to me was, were you sure it wasn't just a false positive? I'm like, that kills me. I'm like even if it was, I thought I was pregnant. I had connected with that baby. So even if it was a false positive, you know, even if my period was just late or whatever, I don't, I think people need to be a little more sensitive. And that's kind of the message that I like to spread and I've written, um, when I was writing on my blog. (T9, 2552-2557)

These messages of invalidation regarding Lissa’s miscarriage were common experiences had by the women within the data set. These messages were often not meant to be offensive, but can be very hurtful and influenced women who were dealing with miscarriage to keep their experience and feelings private.

Deanna shared her experience of having heard friends place judgment on a mutual Facebook friend for sharing “too” much of their life on social media specifically a miscarriage experience. That stopped her from sharing her own miscarriage experience on social media even though it was something she had thought about doing in order to connect with others who have had similar experiences.

> Um, I actually haven't shared our story publicly. And, um, part of the reason for that was we were in a group setting once and I heard, uh, a friend of my husband's comments about another woman that, um, we knew and he was just kinda going on. He was like, Oh, did you see so and so's posted on Facebook? Don't know why she would post about her miscarriage. She’s just oversharer. And he like probably, I mean, and I don't think he meant it in a way, like obviously his wife hasn't gone through a miscarriage. At that point we hadn’t shared that like we had gone through a miscarriage. Um, well that sticks in your head. (T15, 5254-5267)

Deanna felt like she would be judged harshly by her friends if she went public about her miscarriage and that stopped her from sharing her experience both on social media and to her close friends. The fear of judgment and being deemed an “oversharer” by her close friends effectively stopped her from sharing her miscarriage experience. That was a common feeling amongst the women in the data set and influenced many to stay silent about their experience.

These experiences encompassed the theme of lack of supportive messages that constitute the discourse of silence within miscarriage communication. These unsupportive messages may lead women to feel isolated and not understood which may prevent them from sharing their experiences. Along with unsupportive messages when faced with a miscarriage, the women in the data set also communicated about the lack of readily available information about miscarriage. They often spoke of searching the internet for information when they were faced with the

realization that they were miscarrying instead of asking their doctor for more information. The women also communicated about how naïve they felt through the miscarriage process and how unexpected it was for them.

Lack of readily available information and knowledge. The theme of information not being readily available and overall lack of knowledge about the topic of miscarriage was spoken about consistently throughout the women's miscarriage experiences. Many women felt they were not prepared for the prospect of a miscarriage and once faced with one went to the internet specifically, Google, in order to gain an understanding of what was happening to them in terms of their miscarriage. The following were examples of lack of readily available information and knowledge about miscarriage from the women stories.

After her first miscarriage Erika was confused and did not understand what was happening to her body. Directly after leaving the hospital after the doctors confirmed she was having a miscarriage she Googled the information that was relayed to her by her medical provider in order to gain a better understanding about miscarriage. Erika referenced being "very naïve," and not knowing what was happening to her in regards to the miscarriage.

> No nothing in my tubes. Nothing in my uterus. It was nothing. And again I was 22 I was very young I was very naïve. The whole thing was kinda just um… how do.. how do I describe. You were just blissfully naïve. I didn't realize the reality of was happening. You're like yeah I'm pregnant just going for my ultrasound and you go there and your world was crashing down and you don't even know what's happening, it's like there's nothing there. Your doctor's on the phone and he was like we need to bring you in for a D and C. And I didn't even know what that was........Um, I left the hospital where [we] were having the ultrasound and it was like instant google. Like… I need to find out what was a D and C why was there

> no image on the ultrasound you know? why am I not bleeding? Because if there's nothing there shouldn't I have bled? You just have all these questions you don't know what going on. I had no idea what was happening to me. (T2, 434-444)

Erika's experience was not uncommon amongst the data set the majority of the women mentioned googling some aspect of their miscarriage in order to get a better understanding of what they were going through regarding their miscarriage symptoms or to find other women who were dealing with the same experience.

Christie detailed the uncomfortable messages she received from individuals after experiencing a miscarriage. Prior to this excerpt she spoke about how she wished individuals would stop asking her questions about her miscarriage, because she did not know the answers to their questions.

> And everyone kept saying "well you know there wasn't a baby" and they were like "that would be harder." And I'm like yes, it's hard but I thought there was a baby there so to go into a sonogram and look at an empty placenta even…(inaudible) its unfathomable because you don't even know that's a possibility. I had no idea that was even thing. I had never heard of it. (T5, 1443-1446)

Christie found that talking about her miscarriage made the experience harder for her because individuals were insensitive to her experience. That paired with her lack of knowledge on what was happening to her pushed her to remain silent about her miscarriage.

Arden relayed her experience of her overall lack of knowledge on the different ways someone can miscarry. Her doctors told her that since she had not miscarried naturally she had a few options for miscarriage; she could induce a miscarriage at home by taking a pill, she could have a D and C at a hospital under full anesthesia, or a D and C could be done in office but only

a pain pill could be taken to ease the pain during the procedure. Arden decided to have the in-office D and C procedure due to financial reasons, but winded up naturally miscarrying that night.

> So I went to the bathroom and I found that the miscarriage had actually started while I was sleeping. And, um, I miscarried at home over like the next three hours. And I write about it on my blog in like extreme detail and I probably tell too much information. But what happened to me during that first miscarriage I was extremely unprepared for. I was told that it would be a heavy period and that it would just be a bad day. It wouldn't, it would not be as excruciating as it was. I mean, it was terrible. (T12, 3689-3695)

Arden explained how she was completely unprepared for the intense pain and large amount of blood she dealt while miscarrying. Her doctors did not warn her of the physical experience of a miscarriage

April shared a similar story to Arden of not understanding the various ways a woman could miscarriage, and having very little explained to her about the process by her doctor. She went into her 12 week ultrasound and found out that she had lost her baby. April did not realize she would still have to physically release the sac that was carrying her baby.

> Um, so then, you know, they sent me home, I went to the OB and then they gave me my options. You know, you can have a D and C, you can take this pill. And I didn't know, I didn't understand what they were talking about. I didn't know you still had to give birth to, what was it? I didn't know. I know nothing about this. So like the sac and everything that was in there, I still have to give birth to that. So she's like, you can take a pill and go home and do it at home. And I didn't know what was to come. So I'm like, all right, that's better. I'd rather

> do it in the comfort of my own home. Anyways. So I went and got the pills that night. I took them that night and they tell you it's going to be like a heavy period and they're absolutely wrong. It was the most horrific thing you could ever go through.
>
> (T 16, 5784-5786)

April was given various options, but was given little detail on the physical and mental effects of each option. She chose to take a pill that would induce miscarriage at home in hopes that being in the comfort of her own home would make the miscarriage process easier for her. Sadly, she felt like she was going through the full painful birthing experience at home without being able to have a baby at the end of it.

The women of the data set often referenced the lack of knowledge they had about miscarriage and the physical toll it takes on a woman's body much like what Arden experienced. Minimal dialogue between a doctor and patient about how hard a miscarriage was physically and mentally on a woman's body contributes to the silence discourse. The lack of readily available and accessible information in conjunction with the fact that many women were simply not educated on the possibilities of miscarriage were stark examples of the silence discourse within miscarriage at play.

Communicated feelings of shame, guilt, and loneliness. Feelings of shame and guilt were often spoken about by the women in the data set. There was guilt related to not being able to continue on with the pregnancy physically and shame for having miscarried. Many of the women struggled with the guilt and shame of not being able to carry their child to full term and birth them. The following were examples of the women experiences of guilt and shame within their miscarriage journey.

Lissa spoke about her guilt and the blame placed on herself for the miscarriage. She believes that her husband was able to do his part, and she was not able to fulfill what she saw as her responsibility of carrying the pregnancy through to term.

> Um, and there was a lot of guilt, a lot of blaming myself. Like my husband's seems to be doing his job holding up his end of the deal, but what's wrong with me? Like why can't I carry this through? (T9, 2514-2516)

Lissa's feeling of shame and the blame she placed on herself for not being able to carry the pregnancy through was not an uncommon narrative within the data set. American society instilled in women that part of our responsibility as women was to bear children, and when women decided they either do not want to have children or there were challenges to get to that point of having children, women often place blame on themselves or feel blame placed on them by others for not being able to fulfill their "duty" of becoming a mother.

Crystal responded to a question put forth by the moderator of the podcast about why she thinks women do not talk about miscarriage. Her belief was that women were ashamed of their miscarriage so they decided not to share their experience.

> Women were ashamed by it, but we were so strong the things we could go through and heal from. I carried … I carried a baby I didn't think I was going to get pregnant with trying for a year. Gave birth to him at home with no medication even though he was small it sucked. There's really nothing to be ashamed for, if anything, you really have to feel you were the strongest woman like to go through this (T3, 862-866)

Crystal hoped that women could see the strength within themselves both mentally and physically that it takes get through the miscarriage experience. She urged women to not let a miscarriage shame them into silence.

Franciska spoke about her shame that came in the form of humiliation, because she told everyone that she was pregnant and had planned for the baby. She specifically spoke about the undignified and shameful experience she felt while miscarrying in the hospital.

> I also found that my first thought after I got the news was just humiliation like ohhh I thought I was pregnant and now I'm not…. everyone I told which wasn't a lot it's like I had all these plans and now they're not gonna happen. I just felt… I guess the word I keep hearing on the podcast or with others was shame, but it came in the form of humiliation for me like I made a fool out of myself. (T4, 1066-1070)…..I was telling my friend or a family member it's like having a baby except nobody cares. You're not in a hospital with people that care you're by yourself or with your spouse and you're on the toilet. It's so undignified…. It's so yeah. Like somehow the hospital room with all it's disgusting fluid somehow beautiful but with the miscarriage somehow, it's waste that goes into the sewage it just so degrading and it adds to the shamefulness. (T4, 1075-1079)

Franciska highlighted the paradox that birth becomes ugly and shameful when the outcome was not the desired one. Birth was often talked about as beautiful and magical when a baby was born alive and healthy, but when a miscarriage or stillbirth occurs birth turns into something individuals do not want to acknowledge or talk about it.

Beatrice shared her two miscarriage experiences on the *Life After Miscarriage* podcast, and detailed the difference between both. She spoke of the unsupportive messages from close others that made her feel shame over her first miscarriage and led to her not talking about it, and her experience with anxiety and depression. Later in life, after having a healthy pregnancy, Beatrice became pregnant again and miscarried. In the podcast she detailed her close others more

supportive responses to the latter miscarriage, which led her to push past the shame she experienced with her first miscarriage in order to share her story to help others.

> Speaking about it, um, with no shame has been then one thing I've been able to do and just wanting to raise awareness of miscarriage and how common it was and how it's nothing to be ashamed of has really, um, sparked a passion in me to help other women. (T17, 6066-6069) ….. Share your story and feel no shame. That would be my piece of advice because it was a lot more common than we think. And it's, it's your, it's your life. So you need to, to share it like you would with any other events going on. Um, you know, happy, sad. We got to, you know, work through it and, and not, and, and just kind of move on through life with it. It's just the part of us and there's no shame in it and, and, and share it. (T17 6082-6086)

These were direct examples of how shame and guilt over having experienced a miscarriage can prevent women from sharing their miscarriage experiences which in this study perpetuated the dominant discourse of silence. The final theme that was found within the silence discourse was "it can always be worse." Many of the women in the data set struggled with justifying their feelings about their miscarriage to themselves, close others, and especially within the miscarriage community. Many decided that their situation "could be worse" after having heard others miscarriage stories, which kept them from sharing their experience.

It could always be worse. The theme "it can always be worse" supported the dominant discourse because it devalued the experience of women who have had a miscarriage, and left them believing that their story was not valid enough to share**.** Many of the women in the podcasts that were analyzed felt that their experiences with miscarriage were not as "bad" as other women's experiences of miscarriage(s) or in general birth trauma. That created an inferiority complex that cautioned them from sharing their stories.

Franciska had reservations of sharing her story within the miscarriage community because she did not have multiple losses. She questioned whether or not her story was significant enough to share within the miscarriage community. This was an example of the silence discourse at play within the very community created to share miscarriage stories.

> I listened to your other podcasts and some of the women including you went through several losses. It just seems my loss was so insignificant compared to them or I just started on this journey and suddenly I need to share my story. Who do I think I am?,,,,,, [laughter]… so that was one of my reservation cuz I…. there were for sure people who look at me like you know…. This was her age… this probably or whatever it's totally normal. Other people have a lot more stuff to worry about, like women who were told they can't naturally conceive or they have a thin uterine line like there's stuff that goes on…. I know I had a successful pregnancy that just makes things so much easier. I feel like how dare I come on this podcast. (T4, 1169-1172)

Franciska's story was common amongst the podcast storytellers. Often times women who have already had successful pregnancies or "only one miscarriage" felt as though their experience was less valuable story to be shared amongst the miscarriage community. The perpetuation of the belief that someone's story was more worthy to be shared, because the experience was deemed "worse" fed into the silence discourse.

Lissa felt that her story may not have been valid enough to share with the community on the *Life After Miscarriage* podcast, because she *only had two miscarriages*. She compared her experience to that of a friend who had 13 miscarriages, and believed that her experience was less than hers. She then realized that every experience was valid and should be shared.

> I only had two miscarriages. I know there's so many women that have so many more. A friend of mine has had thirteen and I cannot fathom what, how heartbreaking and the mental toll that that would take, let alone the physical toll that that would take on you. That's just so hard for me to even think about. So I feel, I know that I'm lucky and this was like when I was thinking about reaching out to you, it's like I don't even know if I have room to talk, but then I was like, you know, like, yes, I do have a story. I have something I can share. I have room to talk because there were other women who were going through the exact same thing that I am. And I want them to know that it's okay that they have, they, their stories were valid, their feelings were valid. Everything you're going through was valid. And I want them to know that, you know, it's okay to be scared. It's okay if your miscarriage was early, you're still, you're still going through something. You know? (T9, 2594-2604)

It took some time for Lissa to feel that her miscarriage experience was "valid" enough to share. That realization pushed her to tell her story in order to help others with a similar experience or feelings about their miscarriage not being traumatic enough to be shared. Similarly, to Lissa's story Kimberly experienced a comparison battle of thinking her miscarriage experience and the pain and sadness she experienced may be far less than what others were facing. It took a close friend explaining to her that all pain was valid no matter the circumstances for her to feel comfortable enough to lean into her grief and share her experience.

> And I put myself in so many women's shoes, you know, my best friend and his wife had just went through a loss about a year prior. Um, they were about to announce that they were pregnant when they found out that they had lost their baby. And then obviously all these other stories, I have a girl I went to high school with that had just had a stillbirth at 20 some weeks and I did so much comparison and battling with myself, like how dare I be sad. And

> then I had a friend put it into perspective for me and she said, you know, that's like you having a mom and a dad and then you lose a parent and somebody says, well at least you have another parent or you losing, you have three siblings and one of them passes away. And people would never say, well, at least you have two other siblings or know children here on earth. (T13, 4335-4344)

Kimberly was open about how she put herself in others shoes and compared her experiences to her own. Which was something many of the women in the analyzed podcasts stories did. This act of comparing miscarriage experiences often left women within the data set questioning how bad their experience really was which can be detrimental to the communication process of miscarriage with close others and relational partners.

There were many examples of the theme “it could always be worse,” that showed up within the stories of the women in my data set. It was common for women to compare their trauma and pain from their miscarriage to others pain and sorrow and deemed themselves unworthy to share their experience. Coupled by the fear of being judged by others because their story may not have been traumatic or sad enough many women decided to wait to tell their story. This fear of judgment and comparing one’s pain to other’s lead to silence about miscarriage with close others and even within the miscarriage community itself.

Marginalized Discourse of Open and Honest (MDOH).

The MDOH was one that was supported by numerous examples within the women’s stories. This discourse was one that was supported by two themes: community and advocacy between women in the miscarriage community and validation of ones feelings is essential. The themes that make up the MDOH discourse provided examples of how some women who have miscarried prefer to communicate about their miscarriage and the support they receive from the

miscarriage community they reach out to. The women also communicated about how they wish their feelings about their miscarriage were validated by those around them.

Community and advocacy between women in the miscarriage community. The whole podcast was a platform created by a woman who had a miscarriage to bring together other women who have had miscarriages to share their stories openly and as honestly as they were willing to do. The platform gave these women a community in which they often referenced in their stories, that helped them advocate for themselves and one another.

Catherine referenced how the miscarriage community, and hearing the miscarriage experiences of other women within the community has helped her feel less isolated in her own miscarriage journey.

> It has been such a great community because I have found women uhm, going through the same thing and there's a friend from college who has also suffered three miscarriage and I'm friends with her on Instagram and she's every open about it uhm and she's been a really good source too… of just okay I'm not going crazy I'm not alone. (T1, 319-322)

The sentiment of not wanting to feel alone in their pain or crazy for feeling a certain way was a common theme amongst the women in the data set. There was not one story in the data set that did not reference "feeling less alone," because of the connection they forged within the miscarriage community, particularly the *Life After Miscarriage* podcast community.

In the following excerpt Chaney not only credited the community she has created through the podcast and other online miscarriage communities but also the community of close others in her life for encouragement, and care she felt through her miscarriage experience. She felt the miscarriage community gave her the support she needed to advocate for herself.

I've been so encouraged by people and women and uh, and men in my life that have cared and wanted to know and have asked such beautiful questions at a far outweigh the hard ones. They far outweighed the bad experiences, but I will never forget the hard, I'll never forget the bad. Um, and that's why I think being this vulnerable was just so incredibly important. And listening to this podcast has just been another window of opportunity to see that we were all connected and um, challenges and have had our own unique stories, but we were in this together, whether it's through an online community or face to face. And I just am so appreciative of the chance to tell a little bit of my story and, and share it and share it with you, Shelly. (T8, 2354-2362) ……Yeah. Um, gosh, the main thing I think was that your pain was not invisible and that you were not alone. And this podcast in this group of women in the LAM fam community was, was a reminder of that and fight for yourself, um, to fight for your partner and your husband and advocate for yourself and fight for your babies. Um, because you can do it. And like I said, you're not alone. And I hope that, uh, through processes like this, it just continues to women out there facing any loss that, um, they have people in their corner. (T8, 2439-2444)

Chaney detailed how the *Life After Miscarriage* podcast has become somewhat of a reference guide for miscarriage and advocating for oneself within the medical community while dealing with a miscarriage. She advocated for women to share their stories no matter what the circumstances were, because she believed all stories were valid and could help others.

Carolina communicated her gratefulness toward the podcast community for their support and overall knowledge about miscarriage and various tests that can be done after experiencing losses. She went on to explain within the podcast that the community's support and information about miscarriage/reproductive health pushed her to advocate for herself.

I think I have to say like it's a 100% like thanks to your podcast and to every single other woman that have shared their stories. Like I can't even describe how much you guys have really helped, and sharing all the information and all the test and everything has really gave me… has really opened up my world. I was just not aware of 90% of uhm any of those so yeah… it has been amazing. (T6, 1180-1884)

This was just one of the many examples of how the miscarriage community particularly the *Life after Miscarriage* podcast acted as a source for supportive messages, and overall community of hope that things would eventually get better.

Christina relayed a similar message about the podcast as Carolina that the community she found within *Life After Miscarriage* made her feel connected to other women. Although, Christina has still not shared her story on her personal social media pages, and has only disclosed it with some of her close others she felt a sense of relief when she was able to share it within the miscarriage community.

I can't even tell you the sense of community that I felt and I don't know any of these women. I've never talked to them in my life, but I would listen to you guys every day on the way to work or even sometimes during work. Um, and I just, I would be yelling at like my radio or wherever the podcast was coming through. I'd be like, me too. Me too. Like that's me. Yes, yes, yes. You know, because I really, really felt connected to these women and that's actually a big reason too I wanted to be on this, because yes, I'm not some big like social media influencer, but I'm still a woman who had a miscarriage and it's been fucking hell. (T18 6645-6655)

These excerpts served as examples of how the miscarriage community has assisted women who have or were currently dealing with miscarriage through their grief, isolation, and overall feelings of shame by providing support and advice throughout the process. The final theme of MDOH was one of validation. Women who shared their experience on the podcast not only spoke about the community they felt a part of, but also the validation they received from the community that made them feel better about sharing their personal miscarriage stories. The validation they received from others supported the discourse of MDOH, because it allowed them to be more forthcoming about the miscarriage.

Validation of feelings is essential. The final theme of MDOH was the women's need to feel validated within their experience and feelings about their miscarriage. Validation for these women often came in the form of women listening to other's experiences and emotional responses and seeing similarities within their own miscarriage experience. Validation also came in the form of others not judging their physical or emotional response to their loss, and allowed them the space to grieve in whatever way felt necessary to them while comforting them with supportive messages.

Chaney felt that the validation she received about her feelings toward her miscarriage by her psychiatrist made her feel less alone in her pain.

> She normalized my pain in a way that made that invisibility go away. She validated it. She explained that so many women suffer in silence and she also diagnosed me with postpartum depression and explained the course of treatment that would help in the future. (T8, 2270-2273)

She also felt that the diagnosis that her psychiatrist gave her of postpartum depression supported her in her future health. It was also telling that her psychiatrist referenced the fact that

women often times suffered in silence after a miscarriage, which is a sentiment that supports the dominant discourse of silence in miscarriage communication.

Towards the end of relaying her miscarriage story, Erika gave advice to any women who has or was currently going through a miscarriage. She suggested they feel whatever emotion they needed to in order to get through their miscarriage, and that whatever they were feeling was okay.

> Really it's just… you have to give yourself the time to be sad. You have to let yourself go through whatever emotions you were feeling and you have to know it's okay. You can be mad one minute you can be sad another minute, and it's also okay to be happy. It's okay to be okay through it and after it. It's okay to be okay. (T2, 746-749)

Erika's advice was an example of the validation theme because her advice validates all feelings associated with the miscarriage experience. Many of the women in the data set referenced their fluctuating feelings throughout their miscarriage, and Erika alone with many other women in the data set acknowledge and validate those fluctuating emotions.

Lydia described the learning curve of lack of support from both medical staff and close others during her miscarriage. Her experience was validated or normalized when hearing how other women in the podcast were treated during their miscarriages. Although, the treatment from medical staff and close others was less than helpful, being able to share that experience with the other women on the podcast has been helpful to her.

> So that miscarriage I feel like was a learning curve. Um, and I guess it could have been normal, but I guess it was normal for me as I'm starting to realize. Um, and just the help from the hospital (which she explained earlier in her story that the medical staff was not very attentive to her) and to support that you don't get it was just, it just blew my mind. And that's

why this podcast has been so supportive cause I feel like the podcast and everyone that's been on it has just been with me through my journey. and as I go as January when it happens, as I go on the months and then now I'm into my second miscarriage, I feel like I'm saying yes. Yep, yep. I just, I can relate to absolutely everything in every single podcast that it's just, it's great that I do have the support even though it's not coming from where it should be coming from. So thank you for, for doing the podcast. (T14 4714-4723)

Every woman in the data set relayed their appreciation to the moderator for creating a platform for women to heal together within their similar experiences of miscarriage. The validation the women felt that their journey was not one that has not been experienced before was oddly comforting to them.

Deanna talked about how binging the podcast and listening to others stories really helped her heal because she felt validated in her experience. She also highlighted the loneliness women felt if they were not sharing their miscarriage experience.

I think that that was, this podcast was amazing and like I said previously, like I've been binge listening and I think that it's been so healing to hear that I'm not alone even, I mean, everyone says that, right? Like you're not alone. You're not alone, but then if you're not talking about it, you're, you were really. Like you're feeling alone because you're not opening up. And, and I think that just like hearing everyone else's stories and hearing someone else say like, yeah, me too, you know, this happened to me or this was how I'm feeling. Or you know, just to just scream obscenity. (T15 5501-2207)

Validation that there was not a wrong or right way to get through a miscarriage seemed to be a common thread within the women stories which contributed to the MDOH. Another

marginalized discourse that was revealed through analyzing the women's stories was a discourse of Fear and Anxiety (MDFA) with two themes doubt and insecurity, and triggers. It was quickly apparent that every woman in my data set felt some form of fear and anxiety after having a miscarriage. The fear and anxiety were often induced by various triggering events like having their first period after a miscarriage, planning for their next pregnancy, taking a pregnancy test, and/or seeing a pregnant woman, etc. The women shared their doubt and overall insecurity about their reproductive abilities as women after they experienced a miscarriage.

Marginalized Discourse of Fear & Anxiety (MDFA)

A marginalized discourse that was revealed after analyzing the data was the communication of fear and anxiety that accompanies life after a miscarriage, and any pregnancy that follows. Every single participant mentioned in some detail the fear, anxiety and constant questioning they felt after their miscarriage, the process of trying to have another child, and any pregnancy that happened to follow a miscarriage. Many of the women spoke about how any pregnancy after a miscarriage stopped being as exciting and carefree then their pregnancy(s) experience before having had the miscarriage. The themes that were established in this discourse were: communicated feelings of doubt and insecurity, and triggers of anxiety and fear associated with miscarriage.

Communicated feelings of doubt and insecurity. Lissa had one child before her second pregnancy and subsequent miscarriage. She referenced the fear she had that she may never be able to carry another child to term, and the thoughts that her first pregnancy may have just been a "one off miracle." She also questioned whether her own body was the reason she could not carry the child to term.

There was a lot of fear involved after I lost that pregnancy. Um, because I lost it. I was about five weeks pregnant, so it was super, super early. Um, and it was hard because it was like there was these thoughts running through my head. Was my son just a fluke? Am I never going to be able to get pregnant again? Um, am I ever going to be able to carry a baby to term? Like all of these thoughts and these fears running through my head? Is there something wrong with my body? Um, cause it seems like, Oh, I can get pregnant really easy, but it seems like, what if I can't carry a baby? What if Eli was just this one one-off miracle? (T9, 2487-2493)

The theme of feeling doubt about their capability of carrying child and also placing blame on their own bodies for "betraying" them was a common message that came from the women in the data set.

In the following excerpt Franciska spoke of the fear of trusting a pregnancy test after miscarriage. She went on to later explain within her miscarriage story how that experience changed her as person, and made what should have been a happy moment, one of doubt and fear.

It's like when you're trying to get pregnant and you keep getting negative pregnancy tests and waiting for a positive and here I have a positive and I still can't trust it because there was now this fear factor. (T4, 1061-1063)….It's the one that changes you. That changes all the happy hopeful into fear and doubt and uncertainty, and you start to question yourself. (T4, 1189-1190)

Franciska reaffirmed the fear and anxiety discourse by relaying how her miscarriage has changed the way she views any future pregnancy. Christina detailed in her story the long journey through her miscarriages and how she connected with a friend who also had a miscarriage, because they both had fear and did not trust the process of getting pregnant and staying pregnant.

> Everything, the whole journey from, you know, getting pregnant in February to now. It's just been such a crazy whirlwind and I dunno, it's just, it's so traumatizing. Everything was so scary. You know, my girlfriend Terra was, you know, she had mentioned she had a miscarriage and then now she's has a healthy pregnancy. You know, she said the second time you get pregnant after a miscarriage, it's just absolutely terrifying. You know, you're never going to trust it. Anything was safe until, I don't know. I don't even know when you hold the baby. I really think that's probably it. But yeah, I don't know. So I'm like, gosh, well congrats. Well thank you. It just doesn't feel like that, you know, you know, I know that I'm pregnant and I'm trying to just focus on Christina, you're fricking pregnant. Like this was what you want, you're pregnant. But it's just my brain was just not, my mindset was just not in the right headspace. You know? I'm, I'm literally terrified. (T18 6657-6667)

Christina ended the excerpt with having to reassure herself that she was pregnant and should be happy about that, but much like other women in the data set it was hard to move past the fear a miscarriage instilled in her. Christina even went as far as saying she “won’t feel safe” until she was holding her baby.

After having had a miscarriage with her first pregnancy Sarah decided she did not want to deal with any uncertainty at the beginning of her next pregnancy, and told her doctor that she wanted to take all precautions and preventive actions in order to feel more at ease in her next pregnancy. She went on to say that she decided to advocate for herself, because she almost decided not to try again because she felt she could not face the possibility of another miscarriage.

> I even told her afterwards, I'm like, well, when we try for baby number two, um, I want, you know, my levels checked instantly and I wanna you know, be put on progesterone or baby aspirin or whatever. I'm like, cause I do not want to do this again because I spent a good two

> weeks afterwards, you know, convincing myself that I'm like, no, we're just not going to have kids. There's no way I can do this again. I'm like, you know, the excitement of finding out that you're pregnant only to find out that your baby's gone in a matter of a month. I'm like, I can't do this. And it, that's when the emotion started changing more from anger in not accepting that the baby was there to more just being upset that our child didn't get to make it. (T20 7458-7466)

Sarah’s experience was not uncommon many of the women in the data set became proactive in their medical care in order to feel some reassurance that the next time they got pregnant they were able to do everything they could to stay pregnant.

Doubt and insecurity were a prominent part of every women’s experience after having a miscarriage. Through their community and this podcast forum they were able to openly discuss their fear and uncertainties, with the other women in their community in a way they may not have felt as comfortable doing in their everyday life. Along with the doubt and insecurity the women felt after having a miscarriage their anxiety was also made more apparent by various triggers they experienced.

Triggers of anxiety and fear associated with miscarriage. Many women referenced the different reminders of their loss that triggered an emotional response of sadness and anxiety. Some of the triggers that were referenced were due dates, anniversary of losses, seeing babies, and seeing pregnant women. Crystal C. explained how even the most mundane tasks like checking an email could be a constant reminder of what she lost when she miscarried.

> Yeah, like my social media was based around pregnancy and babies and mommies and obviously I’m not going to change any of that, because I do plan on all of that, but every day

you scroll through social media or go into me email, and you have those 20% off coupons from buy buy baby and I'm like always reminded. (T3, 907-910)

The reminder of babies and pregnancy can be hard thing for women who have miscarried to cope with. All of the women in the data set referenced some type of trigger that reminded them of their miscarriage and created some anxiety in subsequent pregnancies or created doubt that they many never get pregnant again.

Krystal P. recounted how dates became an emotional trigger for her. She did not expect for the different dates associated with her miscarriage to affect her mentally and emotionally as much as it did.

I think me and my husband we kinda this month was pretty rough uhm I just had a lot of ups and down's and coming up on a year the dates my actual… so my due date was going to be July 7th. Uhm and working up to it I was like it's going to be fine it won't really be that big of a deal, and yeah then it came and it was a big deal. So, I just… kinda of nervous about the dates coming up. The date of when I had the positive and then the date of when I had the miscarriage. (T7, 2073-2078)

Krystal P. felt that she would be nervous for all the dates associated with her pregnancy that would come to pass, and that supports how long lasting a miscarriage experience could affect women.

Arden actually referenced her "triggers" as PTSD within her miscarriage story. She had two miscarriages and did not think that she was "easily triggered" until she experienced her second miscarriage. Her anxiety was so severe she decided she needed therapy to cope with the

emotional turmoil her miscarriage created for her. Something others would think was a mundane task like using the restroom was extremely traumatic for Arden.

> And this loss, I've been struggling a lot with what I think was PTSD. I kind of had to talked to my husband about it because I, I wasn't sure if it was even considered PTSD, but I have a hard time going to the bathroom and taking showers and, and so I'm actually gonna start some acupuncture for that because it's been, um, I mean it's been a hard couple of weeks with that. …. And it wasn't after my first one, so I considered myself maybe I'm not easily triggered, but this time I'm very easily triggered and it's, it's difficult. (T12 3825-3833)

Sadly, Arden’s experience was not uncommon within the miscarriage community. Many women experience their whole miscarriage on the toilet or shower in their home. A place that was once a cozy refuge to take a bath and relax at the end of the day became a reminder of a horrific experience.

Deanna detailed an experience with her friends a few months after her miscarriage. They revealed to her that another close friend was due with twins around the same time she would have had the baby that she miscarried. That revelation triggered a physical and emotional reaction from her. Further, in her story she talked about the guilt she felt for feeling such sadness when hearing the news that her friend was pregnant.

> And, um, after about, well I guess not few months after the first month, um, my girlfriends kind of a couple of my girlfriends pulled me out and they're like, let's go to this wine bar, let's go drinking. And so we went to this wine bar and, um, they both at the time kind of sat me down and were like, okay, we, you know, another one of our very close friends was pregnant. And I was like, okay. And so then they told me her that she was due in September, which

> was when I was due, would have been due. And, um, and then they said that she was pregnant with twins and I just lost my shit at this wine bar. Like that poor waitress was like, Oh my God, dying. Like she's, she's dying. This was for last her last night. Like I just couldn't handle myself. I just was like hysterically crying simultaneously downing wine because I just couldn't, I couldn't handle it. I was like, everyone around me was like moving on and having babies and living these beautiful lives (T15 5237-5247)

Many women in the podcast battle with triggering events that cause them to feel pain, sadness, grief, anxiety and a plethora of other emotions while also feeling guilty, because they were not automatically ecstatic to hear when a close other or even an acquaintance was pregnant. Women in the podcast felt comfortable opening up about their triggers within the miscarriage community, and detailed the anxiety and fear those triggers brought to them. The topic of triggers after a miscarriage was one the women felt most comfortable talking about within the miscarriage community, because their feelings were validated. The next section covers additional findings that were important to showcase within the study, but were not directly correlated with the main focus of the study which was to explicate the dominant and marginalized discourses of miscarriage communication of the women within the data set.

Other Findings

Along with identifying dominant and marginalized discourses surrounding miscarriage, two other themes emerged that did not directly fit under the RDT focus of this thesis, but were essential to understanding communication in this area and were worth noting. The first additional theme touched on the ways in which women who have experienced miscarriage view their husband's communication about the miscarriage experience. The second additional theme

consisted of examples of supportive messages that would be helpful for women going through miscarriage to hear. These themes were highlighted and expanded upon in the sections below.

Miscarriage experiences were not the same for women and their partners. It was interesting to find that many of the women in the data set mentioned how different their response to the miscarriage was from their husbands/partners response was to the miscarriage. While husbands/partners were not referenced extensively within the podcast when they were mentioned the women often talked about how different their experience of the miscarriage was. Most often they would say they their "grief was not same" that women felt it deeper emotionally because they had to physically experience the miscarriage. Words like "strong," "calm," and "a rock" were often used to describe how the men reacted to the miscarriage experience. The women within the stories often wished that their husbands would have a more emotional response to the miscarriage in order to feel more of a connection with them through the experience. The following were examples of this theme from the women in the data set.

Crystal talked about how she believed her husband reacted to the miscarriage as most men in the same position would. She referenced how her husband held back his emotions like most men would. Which may speak to a unique discourse of silence within how men communicated about miscarriage.

> I think like most husbands he tried being the rock, and held in his emotions for the most part. Um, one thing that stuck with me to this day was he came over to me one evening, and was like "I bow down to you for what you went through." And I think it's made our marriage that must stronger, and I still don't think that he's uhm…. Yeah…. That he's handled it yet. (T3 912-915)

Interestingly, Crystal expanded on her husband's reaction to the miscarriage later in her story by noting how her husband acknowledged the emotional and physical toll the miscarriage had on her. She went on to share that she felt like her husband has not fully come to terms with the miscarriage experience. This excerpt speaks to a discourse of how women may perceive their miscarriage experience as different from their husbands, and it actually may not be.

Similar to Crystal's perception of her husband's reaction to the miscarriage experience Kimberly felt as though her grief regarding the miscarriage was innately different than her husband's grief. Kimberly had a physical grief reaction which showed those around her that she was in a state of mourning while her husband's response to the miscarriage was not like that.

> I know I've heard a lot of women talk about that and say the hardest thing was that the way you grieve was not the way that your husband grieves. And so you're sitting here wondering, why were you not upset? Why were you not just visibly crying in public like I am, you know, and that's just not how men deal with things sometimes. And so we still have to realize that they were grieving just in their own way. (T13, 4427-4432)

Kimberly equated her husband's "lack" of a visible response to the miscarriage as just the way men deal with things. Instead it may be the way society has influenced the way men "deal" with emotionally triggering events such as miscarriage. It was interesting that she acknowledged that even though the grief between her husband was not the same it does not mean that her husband was not grieving over the miscarriage experience.

April described an instance where she actually asked her husband why he had not cried over the miscarriage, and he admitted that he in fact does, but during private moments when he was alone. This was an interesting excerpt because it spoke to how men may both grieve

differently and attempt to hide that grief or processing of emotion during a traumatic event in order to appear “strong” and as the “the rock” of the family.

> So that's just now what we've been doing. We've just been enjoying, you know, we enjoy the summer, we're gonna enjoy football season and, and just feel, you know, both of us, like my husband, he's very, he's a guys guy, he's a tough guy. You just cry, you know. And I'm like, I very rarely see you cry or talk about how you feel. And he's like, Oh, I cry, I just cry in my car on my way to work or you know, things like that. we grieved differently and I'm like, that's fine, but I, you know, I want you to open up to me if you want to do, it's okay I’m your wife. (T16 5862-5868)

April also made it a point to let her husband know that it was okay for him to talk about the miscarriage with her. It would be interesting to take a deeper look into how men communicate about miscarriage and if they feel as though they can openly communicate their experience with their spouse and close others.

These excerpts highlighted an important and understudied part of miscarriage research which was the experience of the husband/partner of the woman who had a miscarriage. Miscarriage is often thought of as an experience that has a greater effect on women who experience it then the husband/partner, but there was research that found that men grieve similarly as women just not as openly (Bute, 2015). There may be another level of silence surrounding how husbands/partners experiences of miscarriage were being dealt with by close others and even the women in their life that have actually experienced the miscarriage. It would be valuable to examine if the women who feel their miscarriage experiences were being silenced were contributing to the silence that surrounds how men communicate about the miscarriage experience.

Examples of Supportive Messages. The dominant discourse of silence identified in the study highlighted the lack of supportive messages from close others and medical staff that prevented the women from being more open and honest about their miscarriage experience. In addition to identifying examples of non-supportive messages within the women's stories I was also able to identify examples of supportive messages given by women. Often times the women referenced how they wished people would address their miscarriage, validate their feelings regarding their miscarriage, and some women occasionally referenced a positive experience they had with their medical staff compared to the negative experiences that were most often talked about.

Chaney described a time in her life in which she was filled with anxiety that was eased by the support of her close others and mentor at church. She had just experienced a miscarriage and was grappling with that grief and five months later found out she was pregnant with twins. She was filled with grief over her miscarriage and mixed emotions of anxiety, fear and excitement over her new pregnancy.

> I also had weekly mentor… mentor times still and being able to tell her exactly how I was feeling without judgment and unwarranted advice just gave me so much confidence to face each and every appointment. My closest friends too, I just can't imagine my life without them. They poured out their love and gave me the chance to say I was grieving while also being excited. It was such a weird thing to say out loud to them. (T8 2347-2351)

This excerpt of Chaney's story highlighted the specific ways in which her mentor and close friends positively supported her during this complicated time. They let her tell her story without fear of judgement and unsolicited advice while also showering her with love when she opened up about feeling both grief and excitement at the same time. The characteristics that

make this a positive supportive message were lack of judgment, not giving unsolicited advice, and out pouring of love when individuals were sharing their miscarriage experience and complicated emotions associated with it.

There were not many examples of support messages given by medical staff that were highlighted by the women in the story, but this experience by Katie with her doctor showcased a supportive message that may help other women who were struggling. If all women were told by their doctors that there was nothing that they did to cause the miscarriage it may bring some comfort to them as it did for Katie.

> So after a little while, the doctor, my doctor came back in and just said, [inaudible] “I'm so sorry.” and there was a few things he said to me that, um, that helped and just kind of gave me comfort I guess. But he told me that there was nothing that I could have done to cause this. He's like, I know you're going to think. “Oh, what if it was this thing or what if it was, I worked out too hard or whatever. He said, nothing you did caused this”. And he said, “unfortunately, we may not ever find out why this happened. (T10 2799-2805)

Experiencing a miscarriage was complex and there may be nothing that could be said or done to fully ease the pain and trauma associated with it, but many of the other women in the data set experienced unsupportive non-comforting messages from their medical staff during their miscarriage experience that caused more grief and pain. Any future expansion of this study may look at if medical staff were consulted on the types of supportive messages that would be helpful for women who were going through a miscarriage and implemented them in their communicative practices, how different the experience may be in regards to the mental and emotional health for that woman.

Throughout her story Deanna often referenced how she tried to stay strong after her miscarriage and made it seem as if everything was okay when in fact she was suffering mentally and emotionally. She talked about how her husband became more supportive of her sharing her feelings about the miscarriage with him and with the miscarriage community, helped her cope with her loss. This particular excerpt was a point in her story where she described what she needed to hear from her close others. She wanted the people around her to acknowledge her loss in order to fully let herself grieve.

> But I think because I spent so much time trying to prove that I was okay and now realizing that I really am struggling with this, I think I need to hear people say, I mean, I mean not necessarily like I'm sorry, but I need to hear people that acknowledge to validate this has been hard and I, it does bother me. Like I feel like I feel support from that, right? Like I need for people, like "I don't know what you're going through and I can't say anything that's gonna make it better, but do you want to talk about it?" Like, that's really what I need to hear. Or, you know, "I'm sorry that you're going through this." Like, I think I hear that more than anything. It's not a trigger for me at all. (T15 5520-5527)

Beyond the acknowledgment and validation, she needed following her miscarriage she wished her close others would have asked her if she wanted to communicate about her loss. That particular revelation was interesting because it seemed as though she felt like she needed permission to openly speak about her miscarriage experience.

Common characteristics within these examples of supportive messages from close others were validation, acknowledgment, and giving women the platform to speak about their miscarriage in whatever way helps them cope. These characteristics were similar to the supportive messages the women in the data set find within the miscarriage community. The

acknowledgement from medical staff that it was not the women's fault that the miscarriage occurred, and that there was nothing they could have done to prevent it also proved to be of some comfort and support. It was important to highlight not only the unsupportive messages that influence women to stay silent about their miscarriage, but also educate close others on the supportive messages that may prove to be helpful to women during their miscarriage experience and may lead to a deeper more open dialogue about the subject.

V. Discussion

This study examined the various ways in which women who have experienced miscarriage communicate about their miscarriage. The various discourses were informed by RDT and the utilization of contrapuntal analysis revealed one dominant and two marginalized discourses both with various themes that supported those discourses. Understanding the various discourses, dialectal tensions and utterance chains of a phenomena were essential to better understanding how individuals create meaning around that phenomena. RDT centers around the various utterance chains that occur during various discursive struggles both culturally and relationally (Baxter, 2011). Individuals create meaning from a phenomenon based on how it was communicated culturally and relationally these discourses often challenge and contradict one another (i.e. marginalized and dominant discourses) which was where the meaning making typically occurs (Baxter, 2011).

This study focused on establishing the dominant and marginalized discourses within the miscarriage phenomena from the perspective of twenty women who experienced a miscarriage(s). The dominant discourse that was found was one of silence with themes of lack of information available to the women who experienced miscarriages, lack of supportive messages, feelings of shame and guilt, and feelings of "it can always be worse." There were two

marginalized discourses found within the study one being Open and Honest with themes of community and advocacy, and validation. Another marginalized discourse was that of Anxiety and Fear with themes of doubt and insecurity, and triggers. Additional findings highlighted the perspective that men experience miscarriage differently women, and examples of supportive messages.

A main future research goal for this particular study was the continuation of analyzing the data in order to find the interplay between the dominant and marginalized discourses that represents meaning making around the miscarriage phenomena. Through the analysis of twenty podcast stories from the perspective of women who have experienced miscarriages and the revelation of the various discourses and themes throughout it, established a basis for further research into women's health communication, men's miscarriage communication, and LGBTQ reproductive loss communication.

Dominant Discourse of Miscarriage as Silence (DDMS).

The DDMS was constituted by lack of information available to the women who experienced miscarriages, lack of supportive messages, feelings of shame and guilt, and feelings of "it can always be worse". These themes constructed reservations for women about speaking on their miscarriage experiences, and revealed the ways in which the medical community and society in general perpetuates the discourse of silence around miscarriage. Speaking to the theme of overall lack of information on miscarriage many women talked about instantly going to Google and the internet to research their miscarriage instead of talking to their doctor.

In regards to the theme of lack of supportive messages women in these studies felt as though their close others and medical personnel both did understand or could not empathize with their miscarriage experience which left them feeling isolated. Bellhouse et al (2018) found in

their research of the social support experience of women who have miscarried that those closest to them simply did not know how they could support them emotionally or tangibly. The lack of understanding of the grief of miscarriage was compounded by others discomfort of communicating about grief and loss and led to topic avoidance (Bellhouse et al 2018). Women also spoke of their feelings of guilt and shame because their bodies were not able to "carry through" with the pregnancy which they believed was their responsibility. Our society places a high value on motherhood and being able to carry and birth a baby. There was this assumption as women that because our bodies were "made" biologically for having children that when the time comes to have children there will be no problems. When problems do occur, it was natural for women to feel shame that their body "could not" maintain the pregnancy or a feeling of inadequacy as women. Layne's (1996) study supported these findings by identifying healthcare providers whether it be conventional (hospital) or alternative (birthing center) created a culture in which avoiding any uncomfortable topic such as miscarriage was encouraged when speaking to patients. Additionally, researchers Nynas et al (2015) found that while the majority of medical providers feel that there should be routine aftercare and psychological support following a miscarriage only a small percentage of them feel like the support being given was adequate. Furthermore, this avoidance of the topic of miscarriage by medical professional has supported the dominant discourse of silence.

Layne (1996) also highlighted the lack of information about pregnancy loss within the pamphlets in doctors' offices and other educational materials for pregnancy and childbirth which gives women the false idea that pregnancy loss was not something that could happen to them. Nynas et al (2015) examined various studies which concluded that patients were deeply dissatisfied by the lack of information given to them by their medical providers about why their

miscarriage may have occurred, the possibilities of another miscarriage, and overall reproductive health. Which also leads women to have to seek out alternative avenues in order to gain more information on pregnancy loss if it does happen to them. This all leads to a cycle of women having to navigate their pregnancy loss with little support from the medical field and those around them. The current study established various ways in which more supportive, open, and honest communication about miscarriage could potentially help women during and long after their miscarriage in order to have a more inclusive and overall culturally and relationally less silent discourse about miscarriage.

The Marginalized Discourse of Open and Honest (MDOH).

MDOH was supported by the themes of community and advocacy, validation, and expressions of fear and anxiety in regards to their miscarriage. Women often referenced their beliefs that they would not have been able to get through their miscarriage without the support of the miscarriage community they found online and within their close others who had also experienced miscarriages. They were also able to use their community as source of knowledge on the next steps after their miscarriages in terms of medical self-advocacy, and overall emotional support. Women felt a sense of validation about their miscarriage experience within their community which was something that may have been lacking amongst their close others and the medical community. Women were able to hear and see other women's experience of miscarriage and feel a sense of connection that their feelings were not only valid, but that they "weren't crazy" for feeling they way that they did in regards to their miscarriage.

There was also a sentiment of validating whatever their feelings may be towards their miscarriage whether it be sadness or just feeling okay about their experience. MacGeorge (2012), found that there were higher quality comfort messages from individuals who had experienced

pregnancy loss, and from individuals who may have had an indirect experience with pregnancy loss such as knowing a close other that had experienced loss. That knowledge about pregnancy loss and the feelings that come with it has created a more empathetic communicative approach to supporting an individual who experienced a miscarriage (MacGeorge, 2012).

According to a research conducted by the American Psychological Association obstetricians and medical staff's encouragement to seek out counseling following a miscarriage acts as an advocacy network and helps break the taboo nature of communicating about miscarriage (Leis-Newman, 2012). Additionally, they found that it was essential to help guide women to web-based resources if they were not ready to communicate about their miscarriage face-to-face or interact with another person about their miscarriage experience (Leis-Newman, 2012). These examples of resources and ways to advocate for one's mental and emotional health support the Marginalized Discourse of Open and Honest within the miscarriage community.

Marginalized Discourse of Fear and Anxiety (MDFA).

The Marginalized Discourse of Fear and Anxiety was established was the fear and anxiety that accompanied their miscarriage, while trying to conceive, and pregnancies after miscarriage. According to researchers Nynas et al (2015), "nearly 20% of women who experience a miscarriage become symptomatic for depression and/or anxiety; in a majority of those affected, symptoms persist for 1 to 3 years, impacting quality of life and subsequent pregnancies". Women in the study often found themselves overcome with grief and struggling to come to terms with their loss and what their next steps would be on the journey to motherhood. Many of the women in the data set spoke of how the excitement of taking a pregnancy test was lost after their miscarriage and replaced by the fear of possibly having another miscarriage or other complications. The women also referenced the fact that they may often be emotionally

triggered by seeing pregnant women or babies. Those triggers may lead to anxious and fearful thoughts for the women about their loss and their potential future pregnancies. Some triggers were also associated with waiting for the return of a menstrual cycle, fears over their reproductive functions, and over additional miscarriages (Nynas 2015).

Researchers Gaudet et al. (2010), conducted a study to examine the psychological experience of pregnancy after perinatal loss in order to better understand and identify the psychological risk factors that could potentially affect the relationship between the subsequent child. They found that women who experienced a previous pregnancy loss had greater anxiety symptomology than the control group (pregnant women who had not experienced a perinatal loss) (Gaudet et al., 2010). There were several factors that contributed to higher anxiety and depressive disorders in the women who were pregnant following a miscarriage such as the stage of the previous pregnancy when the loss occurred, the number of losses that woman had, and the experience of a late loss all of which contributed to higher levels of anxiety and weak prenatal attachment (Gaudet et al., 2010). These findings gave validity to the Marginalized Discourse of Fear and Anxiety.

Other Findings

An important additional theme that emerged was; miscarriage experience was not the same for women and their partners as described from the narrators perspective, which identified the perceived differences in the women's husbands/partners experience of the miscarriage was different, and less emotionally reactive than their experience. The differences in the miscarriage grieving processes and how that was communicated between men and women (marriages/partners), close others, and individually was an understudied phenomenon. It should be noted that the moderator of the podcast that was utilized for the data set had only one podcast

dedicated to her husband's perspective of the miscarriage which makes the males voice very much marginalized within this study. One of RDT's main goals was to highlight the marginalized voices, and a closer look at the male's perspective and communication of miscarriage should be the sole focus of a future study. Another goal of RDT research is to identify conflicting discourses occurring within the same phenomena, and attempting to push forward the marginalize voice (Baxter, 2011). This would be an interesting study to continue research on, because while the women in this podcast feel as though their experience has been marginalized as compared to the dominant discourse of silence, they have also contributed to the marginalization of their husbands/partners experience of miscarriage.

Due et al (2017) analyzed various mixed method studies that focused on the differences and similarities of men and women's responses to miscarriage. They found that men and women actually have very similar responses in terms of a level of anxiety, grief and depression. One of the main differences between men and women's responses to miscarriage was the ways in which the coped with their grief. Men avoided disclosing their feelings about the miscarriage, their topic avoidance level was high compared to women, and they found it hard to communicate their needs for support (Due et al, 2017). Another finding that supported the theme that men experience miscarriage differently than women was that their grief was perceived as less active and open, and they may in fact attempt to suppress their emotions about the miscarriage (Due et al, 2017).

Another study that gave some insight into the possible ways in which men may communicate their grief about miscarriage to their partner was one conducted by Toller and Braithwaite (2009). Toller and Braithwaite utilized RDT to analyze the differences between men and women when grieving the loss of a child. They were able to establish that although there

were some distinct differences between the grieving process between men and women, they were not necessarily detrimental to the overall stability of the relationship (Toller & Braithwaite, 2009). Within that study they found that although men and women grieved differently most were able to come together to support each other in their differing grieving processes instead of letting the experience create a separation between them (Toller & Braithwaite, 2009). Although, the grief process of losing a child in comparison to losing a pregnancy may be different it did provide a possible perspective into how that grief may be communicated. An accompanying study to the one conducted through this thesis could be to examine the husbands/partners experience of miscarriage in relation to their wife/partners experience of the miscarriage. Allowing a platform for men to speak candidly about their miscarriage experience could provide insightful data into miscarriage communication.

Another additional theme was the ways in which women felt that received supportive messages. Most often communicated throughout the data set were the numerous ways in which the women felt unsupported throughout their miscarriage experience and the seldom times a supportive message was extensively talked about it was noted. By expanding the data set and analyzing stories from more women there could be a pattern of optimal supportive messages that can be collected, and therefore establish a dialogue that can be used by close others and medical staff as a go to for better communication with individuals experiencing a miscarriage.

Toller (2011) conducted a study analyzing unsupportive and supportive messages parents received after the loss of a child. Toller utilized the optimal matching model of stress and social support in order to establish what messages proved to helpful and what messages were not during their time of bereavement. Toller found that parents who received tangible aid giving such as helping out with meals and conducting tasks saw that as supportive messages while

informational support was viewed as an unsupportive message (Toller, 2011). Unsupportive messages were seen as ones that came from individuals that gave advice about how to cope with the loss or communicated cliché grief statements such as “they’re in a better place” trivialized their loss. Another example of a supportive message for parents in this particular study were one’s that came in the form of emotional support for close others like giving them the space to communicate about their loss in whatever way helped them cope. Although, the experience of miscarriage may not be the same as losing a child, utilizing the supportive messages established in Toller’s (2011) study could prove to be helpful in comforting and supporting individuals who have experienced a miscarriage.

Theoretical and Practical Implications

This study added to communication research utilizing RDT. It also added to research in women’s health communication and revealed an honest depiction of women’s miscarriage experience from the perspective of the data set. RDT informed the two discourses dominant and marginalized from within the women true reflection of their miscarriage experience. RDT was a theory that employed a critical approach to overturning the dominant discourse while also attempting to promote social change, and better represent the marginalized discourse. RDT helped to establish that the marginalized discourses of open and honest, and fear and anxiety should be better represented when talking about miscarriage within mainstream culture.

Much like Scharp and Thomas (2017) article that informed the various dialogues that exist in prenatal and postnatal depression communication from a mother’s perspective, RDT also helped to inform the various discourses that make up miscarriage communication from a mother’s perspective in the current study. Many of the women suffering from prenatal and postnatal depression in Scharp and Thomas’ (2017) study found themselves silenced by cultures

ideals surrounding what it meant to be a mother, because mothers are positioned in society as selfless beings who should never speak negatively about the experience of motherhood. Another perspective of motherhood was established utilizing RDT in Suter et al (2015) research article, when they examined the discourses and meaning making in female-to-female co-mothering, and called for a reevaluation of how society defines motherhood. It established that the dominant discourse within society presents only one true biological mother while the marginalized discourse presents the idea that motherhood goes beyond biology. These aforementioned studies put into perspective the role of RDT in discursive power and how it manipulates what discourse is dominant within culture when it comes to the definition of motherhood, and how society communicates about motherhood. Similarly to these aforementioned studies, the current study depicts the way women felt silenced in their experience, because they not only believed they did not fit societies ideals on what it meant to be considered a mother, but they also wanted to speak about a very negative experience related to motherhood (i.e. miscarriage and pregnancy loss). Therefore, the current study also utilized RDT to reconceptualize the ideals of motherhood, and overall definition of motherhood, because many of the women in the current study would consider themselves a mother even though they have experienced pregnancy loss. Future RDT research should look at motherhood in a more inclusive way, and study the many nuances of motherhood and the competing discourses that make up the phenomenon.

Correspondingly, a more prevalent theoretical implication is that there simply is not enough RDT research into the various dialogues of pregnancy loss specifically miscarriage from a women's perspective. The current study opens the door to many more avenues in which to explore pregnancy loss discourses utilizing RDT. Admittedly, the current study looks at a very specific type of woman (i.e. one that views their pregnancy loss/miscarriage as a child). A future

study may choose to seek out a more diverse group of women and miscarriage experiences in order to get an idea of what additional discourses may be out there.

As Baxter (2011), made abundantly clear within her text explaining RDT that although the theory does not work as a causal explanation of a phenomenon it may in fact do something even more important when it comes to complex topics such as motherhood, miscarriage/ pregnancy loss, and reproductive health. Which is to help us understand these things more deeply, beyond the dominant discourses that seem to define these phenomena within our culture. Like all RDT research should do the current study reinforced Baxter's (2011) belief the multiple dialogues within a phenomenon are far more superior in gathering a deeper understanding of what may be happening in the phenomena than simply a one-sided monologue (i.e. dominant discourse).

The practical implications of the findings suggest that there is a great need for better medical support and information provided by the medical field to women about miscarriage. The women in the study felt like they had to advocate for themselves in regards to getting more information about their miscarriage and seeking support from outside sources like miscarriage support groups. The findings in this study support the initiative that medical staff should be more informative and supportive to women who (i.e. initial conversation about the possibility of a miscarriage and the process of a miscarriage, providing informational pamphlets informing patients about miscarriages, referring patients to supports groups and other medical professionals to help with their mental and emotional health after/during a miscarriage). Women should not walk out of their doctor's office feeling like they have to find all the answers about their miscarriage on their own. They should walk away feeling well-informed about the various ways in which someone can miscarriage, what the possible physical, mental, and emotional symptoms

of miscarriage could be, and most importantly the resources available to them to help them get through the process.

There was also a call from the women themselves for more sensitivity regarding communication from others about their miscarriage. Due to the taboo nature of miscarriage which keeps this discourse silent women were likely keeping their miscarriage experiences to themselves. Which was not only a detriment to their physical well-being, but their mental well-being as well. There was also a possibility that the silence discourse actually contributed to miscarriages not being recognized or reported to the medical community which leads to inaccurate statistics regarding how many miscarriages actually occur. There is a clear need for a more open, encouraging, and informative dialogue in regards to miscarriage.

Limitations and Future Directions

One clear limitation revealed so far within the study was the inability to ask direct questions to the women in order to streamline the research process. Although, hearing an unobtrusive experience of miscarriage from the women in the form of a podcast interview revealed information that may not have been uncovered through an interview. Another limitation of the study was that the data set was not fully representative of every woman who has had a miscarriage, but may only represent a group of women with similar miscarriage experiences. The data set did not provide any demographic information which is another limitation of this study. Focusing on a different groups of women could lead to different understanding of the issue.

The future direction of the research was the continuation of explicating more findings from the discourses and the various nuances that have been revealed, but not fully explored within this study. A possible research avenue to explore would be to look at the rules and

limitations placed on how women communicate within the miscarriage community based on the number of losses they have had. It was suggested by one of the women within the current study that she actually feared telling her story because she "only" experienced one miscarriage while others in the *Life After Miscarriage* podcast community experienced many more. The themes unpacked in "other findings" should have a study devoted to establishing the various nuances of how men communicate about the miscarriage experience and how it compares/relates to their partners experience. A study that examined how women experience supportive and unsupportive messages regarding their miscarriage would also add to miscarriage and reproductive health communication research.

Another avenue for future research that would prove not only helpful to miscarriage and reproductive health communication research, but also LGBTQ communication research would be to study the communication of same sex couples experience of miscarriage. The data set for this study did not include any same sex couple's experiences. Stories of same sex couple's stories were conspiciously absent from the podcast *Life After Miscarriage.* There seemed to be a resounding absence of research into how same sex couples communicate about miscarriage and reproductive health in within my research and in communication research in general. The dominate discourse in the field of pregnancy loss and miscarriage communication research was centered around a heteronormative narrative. While there was as of late, an increase of communication research about LGBTQ parenting, adoption, and marriage there was little research centered on the communication of pregnancy loss. In fact, much of the very little research there was on LGBTQ pregnancy/reproductive loss was centered around lesbian's experiences, and reference the many different groups of the LGBTQ community. It would be extremely enlightening to center a study on how LGBTQ individuals and couples experience,

and communicate about pregnancy loss in particular miscarriage as compared to heterosexual couples' experiences.

Researchers Craven and Peel (2014), were brought together by their shared experience of reproductive loss as queer women, and their overall desire to better understand the lack of information and research that surrounds the queer experience of reproductive loss. They conducted a study that included both survey and interviews with non-heterosexual women and LGBTQ people who have experienced reproductive loss. Craven and Peel suggest that the various challenges that LGBTQ people face when attempting to start a family whether it be through conception, adoption or other avenues intensify the grief that was experienced when there was a loss (Craven & Peel, 2014). Interestingly, Craven and Peel found through their study that reproductive loss in non-gestational non-normative parents (LGTBQ people) was severely under researched. This study was released in 2014 and the lack of research on this topic currently is still very much obvious. That is why I suggest a future study focused on the ways in which LGBTQ people communicate about miscarriage to contribute to the sorely absent LGBTQ reproductive health communication.

Craven and Peel (2014), also found that LGTBTQ individuals feared the reactions from others about their reproductive loss, because of ignorance and homophobia and further being marginalized by society. Many of the individuals in their study faced prejudice when it came to hospital visits and exam room visits, and their experience was largely misunderstood or obviously ignored by medical staff (Craven & Peel, 2014). There were also stories from lesbian partners that were not experiencing the miscarriage and their interactions with close others and coworkers that did not understand why they could not just "get over" their grief over their reproductive loss.

Researcher Michelle Walks studied the silence surrounding infertility, motherhood, and queer culture (Walks, 2008). Walks (2008) found that the lack of acknowledgement that Queer people would even experience infertility fed into a their already marginalized identities within society. In fact, the LGBTQ community had to work to get past the normative heterosexual belief that Queer people did not desire children particularly biological children (Walks, 2008). It was interesting to note the many obstacles the marginalized group of LGTBTQ people have to face when simply communicating about their experiences of trying to become parents and reproductive loss. As reflected in the absence of research there was a lack of knowledge and simply put understanding of the immense obstacles the LGBTQ people face to have their reproductive journey to becoming parents be communicated. Overall, their experience seemed to feed into the overall dominant silence discourse that surrounds the topic of miscarriage, and the utilization of RDT for future research into this marginalized group would highlight the marginalized discourses in their unique experience of reproductive loss.

To conclude, this study has established the dominant and marginalized discourses in miscarriage communication from women who have experienced a miscarriage(s). It identified some of the complicated ways in which women communicate within the safety of their community whilst the dominant discourse of silence still influences their everyday communication about miscarriage. Future research on this topic should work to identify the interplay between the dominant and marginalized discourses. This study has also established many opportunities for future research into miscarriage communication, reproductive health communication, family communication, women's health communication, and LGBTQ reproductive health communication.

References

Adolfsson, A., Larsson, P. G., Wijma, B., & Bertero, C. (2004). Guilt and emptiness. Womens experiences of miscarriage. *Health Care for Women International*, *25*(6), 543–560. doi. 10.1080/07399330490444821

Adolfsson, A. (2006). *Miscarriage. womens experience and its cumulative incidence*. Linköping. Linköpings universitet, Faculty of Health Sciences.

Baxter, L. A., & Braithwaite, D. O. (2008). *Relational dialectics theory. Crafting meaning from competing discourses.* In D. O. Braithwaite & L. A. Baxter (Eds.), Engaging theories in interpersonal communication. Multiple perspectives (pp. 349-361). Thousand Oaks CA. Sage.

Baxter, L. A., & Montgomery, B. M. (1996). *Relating. dialogues and dialectics* (1st ed.). New York. Guilford.

Baxter, L. A. (2011). *Voicing Relationships. A Dialogic Perspective*. Sage Publications. doi. http.//dx.doi.org/10.4135/9781452230344

Bellhouse, C., Temple-Smith, M. J., & Bilardi, J. E. (2018). "It's just one of those things people don't seem to talk about..." women's experiences of social support following miscarriage. a qualitative study. *BMC Womens Health*, *18*(1). doi. 10.1186/s12905-018-0672-3

Betts, D., Dahlen, H. G., & Smith, C. A. (2014). A search for hope and understanding: an analysis of threatened miscarriage internet forums. *Midwifery*, *30*(6), 650–656. doi: 10.1016/j.midw.2013.12.011

Braithwaite, D. O., & Schrodt, P. (2015). *Engaging theories in interpersonal communication. multiple perspectives* (2nd ed.). Thousand Oaks, CA. SAGE. doi. 978-1452261409

Brier, N. (2008). Grief following miscarriage. A comprehensive review of the literature. *Journal of Womens Health*, *17*(3), 451–464. doi. 10.1089/jwh.2007.0505

Burleson, B. R., & MacGeorge, E. L. (2002). Supportive communication. In M. L. Knapp & J. A. Daly (Eds.), Handbook of interpersonal communication (pp. 374-424). Thousand Oaks, CA. Sage.

Bute, J. J., & Brann, M. (2015). Co-ownership of private information in the miscarriage context. *Journal of Applied Communication Research*, *43*(1), 23–43. doi. 10.1080/00909882.2014.982686

Craven, C. & Peel, E. (2014) Stories of grief and hope. Queer experiences of reproductive loss. In M.F. Gibson (Ed.) Queering Maternity and Motherhood. Narrative and theoretical perspectives on queer conception, birth and parenting. (pp. 97-110) Bradford, Ontario. Demeter Press.

Due, C., Chiarolli, S., & Riggs, D. W. (2017). The impact of pregnancy loss on men's health and wellbeing. a systematic review. *BMC Pregnancy and Childbirth*, *17*(1). doi. 10.1186/s12884-017-1560-9

Gaudet C., Séjourné N., Camborieux L., Rogers R. & Chabrol H. (2010) Pregnancy after perinatal loss. Association of grief, anxiety and attachment, *Journal of Reproductive and Infant Psychology*, 28.3, 240-251, DOI. 10.1080/02646830903487342

Gross, E. (1998). Motherhood in feminist theory. *Affilia Journal of Women and Social Work*, *13*(3), 269–272. doi. 10.1177/088610999801300301

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood*. New Haven. Yale University Press.

Horstman, H. K., & Holman, A. (2017). Communicated sense-making after miscarriage. A dyadic analysis of spousal communicated perspective-taking, well-being, and parenting role salience. *Health Communication*, *33*(10), 1317–1326. doi. 10.1080/10410236.2017.1351852

Kuchinskaya, O., & Parker, L. S. (2018). 'Recurrent losers unite': online forums, evidence-based activism, and pregnancy loss. *Social Science & Medicine*, *216*, 74–80. doi: 10.1016/j.socscimed.2018.09.014

Layne, L. (1997). Breaking the silence. An agenda for a feminist discourse of pregnancy loss. *Feminist Studies*, *23*(2), 289. doi. 10.2307/3178398

Layne, L. (2006). A womens health model for pregnancy loss. A call for a new standard of care. *Feminist Studies*, *32*(3), 573. doi. 10.2307/20459106

Leis-Newman, E. (2012, June). Retrieved from https.//www.apa.org/monitor/2012/06/miscarriage

MacGeorge, E. L., & Wilkum, K. (2012). Predicting comforting quality in the context of miscarriage. *Communication Reports*, *25*(2), 62–74. doi. 10.1080/08934215.2012.719463

Meyer, M. D. E. (2016). The paradox of time post-pregnancy loss. Three things not to say when communicating social support. *Health Communication*, *31*(11), 1426–1429. doi. 10.1080/10410236.2015.1077414

Miller, T. (2007). "Is this what motherhood was all about?" *Gender & Society*, *21*(3), 337–358. doi. 10.1177/0891243207300561

Miscarriage. Signs, Symptoms, Treatment and Prevention. (2019, October 10). Retrieved October 11, 2019, from http.//americanpregnancy.org/pregnancy-complications/miscarriage.

Nynas, J., Narang, P., Kolikonda, M. K., & Lippmann, S. (2015, January 29). Depression and Anxiety Following Early Pregnancy Loss. Recommendations for primary care providers. Retrieved from https.//www.ncbi.nlm.nih.gov/pmc/articles/PMC4468887/

Our Mission and Vision. (2020). Retrieved from https.//starlegacyfoundation.org/mission-and-vision/

Reagan, R. (1988, October). *Proclamation 5890 -- Pregnancy and Infant Loss Awareness Month*. *Proclamation 5890 -- Pregnancy and Infant Loss Awareness Month*.

Saldaña, J. (2015). *The coding manual for qualitative researchers* (3rd ed.). Los Angeles, CA. SAGE.

Scharp, K. M., & Thomas, L. J. (2016). Family "Bonds". Making meaning of parent–child relationships in estrangement narratives. *Journal of Family Communication*, *16*(1), 32–50. doi. 10.1080/15267431.2015.1111215

Scharp, K. M., & Thomas, L. J. (2017). "What Would a Loving Mom Do Today?". Exploring the meaning of motherhood in stories of prenatal and postpartum depression. *Journal of Family Communication*, *17*(4), 401–414. doi. 10.1080/15267431.2017.1355803

Suter, E. A., Seurer, L. M., Webb, S., Grewe, B., & Kellas, J. K. (2015). Motherhood as Contested Ideological Terrain: Essentialist and queer discourses of motherhood at play in female–female co-mothers talk. *Communication Monographs*, *82*(4), 458–483. doi: 10.1080/03637751.2015.1024702

Toller, P. W., & Braithwaite, D. O. (2009). Grieving Together and Apart. Bereaved parents' contradictions of marital Interaction. *Journal of Applied Communication Research*, *37*(3), 257–277. doi. 10.1080/00909880903025887

Toller, P. (2011). Bereaved Parents Experiences of Supportive and Unsupportive Communication. *Southern Communication Journal*, *76*(1), 17–34. doi. 10.1080/10417940903159393

Walks, Michelle (2008) *"Breaking the Silence. Infertility, Motherhood, and Queer Culture."* Journal of the Association for Research on Mothering. Special Issue. Mothering, Race, Ethnicity, Culture, and Class. 9.2 (fall/winter 2007 [March 2008]). 130-143