Reproductive Loss in the Age of Neoliberalism

by

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I dedicate this capstone to all the women in my life who have lost dreams, identities, pregnancies, and children. I hold you and all that you have lost in my heart. I also dedicate this capstone to my own little lost heartbeats. Losing you broke my own heart and in doing so helped me to reconstruct it with meaning and purpose for my future.

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Abstract

Reproductive loss (RL) is common; in Canada 15.7% of couples experience infertility, 15-25% of pregnancies end in miscarriage, 8.1 of 1000 total births end in stillbirth, and 5.4 of 1000 live births end in post-natal (infant) death in the first year (Canada, 2020). Despite its frequency and increasing public visibility, RL remains a complex experience that can include feelings of sadness, grief, guilt, shame, and stress and can lead to more serious mental health complications such as post traumatic stress disorder and prolonged grief disorder. Neoliberalism, as a political philosophy valuing freedom, equal opportunity, and resistance to socialism, constructs ideological conditions that complicate the RL experience. These conditions include pronatalism, meritocracy, and essentialism. I review several forms popular discourse relevant to these conditions and the experience of RL including celebrity news articles about RL, Hulu's The Handmaid's Tale, and the post Roe v. Wade debate over fetal life. Using primarily feminist and social constructionist research, I examine how current popular social discourse reinforces neoliberal ideologies that complicate the RL experience. I review several established and emerging counselling approaches and consider how well they address this contemporary neoliberal socio-political-cultural context of RL. I conclude with recommendations for counselling practice, including recognizing RL as potential trauma, assessing for coping and despair, assessing for discrimination, deconstructing neoliberal ideologies, and constructing meaning and agency within loss.

Keywords: neoliberalism, pregnancy loss, reproductive loss, reproductive trauma.

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Chapter One: Introduction

"Losing a child means carrying an almost unbearable grief, experienced by many but talked about by few." (The Duchess of Sussex, 2020, para. 17)

In November 2020, Meghan Markle, The Duchess of Sussex, published an article about her miscarriage experience in The New York Times titled *The Losses We Share*. Her article was representative of a public shift in the conversation about reproductive loss (RL) - from one talked about by few to one increasingly talked about by many. Markle called her miscarriage "the loss of a child" (The Duchess of Sussex, 2020, para. 17), which is an illustration of the contemporary debate about the identity, value, and rights of a fetus. Markle also wrote about the immensity of her grief, a common emotional response following this type of loss. I will consider each of these themes of RL within our contemporary neoliberal socio-political-cultural context: the increasing visibility, the common experience, the political and public debate over fetal life, the range of emotional responses, and the mental health complications.

In this chapter, I will introduce RL and define the research problem, including a brief overview of the experience of RL and associated mental health complications. Next, I will introduce the contemporary neoliberal socio-political-cultural context that creates a renewed need for research in this area and I will define the purpose of this capstone research project. I will present my feminist and social constructionist theoretical framework, identify my position, and define key terms that are relevant to the capstone. In chapter two, I will review the relevant literature on the contemporary neoliberal socio-political-cultural context and examine how it plays a role in constructing the experience of RL. I will include a review of literature that describes the experience of RL and I will relate the experience to the socio-political-cultural context. Finally, I will present both established and emerging counselling approaches to RL and

examine how these may address the RL experience within today's contemporary neoliberal socio-political-cultural context. In chapter three, I will propose adaptations to established and emerging counselling approaches that consider the research outcomes and the contemporary context.

The Research Context

Reproductive loss (RL) is an umbrella term for the range of loss experiences related to human reproduction. The Government of Canada definition of RL (which they term *perinatal loss)* categorizes RL as: infertility (inability to conceive after one year of regular unprotected sexual intercourse), fetal death during pregnancy or birth (pregnancy loss), and infant death during the first year of life (post-natal death) (Canada, 2020). The category of pregnancy loss includes ectopic pregnancy (pregnancy outside of the uterus), miscarriage (fetal death before 20 weeks of pregnancy), induced abortion (a procedure to end pregnancy for personal or medical reasons), and stillbirth (fetal death before complete birth and after 20 weeks gestation or >= 500 g) (Canada, 2020). These definitions are not consistent in the literature; for example, stillbirth is sometimes defined as a loss after 22 weeks gestation (Cuenca, 2023). Alternative terms for these categories of losses also include perinatal loss (Canada, 2020), reproductive trauma (Brigance et al., 2023; Jaffe, 2017), and adverse reproductive experiences (Brigance et al., 2023).

The Research Problem

Meghan Markle described "an almost unbearable grief" (The Duchess of Sussex, 2020, para. 17) during her miscarriage. While social responses continue to hierarchize some RL experiences over others (Middlemiss & Kilshaw, 2023), the category of RL does not determine a person's emotional response to the experience (Canada, 2020) and it is this experience of loss,

not the category of loss, that is the focus of this capstone project. In this capstone I will call these responses to RL.

RL can encompass tangible, intangible, finite, non-finite, and/or ambiguous types of loss (Harris & Winokuer, 2021). Tangible losses may include the loss of a stillborn baby or an infant, while "an embryo, foetus, pregnancy, part of the pregnant woman" (Middlemiss & Kilshaw, 2023, p. 8) may be ambiguously tangible or intangible. Other intangible losses may include the loss of a possibility, the social role of motherhood, a dream of parenthood and family life, and a personal narrative about one's reproductive journey (Jaffe, 2017; Middlemiss & Kilshaw, 2023). Infertility or recurrent miscarriage may represent non-finite losses due to the ongoing uncertainty and recurrence of the tangible and intangible losses (Harris & Winokuer, 2021).

Responses to RL are diverse and variable and can include profound sadness and grief (Middlemiss & Kilshaw, 2023), guilt and shame (Andipatin et al., 2019; Romney et al., 2021), stress (Faramarzi et al., 2013), and trauma (Brigance et al., 2023; Jaffe, 2017; Jaffe & Diamond, 2011), which will be introduced further in the following sections.

Sadness and Grief

RL is acknowledged as an experience evoking feelings of profound sadness (Lacombe-Duncan et al., 2022) and grief (Bhat & Byatt, 2016). The grief associated with RL has been recognized as disenfranchised grief (Bhat & Byatt, 2016; Middlemiss & Kilshaw, 2023). Doka (2009) defined disenfranchised grief as an "emotion which people experience when they incur a personal loss that is not openly acknowledged, socially sanctioned, or publicly mourned" (p. 2). Doka (2009) wrote that social norms for grieving prescribe how a person is to behave, feel, and think following a loss and that the grieving process can be complicated when a person's

intrapsychic experience is misaligned with the social norms for grieving. Lack of acknowledgment and social validation can further complicate the grieving process (Doka, 2009). Middlemiss and Kilshaw (2023) argued that grief for RL is no longer fully disenfranchised because of increases in public visibility and social recognition. They identified a more complex range of emotional responses to RL and framed these within hierarchies of loss, wherein some types of RL experiences are granted more social validation and legitimacy than others (Middlemiss & Kilshaw, 2023). These differences in social validation and legitimacy may contribute to the development of more severe mental health outcomes such as complicated grief or depression (Bhat & Byatt, 2016).

Guilt and Shame

The dominant social discourse is that pregnancy is a step on the normative path to motherhood (Romney et al., 2021) and that the result of pregnancy is a healthy baby in the parents' arms (Jaffe, 2017). When RL interrupts this normative script, parents can feel broken and guilty (Romney et al., 2021).

Pregnant people are taught not to drink alcohol, to limit caffeine, and not to eat raw cheese, deli meats or sushi (HealthLinkBC, 2015). They are told to keep their pregnancy a secret for the first trimester (Feasey, 2022). When something goes wrong, they can believe that it was because they did something wrong (guilt) and that they should keep it a secret (shame) (Murphy, 2019). For example, Jaffe (2017) shared the story of Amy, who blamed herself for her miscarriage, believing that lifting heavy grocery bags was the cause. While doctors reassure people experiencing RL that it is not their fault, medical discourse that minimizes the experience of early miscarriage and normalizes it as a consequence of an abnormal fetus or other biological

process can leave parents feeling guilty and broken, as if their bodies are defective and they are to blame (Andipatin et al., 2019).

Stress and Trauma

RL is a stressful experience (Cuenca, 2023; Faramarzi et al., 2013). Stress has been identified as both a potential cause and result of infertility (Faramarzi et al., 2013), more the 40% of people experiencing recurrent pregnancy loss report high stress levels (Kolte et al., 2015), and abortion (for any reason) is highly stressful (Cuenca, 2023).

Some literature argues that describing RL as 'stressful' doesn't go far enough and that RL should instead be considered a form of trauma (Brigance et al., 2023). Some recent literature conceptualizes RL as reproductive trauma (Brigance et al., 2023; Jaffe, 2017; Jaffe & Diamond, 2011). Brigance et al. (2023) found that RL experiences are associated with symptoms of post-traumatic stress, with cumulative or recurrent experiences (such as multiple miscarriages and ongoing infertility) measuring higher levels of trauma. They argued that the term reproductive trauma represents a "spectrum of cumulative traumas in which individuals experience waves of distress" (Brigance et al., 2023, p. 7).

Mental Health Complications

Many sources have noted the mental health complications of RL, including depression, anxiety, prolonged grief disorder (PGD; also called complicated grief), and post-traumatic stress disorder (PTSD) (Boulet et al., 2017; Cuenca, 2023; Daugirdaite et al., 2015; deMontigny et al., 2020; Hanschmidt et al., 2018; Kersting & Wagner, 2012). Boulet et al. (2017) found that women who experience infertility or difficulty staying pregnant report poorer mental health than women who have never reported these experiences. Another study found that up to half of women who experience miscarriage may be considered depressed (deMontigny et al., 2020).

Hanschmidt et al. (2018) found that 17-25% of women who abort pregnancies for medical reasons experience post traumatic stress symptoms for up to seven years following the abortion, 17.6% experience complicated grief, and 10.8% experience depression. Paralleling the Government of Canada's statement that the type of loss does not determine the emotional responses to the loss (Canada, 2020), deMontigny et al. (2020) found that gestational age of the fetus at the time of loss was not significantly associated with the experience of depression, anxiety, or grief.

Contemporary Socio-Political-Cultural Context

Historically, pregnancy loss was a non-event and infertility was taboo (Jaffe, 2017); however, the contemporary socio-political-cultural is shifting. There have been recent increases in public visibility of RL, the renewed abortion debate post Roe v. Wade questions the value of fetal life, and challenges to normative definitions of femininity, pregnancy, womanhood, and motherhood are ongoing; these changes each contribute to this shifting context.

Increasing Visibility

Meghan Markle also said that the experience of losing a pregnancy is "talked about by few" (The Duchess of Sussex, 2020, para. 17), although this appears to be changing. Celebrity news articles such as Meghan Markle's story (The Duchess of Sussex, 2020) and Christy Teigen's blog (Teigen, 2020), and increasing public support and awareness in the form of public days of recognition (Judd, 2021), community runs (Butterfly Run, n.d.), and online support groups (Pacific Perinatal Foundation, n.d.) have increased the conversations about this once taboo topic.

Political and Public Debate over Fetal Life

In her article about her early miscarriage experience, Markle labeled her loss "a child" (The Duchess of Sussex, 2020, para. 17), constructing the loss as a person. Since the United States (U.S.) Supreme Court's decision to overturn Roe v. Wade (Totenberg & McCammon, 2022), the conversation about the value of fetal life has been renewed. Some people consider a miscarriage the loss of a person, as in the case of Markle, while others do not (Middlemiss & Kilshaw, 2023). In most countries, including Canada, legal personhood begins at live birth (Andipatin et al., 2019; Government of Canada, 2023). Abortion rights activists are hesitant to acknowledge the loss of something valuable in RL because this would "create a slippery slope to fetal personhood" (Donley & Lens, 2022, p. 1649), although this lack of social validation and acknowledgment of RL may contribute to feelings of disenfranchised grief (Doka, 2009). Biomedical discourses also act to minimize emotional responses to RL—the term *product of conception* acts to deny personhood and constructs the loss as biomedical waste (Andipatin et al., 2019). This language and differing beliefs about fetal personhood are centered in both the abortion debate and in experiences of RL.

Challenges to Normative Discourse

Contemporary gender identity discourse challenges conventional and normative notions of femininity, pregnancy, womanhood, and motherhood (Green, 2021; Walks, 2015) —constructions that are intertwined with the experience of RL. In some experiences of RL, it is the intangible loss of the identity of woman and role of mother that is grieved together with or instead of the tangible physical loss (Middlemiss & Kilshaw, 2023). The cultural assumption that all women should be mothers and all mothers are women complicates the experience of RL for both cis-gendered and transgendered women; cis-gendered women may grieve the loss the role of mother, a normative life course, and feel that their sense of womanhood is threatened

(Middlemiss & Kilshaw, 2023), while trans-masculine pregnancies are under-recognized in the broader social context due to the assumption that pregnancy is exclusively a woman's experience (Riggs et al., 2020).

The changing socio-political-cultural context of RL requires a renewed examination of the contemporary experiences of and responses to RL as well as counselling approaches to RL. Previous researchers have identified gaps in the available research about intersectional experiences of RL considering factors such as race, class, sexual orientation, and gender identity (Lacombe-Duncan et al., 2022; Martin, 2022). There is lack of research consensus about the conceptualization of RL as trauma (Brigance et al., 2023; Jaffe, 2017). Established counselling approaches must be reevaluated in the changing socio-political-cultural context, considering intersectionality, and with updated research considering trauma and mental health complications of RL.

Purpose Statement

My purpose in this capstone project is to examine the RL experience within our changing contemporary neoliberal socio-political-cultural context and to ask if counselling approaches to RL adequately address this changing context. I question how socio-political-cultural constructions of womanhood, motherhood, and personhood as well as experiences of systemic discrimination shape individual experiences of and responses to RL. I question if RL should be treated as a form of trauma, considering the mental health complications that can develop following experiences of RL.

The primary research questions I aim to answer in this capstone are: How does our contemporary neoliberal socio-political-cultural context shape the RL experience? How do

established and emerging counselling approaches to RL consider the contemporary neoliberal socio-political-cultural context?

Theoretical Framework

In this capstone I primarily draw from two theoretical frameworks: social constructionism and feminism. Slaska (2018) wrote that "social constructionist and feminist commitments have a shared philosophical genealogy and shared critique of positivism, essentialism and biomedicalization of women's bodies" (p. 19) and it is in these intersections where I place my theoretical framework.

Social constructionism takes a critical stance towards taken-for-granted knowledge, opposes positivism, argues that understanding is historically and culturally relative, and believes that people construct knowledge through social interaction (Burr, 2015). Within the framework of social constructionism, I will use discursive psychology (DP) to understand contemporary experiences of RL. DP considers discourse as both constructed through a range of cultural words, phrases, expressions, and so forth and constructive of different versions of the world through the way we talk about people, events, actions, and so forth (Wiggins, 2017). DP is situated within a particular place and time (contemporary neoliberal socio-political-cultural context) and is action-oriented (i.e., serves a function) (Wiggins, 2017). I will use our current socio-political-cultural context (Western, neoliberal, post Roe-v.-Wade) to analyze the function of constructed and constructive discourse on responses to various RL experiences.

My feminist perspective draws primarily from intersectional feminism and take a critical perspective on liberal feminism as it relates to RL. Intersectional feminism, as coined by Kimberlé Crenshaw, is a "prism for seeing the way in which various forms of inequality often operate together and exacerbate each other" (Crenshaw, 2020 as cited in Steinmetz, 2020, para.

3). It considers how inequities based on race, gender, class, sexuality, and immigration status intersect to create unique individual inequities (Steinmetz, 2020, para. 3). Liberal feminism (also called post-feminism) emphasizes female empowerment and assumes that gender equality has been achieved (Lebovic, 2019). Most relevant to RL is the liberal feminist rhetoric of individualism, control, and personal choice contrasted with RL experiences that are often uncontrollable and choiceless (Martin, 2022). In this capstone, I will examine how intersectional feminism and liberal feminism have influenced the discourse on RL. Considering the feminist credo *the personal is political,* I will examine the intersections of the personal experience of bearing and caring for human life with the political experiences of capitalism and neoliberalism, especially how this intersection impacts the identities of person, woman, and mother.

I take broad definitions of *woman* and *mother*, recognizing that most of the literature uses these terms in a normative way when discussing RL. For this capstone, *woman* is understood to be a gender identity that may or may not align with the biological female sex. While pregnancy is a biological function available to those with female sexual reproductive organs, *mother* is a role that a person of any gender identity can take that involves tenderly and compassionately caring for a young person as a member of their family (Harper, 2023).

Justification and Contribution of the Research

Given the frequency of RL in the population, it is inevitable that counsellors will encounter people experiencing RL. Counsellors must be aware of the range of RL experiences and responses as well as the mental health complications of RL. As participants in the contemporary social discourse, counsellors play a role in co-constructing a person's experience of RL, so they must also understand how intersectional identity and contemporary social discourse shape these experiences, responses, and complications. Slaska (2018) wrote that

"social constructionist research helps to inquire about how we can change our social, cultural and therapeutic practices" (p. 16)—in this capstone project I aim to include therapeutic counselling practices as part of the broader socio-political-cultural context that shapes experiences of RL. I will propose treatment approaches and supportive interventions that challenge problematic discourses and work constructively to treat complex RL experiences.

Social constructionist discursive psychology is situated in a context (a time and a place) (Wiggins, 2017), so it is relevant to situate the literature that this capstone project will be based on. I will include relevant discursive analyses, ethnographies, and autoethnographies from around 2020 (approximately 2017-2023). Most will be from a culturally Western context, and many will be based on Internet-based discourse (social media, online news media, etc.). I will also include relevant quantitative data and meta-analyses that add to the understanding of the RL experience and the effectiveness of counselling approaches. The conclusions I draw in this capstone project will be relevant at this time, for these people; they are fluid realities that will require adaptation and growth as the socio-political-cultural context shifts and changes.

Statement of Positionality

I am a cis-gendered, heterosexual, White, middle-class woman and I experienced years of RL before it ended with two living children. I know that my outcome is not always the real or the desired outcome for everybody. I have personal, familial, and community-based experience with a variety of RL stories—enough to know that each individual story is vastly different and that none can be compared to another.

I acknowledge that I am privileged in many ways and that these privileges influenced my experiences of RL; my pregnancies were planned and wanted, I had access to medical and paramedical healthcare, and I had work benefits that permitted me the time to grieve. Because of

my dominant social location and normative identity (cis-gendered, heterosexual, White, middle-class woman), I did not experience racism, sexism, homophobia, or other forms of discrimination or prejudice during my RL experience, and I had privileged access to social supports, including peer support groups. Now, my academic position grants me the ability to deeply understand and make meaning of my losses. I choose to hold this privilege as an umbrella to others, so that I can use my work to walk alongside others experiencing RL and potentially help to ease their suffering.

Definition of Terms

Abortion: A procedure to end pregnancy for personal or medical reasons (Canada, 2020).

Disenfranchised grief: An "emotion which people experience when they incur a personal loss that is not openly acknowledged, socially sanctioned, or publicly mourned" (Doka, 2009, p. 2).

Discursive psychology: "A theoretical and analytical approach to discourse which treats talk and text as an object of study in itself, and psychological concepts as socially managed and consequential in interaction" (Wiggins, 2017, p. 4).

Ectopic pregnancy: A pregnancy outside of the uterus (Canada, 2020).

Infertility: "The inability to conceive after 1 year of regular unprotected sexual intercourse" (Canada, 2020).

Intersectional feminism: Considers how inequities based on race, gender, class, sexuality, and immigration status intersect to create unique individual inequities (Steinmetz, 2020).

Mother: A role that a person of any gender identity can take that involves tenderly and compassionately caring for a young person as a member of their family (Harper, 2023).

Miscarriage: The death of a fetus inside the womb and before viability (up to 20 weeks gestation). Also called *spontaneous abortion* (Canada, 2020)

Neoliberalism: a political philosophy prioritizing free and competitive capitalist markets and resisting restrictive social policy; values democracy and freedom. Privileges economic growth above social equity (Flew, 2014; Sugarman, 2015; Vallier, 2022).

Pregnancy loss: The death of a fetus for any reason, including ectopic pregnancy (pregnancy outside of the uterus), miscarriage, abortion, and stillbirth (Canada, 2020).

Reproductive loss: An umbrella term for a range of loss experiences related to human reproduction, including: infertility, fetal death during pregnancy (pregnancy loss), and infant death during the first year of life (post-natal death) (Canada, 2020). Also called *perinatal loss.*

Social constructionism: A critical stance towards taken-for-granted knowledge, arguing that understanding is historically and culturally relative, and believing that people construct knowledge through social interaction (Burr, 2015).

Stillbirth: The death of a fetus that occurs before complete birth and after viability (20 weeks of gestation or>= 500 g) (Canada, 2020).

Woman: A gender-identity that may or may not align with biological female sex.

Outline of Capstone Project

This chapter introduced the research problem of RL and explained the contemporary neoliberal socio-political-cultural context, including increasing visibility of RL, political and public debate over fetal life, and emerging understandings of gender identity and gender roles. The contemporary neoliberal context demands renewed examination of the experience of RL and especially considering disparate RL experiences for populations who experience discrimination. I presented my feminist and social constructionist theoretical framework and my position as a cis-gendered, heterosexual, mother of two and my personal experience of RL. In chapter two, I will use this theoretical framework to define and explore the contemporary neoliberal socio-

political-cultural context of RL, examining how it plays a role in constructing the experience of RL. I will include a review of literature that describes the experience of RL and relates the experience to the socio-political-cultural context. I will briefly review established and emerging counselling approaches to RL, including a critique on their applicability to the RL experience within the contemporary neoliberal socio-political-cultural context. In chapter three, I will consider this critique and propose adaptations to established and emerging counselling approaches that consider the contemporary neoliberal socio-political-cultural context of RL and includes therapeutic activities that actively, constructively, intentionally, and relationally address the experience of RL.

Chapter Two: Literature Review

In chapter one I presented the unique grief and loss experience of RL and explained the varied responses, including sadness, grief, guilt, shame, stress, and trauma as well as the mental health complications. Our contemporary socio-political-cultural context is changing; there is increased visibility of RL, ongoing political and public debate about the value of fetal life, and challenges to normative constructions of femininity, pregnancy, womanhood, and motherhood. My purpose in this capstone is to consider how this contemporary context shapes the RL experience and how well current counselling approaches address this contemporary context. In chapter two I will address the research questions: How does our contemporary neoliberal socio-political-cultural context shape the RL experience? How do established and emerging counselling approaches to RL consider the contemporary neoliberal socio-political-cultural context? The purpose of chapter two is to present a review of relevant and contemporary literature on the topic of RL, with a non-exclusive focus on feminist and social constructionist literature. To locate literature for review, I searched academic journals using Google Scholar and the CityUniversity academic library. I also used independently published books and obtained articles directly from the authors. My searches included key words such as *reproductive loss, pregnancy loss, abortion,* and *reproductive trauma*.

This chapter is organized in three sections: contemporary socio-political-cultural context, the experience of RL, and established and emerging counselling approaches. In the section on the socio-political-cultural context of RL, I introduce the dominant cultural ideologies and forms of discrimination that shape the RL experience, drawing from philosophical, feminist, social constructionist, and gender studies research. I then present three forms of popular social discourse and relevant discursive analyses that explain how this discourse reinforces

problematic ideologies and discrimination and constructs the RL experience. In the next section I draw from both qualitative and quantitative research to describe the RL experience and relate it to the socio-political-cultural context presented in the first section. In the final section, I present literature describing established and emerging counselling approaches and critique how these approaches address different challenges of the RL experience within our contemporary neoliberal socio-political-cultural context.

Contemporary Neoliberal Socio-Political-Cultural Context

In this section I will review the contemporary neoliberal socio-political-cultural context of RL. I include a review of the dominant ideologies that influence the RL experience: capitalism, neoliberalism, liberal feminism, (hetero)patriarchy, pronatalism, meritocracy, and essentialism. I identify how discrimination based on race, sexual orientation, and gender identity impacts the RL experience. Finally, I explore three current and relevant forms of popular social discourse: celebrity articles about RL, Hulu's *The Handmaid's Tale* (Miller, 2017), and the post-Roe v. Wade political era, identifying how each reinforces dominant ideologies and systemic discrimination that shape the RL experience.

Dominant Ideologies

Capitalism, Neoliberalism, and Liberal Feminism

Capitalism is an economic system based on free market exchange of goods and services, governed by a right to private property and private organizations (Vallier, 2022). Neoliberalism is a controversial and oft misconstrued term that is often conflated with capitalism (Flew, 2014; Vallier, 2022). Neoliberalism generally refers to a political philosophy that believes that "society's political and economic institutions should be robustly liberal and capitalist, but supplemented by a constitutionally limited democracy and a modest welfare state" (Vallier,

2022, p. 2). Neoliberalism centers a free and competitive market economy and resists social policy that may restrict this economy (Flew, 2014). Neoliberals argue that socialism, as an alternative philosophical ideology, is inefficient, generates social conflict, and dangerously concentrates power (Vallier, 2022). A key tenet of neoliberalism is democracy, including equal rights to vote for all people (Vallier, 2022). Sugarman (2015) argued that neoliberalism has proliferated globally to the extent that it is now virtually invisible and considered common sense.

Neoliberalism aims to transfer these values of equality and freedom to its understanding of feminism. Within neoliberalism, liberal feminism (so called feminism, sometimes called post-feminism) equates success with the equal and free opportunity for women to participate the capitalist economy (Arruzza et al., 2019). This *equal opportunity feminism* highlights players such as Facebook COO Sheryl Sandberg and U.S. democratic party presidential candidate Hilary Clinton who have cracked the glass ceiling and "leaned-in" (Sandberg, 2013) to climb corporate and political ladders (Arruzza et al., 2019). This view of feminism promotes a kind of false meritocracy wherein the goal for women is a high-profile career, entrepreneurship, and corporate leadership (Fraser, 2017 as cited in Vallier, 2022), although these positions are often only available to those who already have social, cultural, and economic privileges (Arruzza et al., 2019). Arruzza et al. (2019) criticized this view of feminism, arguing that it "refuses to address the socioeconomic constraints that make freedom and empowerment impossible for the large majority of women" (loc. 122-124). This is echoed in another criticism of neoliberalism that argues that increasing economic growth comes at the cost of increasing inequality (Vallier, 2022).

(Hetero)patriarchy and Pronatalism

It may be that this inequality is fundamental and necessary to the function of neoliberalism. Arruzza et al. (2019) argued that the institutional structures of capitalism "separate the making of people from the making of profit" (loc. 218) and value the making of people only as a means to the making of more profit. In this patriarchal system, the role of making profit is assigned to men, while the roles of making, raising, and caring for people are assigned to women (Arruzza et al., 2019). These neoliberal values may influence social and cultural messages about the value of motherhood and reproduction.

The *Encyclopedia of Motherhood* defines pronatalism as "the promotion of reproduction whether by direct policies, such as child subsidies, or indirect influence, such as cultural celebrations of motherhood and childbearing" (Lovett, 2010, p. 1029). Direct policies and indirect influences have historically taken many forms, from nationalist policies to baby bonuses, child tax exemptions, and the construction of family-friendly neighborhoods (Lovett, 2010). Pronatalism is historically associated with nationalism and racism, which are relevant topics in today's political discourse (Lovett, 2010). Lovett (2010) wrote that implicit and explicit social and cultural messages about gender roles and motherhood can influence women's beliefs about their responsibility to reproduce. Bajaj and Stade (2023) argued that pronatalist social and institutional pressure to bear children is widespread, oppressive, and destructive to women's lives. In this capstone, I demonstrate how pronatalism continues to be pervasive and coercive in popular media and culture, how it complicates the RL experience, and how it undermines reproductive autonomy (Bajaj & Stade, 2023). In following sections, I will discuss contemporary pronatalist popular social and political discourses that continue to "celebrate motherhood and childbearing" (Lovett, 2010, p. 1029) as well as morally condemn those who do not follow normative reproductive paths.

Meritocracy and Essentialism

Within capitalism and neoliberalism is the idea of meritocracy—that whomever has merit (is most qualified and has contributed the most) enjoys success and power (Mulligan, 2023). Related to RL, this culture of meritocracy is interpreted as whomever has the best health, self care, and self-discipline enjoys a successful pregnancy and if the pregnancy is not successful, then it must be that the individual lacked merit (Murphy, 2019). This constructs RL as a failure of the individual, contributing to feelings of guilt, shame, and self-blame following RL (Bajaj & Stade, 2023; Feasey, 2022; Murphy, 2019). Feminist anthropologist Linda Layne wrote extensively on RL experiences and argued that both biomedical obstetrics and the women's health movement promote the belief that positive pregnancy and childbirth outcomes are within medical and individual control (Layne, 2003).

Coupled with this meritocracy of motherhood is the idea of the essentialized mother (Murphy, 2019). The essentialized mother is constructed as instinctive, natural, intuitive, and ultimately feminine (Murphy, 2019). This idea suggests that pregnant mothers will have an instinctual knowledge if something is wrong with their pregnancy and seek help; those who do not seek help are seen as deficient or lacking in some aspect of their essential motherhood, and so less deserving of the merit of motherhood (Murphy, 2019).

These messages of merit, control, and essentialized motherhood in the contemporary neoliberal social-political-cultural context of RL complicate an experience that is "fundamentally uncontrollable and choiceless" (Martin, 2022, p. 10). Nonetheless, within a neoliberal and liberal feminist culture it is choice and freedom that young women value; in their discourse analysis of 30 women aged 18-26, Jacques and Radtke (2012) found that the women simultaneously privileged choice and freedom (i.e. neoliberal and liberal feminist values) in the role of wife and

mother (i.e. pronatalist gender role). Even when their analysis identified discourse that exposed gender inequality and injustice (e.g. the man making more money, the assumption that the woman would raise the children), women justified this as a woman's choice, echoing liberal feminist sentiments and demonstrating how neoliberalism has become pervasive and invisible "common sense" (Jacques & Radtke, 2012; Sugarman, 2015, p. 103). I interpret this conflict between the neoliberal values of individualism, personal freedom, and choice together with pronatalist priorities for childbearing and childrearing as a socially constructed gendered quagmire, which Jacques and Radtke (2012) called a "cultural contradiction" (p. 451). The young women in this study positioned themselves "as autonomous individuals making free choices" and "held themselves personally accountable for managing any challenges they faced in negotiating contradictions in their future" (Jacques & Radtke, 2012, p. 453); what happens when this accountability for managing challenges meets RL – a challenge often devoid of choice and control? In a neoliberal and pronatalist meritocratic culture, the essentialized mother is to blame for her failures of reproduction. This is what Jacques and Radke (2012) called "the power and the constraint of individualism" (p. 456)—that in our individual freedom to make personal choices, we also bear individual responsibility for the consequences of our choices, even if the choice was never really a choice at all. Neoliberalism's emphasis on choice, autonomy, and self-reliance degrades the reality that "individuals' predicaments are more than simply their individual choice" (Sugarman, 2015, p. 105). Sugarman (2015) continued to state that these individual predicaments outside of individual choice include access and availability of opportunities and factors related to personal identity and life circumstance; in the next section I will explore how these discriminatory factors within neoliberal society shape the RL experience.

Discrimination

Meghan Markle said that the experience of losing a child is "experienced by many" (The Duchess of Sussex, 2020, para. 17) and she was correct. RL is common—in Canada 15.7% of couples experience infertility, 15-25% of pregnancies end in miscarriage, 8.1 of 1000 total births end in stillbirth, and 5.4 of 1000 live births end in post-natal (infant) death in the first year (Canada, 2020). While RL is common in the general population, it is not the same experience for everybody. Identity and social location can shape both the likelihood of experiencing RL, the experience of RL itself, and the risk of mental health complications (Martin, 2022). Martin (2022) claimed that the media discourse portrays RL as a "great equalizer among women" (p. 12), although research suggests that race, ethnicity, gender identity, sexual orientation, and socio-economic status are factors in both how and if RL is experienced. Next, I will review research on the impact of discrimination based on race, sexual orientation, and gender identity on RL experiences.

Race and Racism

Racism, not race, contributes to increased risk of RL and discriminatory experiences of RL. It is important to distinguish between race and racism and their effect on RL; race is a socially constructed categorization of people, while racism is the discriminatory system that advantages or disadvantages people on the basis of perceived race (van Daalen et al., 2022). Systemic racism has been implicated in RL, with many studies reporting positive associations between racial discrimination and pre-term birth (van Daalen et al., 2022). A prime example of the impacts of systemic racism on RL in Canada is the ongoing birth evacuation policies for Indigenous women (Cidro et al., 2020). Since the 1800s, Indigenous women have been forced to travel out of their communities to receive colonialized and increasingly medicalized birthing care and these 'maternal evacuation' or 'birth evacuation' policies persist today (Cidro et al., 2020).

These policies move expectant women out of their communities, isolating them away from their families and into unfamiliar locations (Cidro et al., 2020). In Canada the fetal morality rate is 2-2.5 times higher for Indigenous women than the population average (Chalmers & Wen, 2004). Cidro et al. (2020) connected these discriminatory birth evacuation policies to "deleterious impacts on preterm births, birth weights, and infant and neonatal mortality" (p. 176).

In the U.S. in 2019, racialized women had higher abortion rates by racial group than White women: Black women reported 23.8 abortions per 1000 women, Hispanic women reported 11.7 abortions per 1000 women, and White women reported 6.6 abortions per 1000 women (Kortsmit, 2021). Canada does not record race with their data on induced abortions (Canadian Institute for Health Information, n.d.), making systemic discrimination on the basis of race with respect to abortion difficult to determine in Canada. The overturning of Roe v. Wade in the U.S. may amount to structural discrimination against women of color; Räsänen et al. (2022) stated that U.S. women of color will experience more deleterious effects of the abortion ban due to increased poverty, lack of healthcare, disparate health insurance coverage, higher rates of abortion, higher rates of infant mortality, and higher rates of adverse birth outcomes and they deduced that this amounts to indirect systemic racism.

Sex and Gender Discrimination in LGBTQ+ Populations

Though studies of RL in LGBTQ+ populations are limited, some research suggests that RL is experienced at higher rates in these populations than the general population (Everett et al., 2019; Riggs et al., 2020). Everett et al. (2019) analysed publicly available data in the U.S. to calculate RL rates (including stillbirth and miscarriage and excluding abortion and ectopic pregnancy) amongst women self-identifying as lesbian or bi-sexual and found that they reported significantly higher rates of miscarriage and stillbirth than heterosexual women. They proposed

that higher rates of discrimination in this population may contribute to these pregnancy outcomes (Everett et al., 2019). Similarly, Riggs et al. (2020) interviewed 51 trans-masculine and non-binary people who had been pregnant and identified 24 experiences of RL in the group, including early and late term losses and multiple losses. Riggs et al. (2020) did not statistically compare the rates RL from their study to rates in the general population, although 24 total losses in a sample of 51 equates to a loss rate of over 47% - much higher than the estimate for just miscarriages in the general population (15-25%).

Minority stress theory is proposed as an explanation for increased RL rates in LGBTQ+ populations (Lacombe-Duncan et al., 2022). Minority stress theory posits that social and cultural stigma and prejudice create chronic and cumulative stress for sexual and gender minority populations and that this increased stress contributes to higher prevalence of mental health problems in these populations (Meyer, 2003). Lacombe-Duncan et al. (2022) interviewed members of the LGBTQ+ community who had experienced RL directly or whose partner had experienced RL. While some experiences of RL stigma were similar to those of cis-gendered and heterosexual populations (self-blame, shame), these experiences of stigma were amplified due to fear of judgment related to their LGBTQ+ identity, creating complex intersectional experiences of stigma and shame (Lacombe-Duncan et al., 2022).

Popular Discourse

Popular discourse serves to construct and reinforce ideologies such as capitalism, neoliberalism, liberal feminism, and pronatalism that shape conceptions of motherhood, womanhood, personhood, and RL (Boyle, 2023; Martin, 2022; Rajabi, 2022). From a social constructionist perspective, I consider that the media plays a constructive role in not only reflecting but shaping society and culture and I ask the research question: *How does our*

contemporary socio-political-cultural context shape responses to RL? In the following sections I will review three contemporary areas of popular social discourse and critically analyze their role in constructing experiences and responses to RL. The three area of discourse that I will review are: online celebrity articles about RL experiences, the Hulu TV series *The Handmaid's Tale* (Miller, 2017), and ongoing political discourse on fetal life and reproductive justice in a post Roe v. Wade era.

Celebrity Articles, Decreasing Stigma, and Ongoing Neoliberal Rhetoric

Recent literature (e.g. Feasey, 2022; Martin, 2022; Rajabi, 2022) has analyzed celebrity articles about their experiences of RL, including Meghan Markle's *New York Times* article about her miscarriage (The Duchess of Sussex, 2020) and Christy Teigen's blog post about her abortion/stillbirth (Teigen, 2020). Celebrity articles have been recognized for raising public awareness of RL (Feasey, 2022) and this increased visibility and social recognition of RL has reduced shame, silence, self-blame, isolation, and disenfranchised grief amongst the many who experience RL (Feasey, 2022; Middlemiss & Kilshaw, 2023). Despite this increased awareness and visibility of RL, celebrity articles and related journalistic commentary continue to reinforce problematic rhetoric of neoliberalism, liberal feminism, pronatalism, and essentialized motherhood and dismiss the impact of systemic discrimination on RL experiences.

Martin (2022) used critical discourse analysis to study the social construction of the RL experience through multiple news articles spanning a one year period that included Christy Teigan's RL (Teigen, 2020). Martin (2022) identified the *cult of true motherhood*, rooted in heteropatriarchal and pronatalist ideals of essentialized motherhood. Media depictions of RL reinforce a woman's reliance on her husband for support, ideals of domestic and familial bliss, and a woman's essentialized power and purpose for reproduction (Martin, 2022). Feasey (2022)

analysed listicles (short-form articles) from 2018 wherein celebrities wrote openly about their RL experiences and summarized the articles as routinely presenting RL as "a back story to a successful pregnancy outcome" (p. 1), positioning motherhood as the only legitimate desired outcome and upholding Martin's (2022) *cult of true motherhood*.

Media messages echo and reinforce ideologies of meritocracy and essentialism, telling women that they are in control of their purity and therefore are to blame if the pregnancy ends: "I did all the right things during my pregnancy. I did not drink or smoke. I switched to decaf coffee. I read the baby books. I even changed to organic shampoo and conditioner. I did everything I could to keep my baby safe, and yet ultimately, I could not protect him" (Washington Post, Oct 2020, as cited by Martin, 2022). Liberal feminist desire for control extends to the miscarriage experience, "a fundamentally uncontrollable and choiceless experience" (Martin, 2022, p. 10), where sadness following miscarriage is relieved by the experience of regaining control, what Martin (2022) identified as a contrast to the common rhetoric of miscarriage as tragic.

While Feasey (2022) stated that RL "is a leveller within and beyond the celebrity arena" (p. 9), affecting people regardless of their identity, Martin (2022) disagreed. Martin (2022) argued that while media rhetoric may construct miscarriage as "a great equalizer among women" (p. 12), the reality is that race, class, and social position impact both the experience of RL and whether RL is experienced at all, as I have already demonstrated in a previous section. Martin (2022) critiqued this lack of media conversation about systemic inequality as neoliberal individualism, with the journalistic focus on the individual story rather than systemic discrimination or privilege of social position.

While Martin's (2022) focus was on journalistic representation of celebrity RL experiences, Rajabi (2023) examined public reactions to celebrity RL experiences in the form of

Twitter posts. Rajabi's (2023) contrasted public reactions to Christy Teigan's and Megan Markle's RL experiences with public reactions to Jesse J's RL experience. Teigan and Markle are both of mixed-race descent, and Jesse J is racially White. Rajabi (2023) observed that as non-White women, public responses to Teigan and Markle's RL experiences were interwoven with racial commentary, in what Rajabi calls the vitriolic "spoken/unspoken specter of race" (p. 11). Rajabi (2023) said that Markle's race and celebrity status were used to discursively ostracize her; a stark argument against Feasey's (2022) statement that RL "is a leveller within and beyond the celebrity arena" (p. 9).

Online celebrity articles about RL and journalistic and public responses to these articles and experiences continue to reinforce problematic rhetoric of neoliberalism, liberal feminism, pronatalism, and essentialized motherhood and fail to adequately address the realities of intersectional experiences of RL. While celebrity articles and online conversations have made progress in increasing the visibility and reducing the shame and isolation of RL, they continue to construct narratives that reduce women's purpose to reproduction and individualize both their choice and responsibility for loss in ways that do not acknowledge systemic inequities and the often-inherent choiceless nature of RL.

Hulu's *The Handmaid's Tale*, Domestic Feminism, and Idealized Motherhood

While lauded as a feminist television series promoting women's and reproductive rights, Hulu's *The Handmaid's Tale* (Miller, 2017) covertly reinforces neoliberal and pronatalist values and constructs the idealized and essentialized mother as White, middle class, and cis-heteronormative (Boyle, 2023). Boyle (2023) argued that Hulu's *The Handmaid's Tale* (Miller, 2017) increasingly promotes so-called *domestic feminism* over its five seasons, wherein it emphasizes women's roles as wives and mothers and idealizes marriage, family, and

motherhood. As the main character, June's mission from the first episode is to fight against Gilead's forcible destruction of her nuclear family and to survive for the sake of her daughter Hannah first (role of mother), her husband Luke second (role of wife), and for herself last (Boyle, 2023). Boyle (2023) contrasts Hulu's presentation of this scene as June's desire to survive for the sake of her family and her role as mother with Margaret Atwood's (1985) original representation as June's intention "to last" (Atwood, 1985, p. 8) "as a human being without qualification" (Boyle, 2023, p. 5). This narrative highlights June's role as wife and mother, reinforcing pronatalist values and misconstruing her fight for freedom from Gilead's control as feminism, while her choice is still that of wife and mother. Jacques and Radtke (2012) wrote that "neoliberal discourses of individualism and choice serve to support rather than undermine women's traditional mandate" (p. 458). From a neoliberal and liberal feminist perspective, June's fight for freedom is her fight for her ability to choose to be wife and mother, although in the series narrative, that domestic story is still central; hence, *domestic feminism* – "a tactical employment and subversion of feminist rhetoric for regressive purposes" (Boyle, 2023, p. 9). This echoes Jacques and Radtke's (2012) research with young women who centralized traditional and conservative gender roles, positioning these roles as acceptable so long as they were chosen.

Beyond centralizing domestic feminism, Hulu's *The Handmaid's Tale* (Miller, 2017) also constructs the idealized mother as White and cis-heteronormative (Boyle, 2023). Boyle (2023) noted that the TV series highlights utopic and nostalgic images of maternal bliss between June, her daughter, and her husband, painting warm fantasy images of middle-class, cis-heteronormative familial bliss. Birth scenes romanticize and glamourize motherhood as the path to fulfillment, idealizing motherhood and, Boyle (2023) argued, White motherhood. Boyle

(2023) points out that birth and motherhood stories of black characters are not granted the same rosy utopian view, underrepresenting black motherhood and valorizing White motherhood as pure and ideal and black motherhood as tragic and largely absent from the story. This reflects Rajabi's (2023) observation that racialized celebrity mothers experience more discursive ostracism and vitriol in online commentary about their RL experiences.

These representations of women and motherhood in the contemporary Hulu version of *The Handmaid's Tale* (Miller, 2017) serve to reinforce societal messages of pronatalism, women's identity as mothers, and essentialized motherhood. Women receive the message that their innate purpose is to birth children and aspire to an idealized (White, heterosexual, nuclear) family life and that birth and family are utopian and blissful. These messages – social constructions – contrast with real-word experiences wherein not all women are White and heterosexual, not all families are nuclear, not all women want children, not all people who want children are women, not all births are blissful, and family life is not utopian. These contrasts create a jarring internal conflict for people who find themselves in RL experiences that shatter assumptive worlds that are internalized versions of these social constructions. Layne's (2003) seminal work purposely told vivid "reproductive horror stories" (p. 1884) of birth gone awry to counter these constructions, stating that "even for middle-class, White, married women who get good prenatal care, conscientiously take their vitamins, eat well, and abstain from cigarettes, alcohol, and caffeine-birth does not always work out as hoped or expected" (p. 1883). Similarly, Bajaj and Stade (2023) argued that stories of people who regret having children are absent from cultural narratives. Ongoing popular media such as Hulu's *The Handmaid's Tale* (Miller, 2017) uphold pronatalism and the essentialized mother, erasing the counter stories of horrific birth,

tragic endings, and childless-by-choice women. This moral crime – to not want children – is central to the abortion debate which I will explore next.

The Post-Roe v. Wade Era

In 2022, the U.S. Supreme Court reversed *Roe v. Wade*, the constitutional right to abortion for Americans (Totenberg & McCammon, 2022). Broad abortion bans in many U.S. states have led to women being denied abortions in cases of medical emergencies (Sherman, 2023). Vague non-medical political language has led to ambiguity as to what is considered an abortion and prevented doctors from providing medical care because of fears of litigation (Sherman, 2023). Social constructionism considers that language plays a key role in structuring experiences of the world (Burr, 2015). The language of abortion in the U.S. is ambiguous, lacks consensus, and is rapidly changing. Discursively, there appears to be a moral rather than medical distinction in the linguistic use of *abortion* and *miscarriage*; women may label their RL an abortion if a child was not wanted, while they may label it a miscarriage when the child is wanted (or they don't want to admit the moral fault of not wanting a child), regardless of the medical means of termination (Noor, 2022). For example, Christy Teigan struggled to define her RL as an abortion or a miscarriage, passively accepting media reports of the loss as a miscarriage, but realizing later that according to medical definition it was an abortion for maternal health reasons, which would now be illegal in many U.S. states (Donley & Lens, 2022; Sherman, 2023). Rushton (2023) wrote that, "there are mothers and then there are women who have abortions" (para. 1). Labelling a loss as a miscarriage rather than an abortion may be an agential choice for some women to bring more legitimacy for their grief and to their desired role as mother; women can feel that their grief is less justified in the case of abortion and hesitate to label terminations for medical reasons as abortions because they fear moral judgement

(Middlemiss & Kilshaw, 2023). Thus, the word *abortion* as it is used discursively implies the moral crime of not wanting a child, an unspeakable truth in a pronatalist society.

This section has described the cultural, social, and political contextual stage on which RL is experienced, including the dominant neoliberal ideologies, systemic discrimination, and popular discourse that continues to set this stage. The following section will consider this context in its review of the experience of RL.

The Experience of Reproductive Loss

In the following sections, I thematically review literature related to the experience of RL and relate this to the contemporary neoliberal socio-political-cultural context I explored in the previous section. Themes include: a lack of cultural understanding and validation; internalized guilt and shame; assumptive worlds, reproductive stories, and identity confusion; reproductive stress and trauma; mental health complications; and fetal personhood and social birth.

Lack of Cultural Understanding and Validation

Celebrity RL stories such as Megan Markle's and Christy Teigan's have contributed to an increase in public visibility and social recognition of RL (Feasey, 2022; Middlemiss & Kilshaw, 2023). While this increased visibility and social recognition may serve to decrease the stigma of RL, there is still a general lack of understanding and support for many RL experiences, including a lack of cultural scripts for grief and hierarchies of loss that delegitimize the grief for some categories of loss.

The lack of cultural scripts related to how to grieve the loss of a pregnancy or ability to reproduce is often acknowledged in the literature (e.g., Andipatin et al., 2019; Littlemore & Turner, 2020). Cultural scripts define behavioural norms and rituals for grief and bereavement, such as memorial services, offering of condolences, and displays of emotion (Andipatin et al.,

2019; Littlemore & Turner, 2020). The ambiguity over *what* is lost in the case of RL (pregnancy, person, role as parent, hope, dream) contributes to the ambiguity over culturally appropriate and acceptable ways to grieve the loss. Parents of a stillborn infant may be offered photos, handprints, and an opportunity to cuddle and wash their baby (Lafarge et al., 2019; Littlemore & Turner, 2020); however, Western cultures have few culturally accepted grief rituals for RL, especially if what is lost does not include a body that can be washed and cuddled (Kuberska & Turner, 2019). Japanese Buddhist cultures use a memorial service called *Mizuko kuyo* to bring meaning and connection to lost fetuses; no comparable generally- and widely- accepted ritual exists in the West (Senda, 2021). Disenfranchised grief is experienced when a person's loss is "not openly acknowledged, socially sanctioned, or publicly mourned" (Doka, 2009, p. 2). Because of the ambiguous nature of what is lost in RL and lack of cultural scripts related to these ambiguous losses, the grief of RL may be experienced as disenfranchised grief.

Different categories of RL are granted more social legitimacy than others (Middlemiss & Kilshaw, 2023). Robson and Walker (2013, as cited in Middlemiss & Kilshaw, 2023) defined the concept of *hierarchies of loss* "in which social norms define which deaths it is legitimate to grieve, to what degree, in relation to those who are bereaved" (p. 3). In a biomedical context, miscarriages are constructed as routine or normal, effectively delegitimizing grief responses to miscarriages (Andipatin et al., 2019). Middlemiss and Kilshaw (2023) confirmed this socially imposed hierarchy of loss based on gestational age in their ethnographic research of women's experiences of RL; one woman called this hierarchization of loss based on gestational age "a competition as to who's had the worst heartache" (Tamsin, as cited in Middlemiss & Kilshaw, 2019, p. 6). Within these hierarchies, grief responses following later gestational age losses (e.g. stillbirth) are granted more social legitimacy than grief responses following earlier gestational

age losses (e.g. early miscarriage) (Middlemiss & Kilshaw, 2023). Medical, legal, and social conceptualizations of personhood may contribute to perceptions of what was lost – a fetus, a pregnancy, or a baby person (Middlemiss & Kilshaw, 2019) and the social legitimacy granted to the responses to loss. It may be that mismatches between these social perceptions of what was lost and personal experiences of what was lost contribute to the experience disenfranchised grief.

Internalized Guilt and Shame

Guilt is a common, real, and complex reaction to RL that requires recognition and validation:

> When I tell you that I feel guilty for not saving my baby, I'm stating a fact…I feel guilt. I will always have ten million what if's (sic) crowding my head because my baby died… . When you shut this down, you tell me that I can't talk to you about the heaviest and ugliest parts of grief. . . Don't try to fix me. Love me even though I can't always love myself (Grief_Club, 2022 as cited in Rajabi, 2023, p. 8).

This guilt may be helpful or unhelpful and both types can be understood as psychological discomfort; helpful guilt is related to "something we've done that is objectively wrong," while unhelpful guilt is related to "something we've done against our unrealistically high standards" (nicabm, 2017, para. 8). Previous sections have examined how liberal feminism, the meritocracy of motherhood, and the ideal of the essentialized mother individualize blame for RL, which may contribute to feelings of guilt related to misperceived and misrepresented unrealistically high standards for reproduction.

While guilt may be related to a sense that we've done something wrong, shame is an intensely painful feeling that we are fundamentally flawed (nicabm, 2017). Shame is a social emotion and as such social and cultural influences are key to its construction (Facchin et al.,

2021). Murphy (2019) argued that essentialized motherhood shames and stigmatizes women who experience RL because it suggests that they are somehow either not worthy or not capable of motherhood; that is, fundamentally flawed as a woman. One woman said:

> I think I was sort of ashamed to tell other people that I hadn't, um, I had failed, you see. I had, had failed again. I guess it's that failure thing, I'd failed to produce a baby and I'd failed to notice when the baby was in distress (Grace, as cited by Murphy, 2019, p. 19).

The lack of cultural scripts related to RL may also contribute to feelings of guilt and shame. When people experience grief that they believe is culturally inappropriate or unsanctioned, they may repress it and convert it to feelings of shame (Doka, 2009).

Reproduction, like death, lies at the cusp of life. Layne (2002) described the contrasting and confusing complexities of RL:

> Dead newborns combine the potency of women's life-giving power with the destructive, polluting power of life-forces gone awry; thus it is not surprising that such entities should be subject to taboo. Dead embryos or newborns are an unwelcome reminder of the fragility of the boundary between order and chaos, life and death (p. 65).

Despite what biomedical discourses, meritocracy, essentialism, and liberal feminism may lead us to believe, we cannot always control the outcomes of reproduction, pregnancy, and childbirth and often there is no apparent explanation or reason for a loss (Andipatin et al., 2019; Layne, 2003). Neoliberalism may be based on freedom and equal rights, but it is a mistake to assume that women's ability to choose can be equated with power to control the subtle mysteries of life and death. Discourses that valorize and essentialize motherhood, such as Hulu's *The Handmaid's Tale* (Miller, 2017) and celebrity stories that portray RL as a step on the normative path to motherhood continue to equate a woman's worth with reproduction (Boyle, 2023; Martin, 2022).

When reproduction does not proceed down the normative path, women may struggle with feelings of unworthiness.

Loss of Assumptive Worlds and Identity Confusion

A person's assumptive world is their set of fundamental beliefs about "how the world works and how others and one's self are viewed" that gives a sense of safety and security (Harris & Winokuer, 2021, p. 23). RL is understood to shatter this assumptive world, particularly fundamental core beliefs related to pregnancy, childbearing, and motherhood (Freedle & Kashubeck-West, 2021; Wenzel, 2017). A person's assumptive world about pregnancy, childbearing, and motherhood may also be called their *reproductive story* (Jaffe, 2017). Jaffe (2017) argued that everyone has a reproductive story and it is part of our self-narrative; our internal story about who we are and our expectations for life. The story may be linear and heteronormative: marry a person of the opposite sex, get pregnant, and have a certain number of children. The story may be that the person does not want children. The story may be that biological children are the preferred option. Another story may be that they support abortion, but they would never have one themselves (Lindemann, 2009). The reproductive stories we tell ourselves about our identities as parents and who our children will (or won't) be are largely unconscious, bound in culture, and usually begin to develop in childhood (Jaffe, 2017). These stories are also continually shaped by the ongoing social discourse, such as celebrity stories that seem to say that miscarriage is a mere bump on the road to the desired outcome of motherhood (Feasey, 2022). Layne (2003) wrote that both biomedical stories and natural birth stories focus on happy endings and in her influential work, oft cited in literature on RL (e.g. Feasey, 2022; Lacombe-Duncan et al., 2022; Martin, 2022; Murphy, 2019; Rajabi, 2022), she told stories of

tragedy and loss in an effort to counter and reconstruct the "happy ending" narrative of pregnancy, childbirth, and motherhood.

Western culture intertwines understandings of womanhood, motherhood, femininity, and pregnancy (Besse et al., 2020; Walks, 2015). For many cis-gendered women, the role of motherhood is an important aspect of their identity as a woman and some research has suggested that RL (in desired pregnancies) may, at least temporarily, increase the importance of the identity of mother and role of motherhood (Erato et al., 2022). Trans-gendered pregnant men can struggle with lack of social recognition that pregnancy can be a masculine experience and some may experience increases in gender dysphoria while pregnant (Murray et al., 2017; Walks, 2015). RL can include the intangible loss of the role of motherhood, which some may conflate as a loss of womanhood, following the socio-political-cultural pronatalist and patriarchal messages that reinforce the importance of motherhood as the most important gender role for women (Bajaj & Stade, 2023; Lovett, 2010). RL can introduce these internal conflicts of identity and gender role within a shattered assumptive world and challenged reproductive story.

Reproductive Stress and Trauma

RL is commonly acknowledged as a stressful life experience (Cuenca, 2023; Faramarzi et al., 2013). Recurrent pregnancy loss, unintended pregnancies, and infertility may be particularly stressful (Bhat & Byatt, 2016; Cuenca, 2023). Stress increases cortisol, which increases the risk of developing major depressive disorder (MDD; Kennis et al., 2020). Stress has also been associated with poorer health outcomes for mother and child, such as preterm labour and low birth weight (Cuenca, 2023; van Daalen et al., 2022).

Feasey (2022) noted that celebrity listicles continue to implicate stress as a contributing factor to RL, upholding liberal feminist and meritocratic ideas that the woman is in control of,

and therefore responsible for, her loss. It may be that it is systemic rather than individual factors that exacerbate stress for pregnant people; van Dallen et al. (2022) implicated systemic racism as the source of this stress for racialized pregnant people and Lacombe-Duncan et al. (2022) blamed minority stress for poorer pregnancy outcomes in pregnant LGBTQ+ people.

For many, the experience of RL itself is stressful and this may compound with other sources of individual, systemic, and/or minority stresses, putting parents at risk of developing depression, anxiety, and other mental health disorders (Boulet et al., 2017; Cuenca, 2023; Daugirdaite et al., 2015; deMontigny et al., 2020; Hanschmidt et al., 2018; Kersting & Wagner, 2012) . Some argue that describing RL as 'stressful' minimizes the experience and it should instead be labelled *reproductive trauma* (Brigance et al., 2023; Jaffe, 2017; Jaffe & Diamond, 2011). This controversy over RL as trauma is also related to the academic debate over what trauma is; the DSM-5-TR defines trauma as an exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2022), while others take a broader definition that "an event is traumatic if it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (Briere & Scott, 2015, p. 10). Brigance et al. (2023) argued that RL, while it may fall outside the DSM-5-TR definition of trauma, is nevertheless an adverse life event that may cause posttraumatic stress symptoms and women who experience RL often label it a traumatic event (Freedle & Kashubeck-West, 2021). It may be helpful to differentiate the event, which may or may not be characterized as trauma, from the individual response, which may sometimes characterize a post-traumatic stress response. I will next examine two related mental health complications of RL: prolonged grief disorder and post-traumatic stress disorder.

Mental Health Complications

Prolonged Grief Disorder (PGD), also called complicated grief (CG), persistent complex bereavement disorder (PCBD), or traumatic grief (TG), is characterized in the DSM-5-TR as distress that persists beyond 12 months of a loss, intense yearning/longing, preoccupation, and at least three of the following symptoms: identity disruption, disbelief, avoidance of reminders, intense emotional pain, difficulty reintegrating into normal life, emotional numbness, meaninglessness, and loneliness (American Psychiatric Association, 2022; Harris & Winokuer, 2021). Although research is limited, two studies have estimated that 15-25% of women who experience RL may have ongoing mental health problems (anxiety, depression, PTSD) which may suggest ongoing PGD (Farren et al., 2016; Grauerholz et al., 2021).

The Perinatal Grief Scale (PGS; see Appendix) is a reliable and validated 33-item scale that measures reactions to RL, including "depression, anger, social functioning, spirituality, desire for counseling, loss of control, and guilt" (Setubal et al., 2021, p. 248). Higher scores on the "Difficulty Coping" and "Despair" subscales are predictors of PGD (Setubal et al., 2021). Goldstein et al. (2019) studied PGD in mothers whose infants died suddenly and found that pre-loss risk factors of anxiety, depression, alcohol use, other children at home, and previous child loss predicted PGD. While more research is needed, these risk factors may also extend to the development of PGD for other forms of RL. PGD is associated with physical health risks, increased substance use, reduced quality of life, and suicidality, thus prevention and treatment are important considerations for counsellors (Grauerholz et al., 2021; Harris & Winokuer, 2021).

Research has found that meaning-making mediates the development of PGD and that those who struggle to make meaning of their loss may experience more symptoms of PGD if they also have higher levels of rumination (Milman et al., 2019). This suggests that interventions that focus on meaning-making and reducing rumination may prevent the development of PGD

following RL. Freedle et al. (2021) differentiated intrusive rumination from deliberate rumination and suggested that high levels of intrusive rumination prevent post-traumatic growth, while deliberate rumination (which may also be facilitated by intrusive rumination) may play a constructive role in meaning making and post-traumatic growth. Like the importance of meaning-making, integration of the loss into personal narrative may be key to preventing the development of PGD. Hasson-Ohayan et al. (2017) studied the association between dissociation and the development of PGD for many types of losses, not only RL. They argued that integration of a loss into a personal narrative is an important element of grieving and that dissociation can interfere with this integration, risking both PGD and PTSD symptoms (Hasson-Ohayon et al., 2017). They found that losses due to non-natural causes were associated with less integration and more symptoms of PGD and that closeness to the deceased and length of time since the loss made no difference to integration or PGD symptoms (Hasson-Ohayon et al., 2017). Extrapolating these results to the RL experience, RL that deviates from socially constructed normative expectations of the course of reproduction and pregnancy may be perceived as "non-natural," with relationship/attachment to what was lost, the length of gestation, and time since the loss being less relevant to the integration of the loss. This finding contrasts the socio-political-cultural hierarchization of later-gestation losses (Middlemiss & Kilshaw, 2023); it is not how close the fetus was to viable birth nor the parents' or others' relationship to what was lost that predicts PGD, but the unnatural, inconceivable, incomprehensible nature of the loss itself that can risk development of PGD; more research is needed to study these risks. Hasson-Ohayon et al. (2017) suggested that therapists should assess for dissociative symptoms and consider treating these symptoms as well as focusing on treatments that facilitate integration of the loss into personal narrative.

The DSM-5-TR characterizes PTSD as an exposure to actual or threatened death or serious injury with intrusive, cognitive, mood, and behavioural symptoms persisting for more than one month and significantly impairing functioning (American Psychiatric Association, 2022). Intrusive symptoms must include one or more of the following: recurrent and intrusive memories, recurrent distressing dreams, dissociative reactions, intense or prolonged psychological distress, and marked physiological reactions to reminders of the traumatic event (American Psychiatric Association, 2022). Cognitive and mood symptoms include two or more of the following experiences: dissociative amnesia, negative beliefs, distorted cognitions about cause of consequences of the traumatic event (self-blame), negative emotionality, diminished interest in activities, detachment, and inability to experience positive emotions (American Psychiatric Association, 2022). Behavioural symptoms include two of more of the following: irritability/angry outbursts, self-destructive behaviours, hypervigilance, exaggerated startle response, problems concentrating, and sleep disturbances (American Psychiatric Association, 2022).

There is a strong positive longitudinal association between PGD and PTSD (Glad et al., 2022). PTSD symptoms may predict later PGD, although evidence is inconsistent and may be related to the nature and exposure to the traumatic event (Glad et al., 2022). I explored the conceptualization of RL as a traumatic event in a previous section. Brigance et al. (2023) used the PCL-V, a scale to assess for symptoms of post-traumatic stress, to measure PTSD symptoms in 281 participants who had experienced RL and compared to normative group. They found that 46% of their RL participants met the criteria for a provisional diagnosis of PTSD, compared to 24% in their control (normative group) (Brigance et al., 2023). Importantly, they found higher PTSD symptoms compared to the normative group for all types of RL except for single

miscarriages and significantly higher for fetal distress during pregnancy, premature birth, and stillbirth (Brigance et al., 2023).

Feelings of disenfranchised grief, guilt, and shame and the incongruence they create between one's internal experience and the social (in)validation offered may be related to PTSD symptoms. Perceived ostracism was found to be associated with higher PTSD symptoms in a population of 97 cisgendered women who had experienced an average of 1.54 miscarriages (Wesselmann & Parris, 2022). Wesselmann and Parris (2022) suggested that mental health practitioners should consider the effects of social ostracism for women experiencing distress following RL and that more research is needed on the relationship between experiences of ostracism, disenfranchised grief, and PGD.

Fetal Personhood and Social Birth

When a fetus becomes a person with moral value is central to the abortion debate (Donley & Lens, 2022; Stoyles, 2015). This debate has a precarious relationship with acknowledgment of pregnancy loss, as some consider an acknowledgement that something/someone was lost akin to an acknowledgement that fetal personhood begins with the first heartbeat (Donley & Lens, 2022). Current law in Canada defines personhood as beginning with live birth (Government of Canada, 2023). Canada does not have any specific abortion law and provinces and territories are responsible for regulating gestational limits and access to abortions (National Abortion Federation (NAF) Canada, n.d.).

There are varied perspectives on when moral personhood begins, though despite the legal and moral ambiguity, many women who experience miscarriage or stillbirth believe that what was lost was a person (Freedle & Kashubeck-West, 2021). From a biomedical perspective, personhood may be considered to begin at *biological birth* when a baby's body becomes separate

from its mother through birth (Andipatin et al., 2019). *Social birth* is more nuanced and individual and is distinct from biological birth (Andipatin et al., 2019). This adds more nuance to the argument that acknowledging the grief of RL is "a slippery slope to fetal personhood" (Donley & Lens, 2022, p. 1654) and creates space to acknowledge the complexities of grief in the RL experience.

Lindemann (2009) introduced the social activity of *calling the fetus into personhood* and Stoyles (2015) extended this to include the social activity of *calling a person into parenthood*. These social activities occur over time between the parents and the growing fetus throughout the pregnancy and involve the social and relational process of becoming son, daughter, mother, and father; of relating to the growing life with "intentions, emotions, beliefs, attitudes, and other manifestations of personality" (Lindemann, 2009, p. 45). These highly personal processes may develop with gestational age and may have begun to develop pre-conception or even in the early life of the parent-to-be (Jaffe, 2017; Stoyles, 2015). Thus, the creation of these bonds between parent(s) and child(ren) is highly personal and, most importantly, *real* to those who experience them, even though the outside world may fail to recognize them due to lack of physical evidence of life or experienced relationship (Littlemore & Turner, 2020). The loss of these in-vitro relationships to fetus and to self represent significant intangible losses.

While medicine may define biological birth (Andipatin et al., 2019) and the law may define legal personhood (Government of Canada, 2023), only a person in relationship to another can determine their social birth. It is the conflation of biological birth, legal personhood, and social birth that complicates, confuses, hierarchizes, and silences individual experiences of RL. Social birth occurs through ongoing relational and social processes of *calling a fetus into personhood* (Stoyles, 2015). While a lack of cultural scripts has historically limited social

recognition of certain types of RL (Andipatin et al., 2019; Littlemore & Turner, 2020), the activity of social birthing may be a creative and healing opportunity for agency, meaning making, and integration of a RL.

Established and Emerging Counselling Approaches

With awareness of the contemporary neoliberal socio-political-cultural context of RL and how they influence the complex experiences of RL, how can counsellors work with this population? The previous section has suggested that counsellors should assess for dissociation and distress, address feelings of disenfranchised grief, guilt, shame, and identity confusion, encourage social supports to counter ostracism, and facilitate meaning-making and integration of the RL experience into a client's narrative. In the following section I will review cognitive-behavioural, narrative, eye-movement desensitization and reprocessing (EMDR), somatic, and internal family systems (IFS) approaches to RL.

Reframing Beliefs: Cognitive Behaviour Therapy

Cognitive behavior therapy (CBT) evolved from Aaron Beck's cognitive therapy and Albert Ellis' rational emotional behavior therapy and its theoretical basis extends into second-wave approaches that include dialectical behavioural therapy (DBT) and acceptance and commitment therapy (ACT) (Beck, 2021; Hofmann et al., 2012). CBT is based on the premise that thoughts, emotions, and behaviours are strongly linked to each other, are evoked through environmental situations or events, and are shaped by people's core beliefs about the self, the world, and others (Beck, 2021; Wenzel, 2017). CBT uses cognitive and behavioural approaches to promote deliberate rumination, meaning making, and the assimilation of changes to one's assumptive world into their cognitive schemas (Freedle & Kashubeck-West, 2021; Wenzel, 2017).

When working with people who have experienced RL, unhelpful core beliefs may include both those shaped through formative experiences (e.g., "I'm unworthy") and those related to pregnancy, childbearing, and motherhood (Wenzel, 2017). I have already explored the contemporary neoliberal socio-political-cultural context that may influence core beliefs related to pregnancy, childbearing, and motherhood. In addition to these contextually-influenced beliefs, Wenzel (2017) notes that RL may also activate "more general beliefs about worthiness (vs. unworthiness), deservingness (vs. undeservingness), and competence (vs. incompetence)" (p. 401). Cognitive restructuring teaches people to identify their negative thoughts and beliefs, to assess their accuracy, and moderate them (Wenzel, 2017). In a RL context, these negative thoughts and beliefs may follow three main patterns: (1) excessive guilt and misplaced responsibility for the loss, (2) beliefs of defectiveness or failure, and (3) beliefs of social stigma due to the loss (Wenzel, 2017). Freedle et al. (2021) suggested that counsellors should explore these types of intrusive and negative thoughts and beliefs, normalize the experience, and work to promote the type of deliberate rumination that is associated with post-traumatic growth. Wenzel (2017) suggested gentle, validating, and compassionate questioning to challenge these negative thoughts and beliefs about RL, as well as behavioural activation and acceptance strategies to prevent depression and promote healing.

Reauthoring the Reproductive Story: Narrative Therapy

Narrative therapy considers that social "discourses powerfully shape a person's choices about what life events can be storied and how they should be storied" (Freedman & Combs, 1996, p. 43) and seeks to expand personal choice through expanding people's stories about their realities (Freedman & Combs, 1996). Narrative therapy utilizes a not-knowing, non-pathologizing, listening stance that works to externalize the problem from the person and help

the person to actively reconstruct and shape their life narratives (Freedman & Combs, 1996). I have demonstrated how internalized social discourses about mothers, motherhood, pregnancy, and RL can contribute to feelings of disenfranchised grief, guilt, shame, stress, and trauma. Narrative therapy posits that "problems develop when people internalize conversations that restrain them to a narrow description of self" (Adams-Westcott, Dafforn, and Sterne, 1993 as cited in Freedman & Combs, 1996, p. 48). Thus, the therapeutic work from this narrative perspective is to externalize these conversations and to open new understandings and relationships to self.

Narrative treatment approaches to RL help people to regain choice and control through editing their own reproductive story (Jaffe, 2017). People may enter counselling with problem-saturated reproductive stories that include internalized socio-cultural discourses about the RL experience (Romney et al., 2021). Romney et al. (2021) proposed that a narrative approach to RL may include the following activities: inviting people to share their story, externalizing the problems, finding unique outcomes, and solidifying new possibilities and change. Inviting people to share their story not only facilitates the beginning of a narrative reconstruction, it brings voice and witness to grief that is often internalized, silenced, and kept secret (Romney et al., 2021). A key tenet of narrative therapy is that *the person is not the problem, the problem is the problem* (Freedman & Combs, 1996); externalizing the problems (e.g. guilt, shame) outside of the person using techniques such as *relative influence questioning* and *mapping the influence* may help to free people from the personal responsibility they feel for these problems (Romney et al., 2021). To find unique outcomes, counsellors can help people to seek exceptions to the problem narratives and magnify them to highlight narratives of strength and resistance, which can be used

to uncover new possibilities, solidify change, and support meaning-making (Romney et al., 2021).

Reclaiming Body and Self: Emerging Trauma-focused Therapies

I will now outline three emerging trauma-focused therapies that may be useful in treating reproductive trauma and adverse experiences of RL, including EMDR, somatic therapy, and IFS.

There is growing evidence for the use of EMDR for integration of adverse life experiences and traumatic experiences, including for PTSD (Wilson et al., 2018). EMDR unblocks processing of traumatic and adverse memories , reprocesses them, and restores them in a safe therapeutic context (Vucina & Oakley, 2018). Wilson et al. (2018) identified a total of six meta-analytic reviews and randomly-controlled trials studying the efficacy of EMDR on PTSD symptoms and found that EMDR is significantly effective cross-culturally and comparatively to other approaches and control groups (CBT, relaxation therapies, wait lists). EDMR has been applied for women with traumatic birth experiences (Kranenburg et al., 2022; Pašali & Hasanoviü, 2018) and one case study reports its use for reproductive trauma (Vucina & Oakley, 2018).

Somatic therapy attends to dissociation and disconnection of body and mind that may happen following traumatic experiences (Shapiro, 2020). RL can involve blood, intense pain, cramping, contractions, invasive medical procedures, diarrhea, vomiting, lactation, and risk to life of the parent (Benson et al., 2021; Hassan & Holmes, 2023; Kuberska & Turner, 2019). Norwood and Boulton (2021) called this the “uniquely corporeal experience of perinatal death” (p. 1). As a means of coping with the pain, confusion, and guilt, some women may distance and separate body from self and place responsibility and blame for the loss on the separate body: “my body had failed me totally” (WP4-T7-M-6, as cited in Littlemore & Turner, 2020). This

separation from body to cope with an overwhelming experience may be understood as a dissociative response, and this aligns with definitions of RL as trauma (Briere & Scott, 2015; Jaffe, 2017; Shapiro, 2020). Shapiro (2020) explained that embodiment – the cohesive experiencing of thoughts, feelings, actions, and intentions throughout the body – is the opposite of dissociation. Thus, reconnection to body following RL may be achieved through somatic-based therapies that seek to repair and integrate traumatic experiences throughout the mind and body (Shapiro, 2020).

While there is little direct research on somatic approaches to RL, some indirect research suggests that somatic embodiment approaches may be helpful. Littlemore and Turner (2020) wrote about healthcare practices that allow parents to cuddle and wash stillborn babies. Others may tattoo their body as a way of "putting [the baby] on my body" (WP4-T10-FA-2, as cited in Littlemore and Turner, 2020, p. 8). A yearning for the weight of an infant may be satisfied with a blanket cuddled to the chest (Norwood & Boulton, 2021). These somatic exercises may support an embodied relationship with the lost baby. To address a woman's relationship to her own body, somatic exercises that support a reintegration of mind and body such as breathwork, body scans, and yoga may be helpful (Shapiro, 2020). Somatic approaches are relevant to the corporeal and traumatic nature of the experience of RL, although more research is needed in this specific population.

Richard C. Schwartz originally developed IFS in the 1980s to work with a person's internal *parts* in a similar way to how a family systems therapist would work with members of a family (Anderson et al., 2017). IFS aims to find and befriend different internal parts that work in sometimes extreme ways to protect other wounded, vulnerable, and exiled parts of self (Anderson et al., 2017). With a goal to embody Self-energy (capitalization intended; see

Schwartz, 2021, pp. 22-23), having qualities of curiosity, calm, clarity, connectedness, courage, creativity, and compassion, IFS heals internal wounds using the client's own internal resources (Anderson et al., 2017). IFS has emerged as a trauma-informed treatment for PTSD and has broad application to many other mental health disorders (Anderson et al., 2017).

I have explored the social-cultural influence of neoliberalism, (hetero)patriarchy, pronatalism, racism, and systemic discrimination on the RL experience. IFS conceptualizes the dominant cultural and social narratives driven by racism, patriarchy, individualism, and materialism as *legacy burdens* that can be taken on by internal parts (Schwartz, 2021). RL responses such as guilt, shame, grief may be conceptualized as many other parts that would each be worked with in turn. The IFS approach uses the *6 Fs* (**F**ind, **F**ocus, **F**lesh-out, **F**eel, be**f**riend, and **F**ears) to identify and differentiate each of these parts (Anderson et al., 2017). IFS addresses potential dissociative responses to reproductive trauma through *unblending* and *unburdening*; that is, bringing each part to a state where it is present, separate, and accessible but not dominant and no longer required to carry painful or legacy burdens (Anderson et al., 2017).

There is limited quantitative research or meta-analyses that examines the effectiveness of IFS and virtually no academic research on the use of IFS for RL. Nonetheless, IFS is a popular contemporary clinical approach, with demand for IFS training consistently exceeding supply (IFS Institute, n.d.). Specialized training is available that focuses on IFS applications for perinatal populations (Canadian Perinatal Mental Health Trainings, 2016). EMDR, somatic therapy, and IFS have been used together as integrative trauma-focused treatments (e.g., Brown, 2020; McConnell, 2020).

Critique of Counselling Approaches

CBT and narrative approaches to RL are the most well represented in the literature. CBT focuses on addressing unhelpful thoughts and beliefs related to guilt, shame, and stigma to due the lack of cultural understanding and validation for RL. CBT acknowledges excessive guilt and misplaced responsibility, although it focuses on the individual's own role in misplacing the responsibility for the loss on themselves rather than identifying culture and society's role in placing blame and responsibility on the individual (Prochaska & Norcross, 2014; Wenzel, 2017). CBT's focus on individual beliefs, thoughts, and feelings may not fit well within cultural and feminist perspectives that value other ways of knowing and being in relationship with the world and others (Prochaska & Norcross, 2014). Cognitive approaches may reinforce neoliberal individualism that locates the solution to problems within the self (Sugarman, 2015). Narrative therapy directly addresses cultural and social influences and focuses on externalizing these problems outside of the person. Reauthoring the reproductive story may be a helpful way to find meaning and integrate the loss into a personal narrative, however narrative therapy's focus on externalization and story may fail to address deep physical and emotional wounds as well as rational behavioral changes that may support healing (Prochaska & Norcross, 2014).

Although there is limited-to-no specific research on the use of EMDR, somatic, or IFS therapies with those experiencing RL, some see their potential (C. Cunningham, personal communication, January 3, 2023). EMDR addresses the need to re-process and integrate the RL experience, particularly for traumatic RL experiences. Somatic therapies directly attend to the physical nature of RL, something no other approach focuses on. IFS both externalizes social and cultural influences as well as heals internalized guilt and shame from a trauma perspective. These emerging approaches to RL have promise and require more research.

None of the reviewed approaches directly addresses the potential therapeutic power of the social construction of continuing bonds through the active relational process of social birth. Somatic therapy comes closest to this activity, with its focus on embodiment and physical relationality (e.g. cuddling and tattoo). The social and relational activities of *calling the fetus into personhood* and *calling a person into parenthood* may be therapeutically relevant, useful, and aligned with the social constructionist and feminist theoretical perspective I take in this capstone paper (Lindemann, 2009; Stoyles, 2015). In the following chapter I will propose how established and emerging counselling approaches may be integrated and augmented with intentional and relational social birthing practices that may add to the construction of meaning and integration of RL into a person's reproductive story while addressing feelings of grief, guilt, and shame.

Chapter Summary

I began this chapter with a review of dominant ideologies that influence the RL experience, including capitalism, neoliberalism, liberal feminism, (hetero)patriarchy, pronatalism, meritocracy, and essentialism. In our capitalist, neoliberalist, pronatalist, and meritocratic culture, the essentialized mother is blamed for her reproductive failures which contributes to feelings of guilt and shame (Bajaj & Stade, 2023; Feasey, 2022; Murphy, 2019). RL is common, although discrimination based on race, sexual orientation, and gender identity contributes to increased rates of RL in marginalized populations, minority stress, and poorer mental health outcomes (Chalmers & Wen, 2004; Cidro et al., 2020; Everett et al., 2019; Räsänen et al., 2022; Riggs et al., 2020). Popular social discourse such as celebrity news articles and popular pseudo-feminist television programs erase these differences, arguing that RL is the "great equalizer" (Martin, 2022, p. 12). They reinforce dominant ideologies of liberal feminism, pronatalism, and the essentialized mother, valorizing White motherhood and constructing loss as

a brief misstep on the path to motherhood (Boyle, 2023; Feasey, 2022). The abortion debate complexifies conceptions of fetal personhood and diminishes the social-birthing relational activities of calling a fetus into personhood and person into parenthood (Andipatin et al., 2019; Donley & Lens, 2022; Lindemann, 2009; Noor, 2022; Stoyles, 2015).

The experience of RL commonly lacks cultural understanding and validation in Western cultures (Andipatin et al., 2019; Littlemore & Turner, 2020). Different categories of losses are granted varying levels of social legitimacy, leading to some grief experiences being disenfranchised (Doka, 2009; Middlemiss & Kilshaw, 2023). Pronatalism, essentialism, and meritocracy can contribute to feelings of guilt and shame for those experiencing RL and can contribute to beliefs of unworthiness (Boyle, 2023; Martin, 2022; Murphy, 2019). RL shatters people's assumptive worlds and reproductive stories about their identities and roles (Bajaj & Stade, 2023; Freedle & Kashubeck-West, 2021; Jaffe, 2017; Wenzel, 2017). Some literature extends the stressful RL experience and labels it *reproductive trauma,* acknowledging mental health complications such as PTSD and PGD (Brigance et al., 2023; Glad et al., 2022; Jaffe, 2017; Jaffe & Diamond, 2011; Setubal et al., 2021). Activities to that facilitate social birth may bring agency and meaning to the loss experience and help to integrate it into the person's edited reproductive story (Andipatin et al., 2019; Lindemann, 2009; Stoyles, 2015).

Established and emerging therapeutic approaches that facilitate meaning-making and integration for RL include cognitive behavioural, narrative, EMDR, somatic, and IFS therapies. CBT focuses on reframing negative beliefs about pregnancy, childbearing, and motherhood using cognitive and behavioural approaches to promote meaning making and the assimilation of changes to one's assumptive world into their cognitive schemas (Freedle & Kashubeck-West, 2021; Wenzel, 2017). Narrative therapy aims to reauthor a person's reproductive story,

externalizing socio-cultural discourses and helping people to regain choice and control (Jaffe, 2017; Romney et al., 2021). EMDR reprocesses reproductive trauma in a safe therapeutic space and has been used for childbirth trauma (Vucina & Oakley, 2018; Wilson et al., 2018). Somatic therapies reconnect people to their bodies, as they may have disconnected from them as a means of coping with their perceptions of their body's failure to reproduce (Littlemore & Turner, 2020; Shapiro, 2020). Finally, IFS helps people to reclaim loving and compassionate Self-leadership, unblend from their protective parts, and unburden personal and legacy burdens that may contain neoliberalism, patriarchy, pronatalism, meritocracy, essentialism, discrimination, trauma, guilt, and shame (Anderson et al., 2017; Schwartz, 2021).

In chapter three I will consider the literature reviewed in chapter two and address the research question: How can counsellors adapt their treatment considering the contemporary neoliberal socio-political-cultural context and its effects on the RL experience? I will propose adaptations to established and emerging counselling approaches that consider the contemporary neoliberal socio-political-cultural context of RL and includes therapeutic activities that actively, constructively, intentionally, and relationally address the experience of RL.

Chapter Three: Discussion and Applications to Clinical Practice

Reproductive loss is a common yet diverse experience, with categories of loss including infertility, pregnancy loss (including ectopic pregnancy, miscarriage, abortion, and stillbirth), and infant death. In chapter two, I examined RL within the contemporary neoliberal socio-political-cultural context of increasing visibility, the renewed abortion debate, and developing understandings of gender roles and identity and from a social constructionist and feminist perspective. I asked the research question: *How does our contemporary neoliberal socio-political-cultural context shape the RL experience*? I identified capitalism, neoliberalism, liberal feminism, pronatalism, meritocracy, and essentialism as ideological constructs that are reinforced through popular social discourse and which contribute to the complex experience of RL. I explored themes of the RL experience as they relate to these ideological constructs including: a lack of cultural understanding and validation, internalized guilt and shame, assumptive worlds, reproductive stories, and identity confusion, reproductive stress and trauma, mental health complications, and fetal personhood and social birth. To address the research question *How do established and emerging counselling approaches to RL consider the contemporary neoliberal socio-political-cultural context?*, I introduced and critiqued several established and emerging counselling approaches to RL, including CBT, narrative therapy, and trauma-focused therapies.

This final chapter will review the outcomes of my research, providing interpretation considerations as well as limitations to my research conclusions. I will provide recommendations based on my research conclusions for how counsellors can adapt established and emerging counselling approaches to consider the contemporary neoliberal socio-political-cultural context. I will offer suggestions for future research and final conclusions for this capstone project.

Discussion

In this section I will discuss the outcomes of my two research questions as well as interpretation considerations, limitations, and conclusions.

Outcomes of Research Questions

How does our contemporary neoliberal socio-political-cultural context shape the RL experience?

Neoliberalism and liberal feminism promote freedom, meritocracy, and individual choice, despite systemic discriminatory inequities in access to the privileges of capitalism (Arruzza et al., 2019; Flew, 2014; Vallier, 2022). When applied to reproduction and motherhood, these neoliberal and liberal feminist values construct the *meritocracy of motherhood*, wherein only those who are most worthy of motherhood achieve it, and the *essentialized mother*, a mother who is instinctual, natural, intuitive, and feminine (Mulligan, 2023; Murphy, 2019). Pronatalist values overtly and covertly pressure women to bear children, reducing their value within neoliberalism to the making of and caring for people (Bajaj & Stade, 2023; Lovett, 2010). Popular media reinforces these constructions; for example, Hulu's *The Handmaid's Tale* (Miller, 2017) constructs the essentialized mother as White, cis-gendered, and heterosexual and valorizes motherhood and the nuclear family as June's ultimate goal in its portrayal of *domestic feminism* (Boyle, 2023). The news media reflects this domestic feminism in its reinforcement of a woman's reliance on her husband, emphasis on a woman's purpose for reproduction, and reproductive loss as a mere bump on the path to motherhood (Martin, 2022). These discourses continue to erase diverse experiences of motherhood that do not fit the constructions of the meritocracy of motherhood and the essentialized mother (Martin, 2022) as well as experiences of motherhood, pregnancy, and family that do not have happy endings (Layne, 2003). The news

media does not address systemic inequalities that contribute to disparate RL experiences such as maternal evacuation policies for Indigenous people in Canada, higher abortion rates for racialized women in the U.S., and higher RL rates in LGBTQ+ populations (Cidro et al., 2020; Everett et al., 2019; Kortsmit, 2021; Martin, 2022; Riggs et al., 2020).

This context shapes the RL experience through misplacement of blame and responsibility for RL onto the individual, which can be internalized as unhelpful guilt and shame (Martin, 2022; Murphy, 2019; nicabm, 2017; Rajabi, 2023). Constructions of the essentialized mother and pronatalist values influence linear reproductive stories wherein the only outcome is a healthy pregnancy and happy family (Feasey, 2022; Jaffe, 2017). The stigmatization of abortion, renewed following the reversal of *Roe v. Wade* in the U.S., morally condemns reproductive stories that do not end in a healthy baby, whether by choice or by chance (Middlemiss & Kilshaw, 2023; Noor, 2022; Rushton, 2023). This moral condemnation as well as the political conflation of the words *abortion* and *miscarriage* can contribute to hierarchies of loss wherein grief for some types of RL are granted more social legitimacy than others (Middlemiss & Kilshaw, 2023; Noor, 2022). Lack of social acceptance and validation of RL, as well as guilt, shame, and stigma may contribute to the experience of RL as trauma and lead to long term mental health complications, including PGD and PTSD (Brigance et al., 2023; Farren et al., 2016; Jaffe, 2017; Jaffe & Diamond, 2011).

How do established and emerging counselling approaches to RL consider the contemporary neoliberal socio-political-cultural context?

The most common established counselling approaches to RL are CBT and narrative therapy; CBT challenges unhelpful thoughts and beliefs, particularly related to guilt, failure, and stigma, while narrative therapy aims to externalize the problem and reauthor the reproductive

story (Jaffe, 2017; Romney et al., 2021; Wenzel, 2017). Emerging counselling approaches to RL use a trauma-informed lens and work on the integration of memories (EMDR), connection to body (somatic therapy), and unblending of parts and reconnection to Self (IFS). In my critique of the established and emerging counselling approaches to RL, I identified that none of these approaches directly includes intentional social birthing activities that may serve to construct meaning and relationship with what is lost. This is important because it challenges political and social messages of what is lost and the value of what is lost and instead creates agency in the individual to determine the nature and the meaning of the loss to them. The outcomes of the first research question imply that there is important work to be done in deconstructing pronatalism, the *meritocracy of motherhood*, the *essentialized mother*. These ideologies reduce a woman's worth to motherhood, privilege motherhood to the most deserving (cis-gendered, heterosexual, and White) women, and assume that motherhood and pregnancy are innate and instinctual. CBT challenges internalized thoughts and beliefs related to these ideologies and narrative therapy externalizes these problems outside of the person. Trauma-informed therapies unblend these ideologies from Self, externalizing them and integrating them into the experience of RL.

I argue that this is not enough, and that from a position of activism and social justice there is more work to be done in directly naming and challenging these ideologies politically and socially. Our world socially gaslights women, telling them one thing and expecting another. Neoliberalism promotes the freedom of individual choice, yet also entraps us in individual responsibility for these choices. Liberal feminism tells women that we can have it all, yet overt and covert pronatalism tells us our value as women is to bear children. The meritocracy of motherhood tells us that if we behave with merit (exercise, eat well, take our vitamins) we will be rewarded with a healthy pregnancy, yet adverse pregnancy outcomes can and do occur even

for the most so-called *deserving* of mothers. The essentialized mother tells us that our gender provides us with supernatural intuitive powers to nurture, yet nurturing is a human skill not a gendered skill (Walks, 2015). Layne's (2003) provocative work aimed to deconstruct these messages in her stories of unhappy pregnancy outcomes and I argue that to continue to deconstruct these ideologies, popular discourse must shift in Layne's direction. We need to hear stories of women who have merit and don't have and never have healthy pregnancy outcomes. We need to hear stories of women who do not have merit and do have health pregnancy outcomes. We need to hear stories about how the role of motherhood is learned, not innate. We need to hear fertility, pregnancy, RL, and parenting stories of people who do not match the construction of the essentialized mother within the meritocracy of motherhood – i.e. non-White, not cis-gendered, not heterosexual, and not women.

Interpretation Considerations

I make my arguments from a position and an identity that aligns with current social constructions of the essentialized and idealized mother. I am White, cis-gendered, and heterosexual. I grew up within neoliberalism, liberal feminism, and pronatalism, where I was both encouraged to climb corporate ladders and to be a caregiver/mother. When I wanted to become pregnant, I took my vitamins, exercised, ate well, and visited my doctor. I believed I fit within the meritocracy of motherhood, and I found it jarring, perhaps traumatic, when my pregnancies repeatedly ended abruptly. My assumptive world and my reproductive story were shattered. When I finally did have children, I found it extremely difficult and most certainly not an innate skill – another shattering of the construction of the essentialized mother. It took years of personal work, learning, and social support to become the person (first) and mother (second) I am today. I share these personal insights because they both highlight my potential bias in the

interpretation of my research results and also because telling them serves as a form of activism to deconstruct linear reproductive stories and challenge essentialism in motherhood. My story is just one view; stories from those who hold different social positions from mine also need to be told and need to be heard.

Limitations

This research was limited primarily to the experience of RL when pregnancies are desired. I hold that many of the same experiences of RL, such as guilt, shame, and lack of cultural understanding and validation can occur in experiences of RL when the pregnancies are not desired, although there is nuance here that I did not explore in depth in this paper. I included infertility in my definition of RL, although this is also a nuanced experience that overlaps with the RL experience but is different in its own way. I did not consider the experience of RL that occurs when a person loses their reproductive capacity due to age. I also focused on the experiences of people identifying as women and mothers.

While I considered elective abortion as it relates to the definition of fetal personhood and overlaps with social conceptions of the value of what is lost in RL, abortion itself is a complex topic that could warrant another capstone project. This capstone identified the ambiguity in the discursive use of the word *abortion* – this alone requires more research.

Research Conclusions

My research demonstrated the need to deconstruct neoliberal ideologies of pronatalism, meritocracy, and essentialism in popular discourse. Following Layne's (2003) seminal work, I propose that telling stories that counter these ideologies are an act of activism and social justice, particularly when they are told in the popular media. This aligns with Martin's (2022) conclusion that the popular media lacks conversation about class privilege, race, and systemic inequality in

its depictions of RL experiences and that "the few journalists and women that framed the miscarriage experience as varied and complex offer a path forward for more representative, fair, and honest news coverage of pregnancy loss" (p. 14).

I propose that to counter these socio-cultural-political definitions of women, motherhood, and the value of RL, counsellors can work with individuals to locate their power, agency, and choice to define who they are to themselves, who they are to others, who they are to what was lost, what it is that was lost, and the meaning and value of what it is that is lost. These activities align with the research of Lindemann (2009), Stoyles (2015), and Littlemore and Turner (2020), who propose that social birthing activities can purposefully *call a fetus into personhood* and *call a person into parenthood*. These activities also permit a reauthoring of the reproductive story, meaning-making, and an integration of the RL experience. This aligns with research that suggests that meaning-making and integration can prevent and treat post-traumatic symptoms of RL (Hasson-Ohayon et al., 2017; Milman et al., 2019).

I also propose that it may be useful to view RL from a trauma-informed perspective. RL may include physical experiences that may be considered traumatic, and I also argue that the abrupt shattering of assumptive worlds and reproductive stories in a way that so starkly contrasts with the socio-cultural-political messages of pronatalism, meritocracy, and essentialism may create a type of internal fragmentation that may be experienced as trauma. This aligns with research that proposes that dissociation, PGD, and PTSD are potential mental health complications following RL, although more research is needed to determine the frequency and risk factors of these complications (Brigance et al., 2023; Farren et al., 2016; Glad et al., 2022; Goldstein et al., 2019; Grauerholz et al., 2021; Setubal et al., 2021; Wesselmann & Parris, 2022).

Recommendations for Practice

In the following sections I review recommendations for clinical practice informed by my research conclusions. These recommendations include: recognize potential trauma, assess coping and despair, assess discrimination, deconstruct neoliberal ideologies, and construct meaning and relationships.

Recognize Potential Trauma

Following my research conclusion that it may be useful to view RL from a trauma-informed perspective, I recommend that counsellors take a trauma-informed approach to working with people who have experienced RL. Specifically, this trauma-informed approach may include the trauma-focused therapeutic methods that I identified in chapter two, including EMDR, somatic therapy, and IFS. I make these suggestions tentatively using conditional language because, while I conclude that RL may *sometimes* be experienced as trauma, it may not *always* be. Taking a trauma-informed approach implies that counsellors view individual coping mechanisms (dysregulation, dissociation, substance use, reactivity, etc.) as reactions to what happened rather than as defects of the person (BC Provincial Mental Health and Substance Use Planning Council, 2013). For example, IFS views these coping mechanisms as potential protective parts of a system that emerged as a response to a trauma or life experience and aims to befriend, unblend, and integrate these parts to treat trauma (Anderson et al., 2017). People who experience RL often label it as traumatic and at least 15-25% of women who experience RL may have ongoing mental health problems (Farren et al., 2016; Freedle & Kashubeck-West, 2021). Beginning with a trauma-informed perspective contextualizes these mental health problems and associated coping mechanisms within the lens of trauma and frames therapeutic treatment in a non-pathologizing stance that considers the context within which distress emerged.

Assess Coping and Despair

Following this trauma-informed perspective, I recommend using the revised Perinatal Grief Scale (PGS; see Appendix) to assess for higher levels of "Difficulty Coping" and "Despair" that may predict PGD and PTSD (Setubal et al., 2021). I have proposed a revised version of the PGS (see Appendix) based on the research that I reviewed in this capstone project. In this revised version, I have updated language that constructs what was lost as a person (*baby* replaced with *loss*), neutralized gender pronouns (*he/she* replaced with *the loss*), and generalized language referring to the nature of the loss (*died/death* replaced with *the loss*). These changes resists hierarchizing RL, returns power to the person to determine what was lost (hope, dream, role, embryo, fetus, baby, person, pregnancy, and so forth), and expands the usefulness of this scale beyond categories of RL that include a baby and a biological death. Future research should validate this revised PGS.

Setubal et al. (2021) suggested that perinatal grief should be evaluated as a preventative health measure after RL; following this, I suggest that counsellors should use the PGS as part of their assessment for any client who has experienced RL. Results of the PGS are not diagnostic; rather they are a screening tool to help identify clients who are having more difficulty coping with their grief, are experiencing more intense despair, and who may be at higher risk of developing mental health complications such as PGD or PTSD. PGD is associated with physical health risks, increased substance use, reduced quality of life, and suicidality and is also strongly associated with PTSD (Glad et al., 2022; Grauerholz et al., 2021; Harris & Winokuer, 2021). Higher assessed levels of "Difficulty Coping" and "Despair" on the PGD may suggest that a trauma-informed approach is required, centering activities such as integration of the loss into the personal narrative to address dissociation (Hassan & Holmes, 2023). These activities may be addressed through trauma-focused techniques such as EMDR, somatic therapy, or IFS. Lower

assessed levels of "Difficulty Coping" and "Despair" on the PGD may suggest that the client is more capable of coping with the grief and despair of the loss and at lower risk of longer-term mental health complications.

Regardless of the assessment of perinatal grief and ability to cope using the PGS, counsellors should consider the complex experiences of RL that extend beyond grief, and which have already been reviewed in chapter 2. Counsellors should attend to lack of validation, guilt, shame, identity confusion, and stress as well as the potential for trauma. These may be addressed through cognitive behavioural or narrative techniques. For example, identity confusion may be treated using narrative re-storying techniques that author an alternative reproductive story that normalizes loss in reproduction.

Assess Discrimination

My research demonstrated that RL is not a "great equalizer among women" (Martin, 2022, p. 12), and that experiences of racism, sexism, and gender discrimination can contribute disparate RL experiences (Chalmers & Wen, 2004; Cidro et al., 2020; Everett et al., 2019; Kortsmit, 2021; Lacombe-Duncan et al., 2022; Räsänen et al., 2022; Riggs et al., 2020; van Daalen et al., 2022). Given this, and taking an intersectional feminist perspective (Crenshaw, 2020 as cited in Steinmetz, 2020), counsellors must inquire about a client's intersectional identity and social location and consider how experiences of discrimination may have shaped their experience of RL. From a narrative perspective, therapeutic techniques may include externalizing these systemic discriminatory factors outside of the person to address internalized feelings of guilt and shame.

Deconstruct Neoliberal Ideologies

Counsellors must not be complicit in promoting neoliberalist messages that complicate the RL experience and are bound to the ethical principle of social interest (CCPA, 2020; Sugarman, 2015). Counsellors must actively work with both clients and within the greater socio-political-cultural context to actively deconstruct neoliberal ideologies of pronatalism, meritocracy, and essentialism that complicate the RL experience. Narrative therapy is well suited to this work with its focus on externalizing these neoliberal ideological problems, finding unique outcomes, and solidifying new possibilities and change (Romney et al., 2021). Counsellors must not reinforce linear reproductive narratives and instead help clients to retell their stories in ways that allow for unhappy/non-normative paths and endings. For example, this includes telling and witnessing stories that do not end in a healthy baby or happy family, stories of learning to mother, stories of mothers, parents, and families who are not White, cis, or heterosexual, stories of womanhood that do not include motherhood, and stories of motherhood that do not include womanhood. These foci follow in Layne's (2003) footsteps, reauthoring the reproductive story (Jaffe, 2017), and integrating the loss into the personal narrative (Hasson-Ohayon et al., 2017).

From an IFS perspective, counsellors can work with clients to deconstruct or *unblend* (in IFS language) parts of their identity, particularly neoliberal definitions of woman and mother. Specifically, counsellors can work to separate the neoliberal and pronatalist conflation of womanhood and motherhood. Murphy (2019) argued that essentialized motherhood implies that women who experience RL are not worthy or capable of motherhood and are fundamentally flawed as women. Counsellors can challenge this by defining client's identity and self-worth outside of motherhood, outside of liberal feminism, and outside of capitalism. This approach challenges the meritocracy of motherhood and liberal feminism, addressing feelings of shame within the RL experience.

Construct Meaning and Relationships

Within these reconstructive non-linear reproductive narratives, counsellors can allow the client to define what it is that was lost and to define their relationship to what was lost, witnessing the client's individual experience of grief. This resists disenfranchising grief and hierarchizing what was lost (Doka, 2009; Middlemiss & Kilshaw, 2023), placing the power in the person to define their loss and grief rather than in society, culture, or politics.

Following the concept of *social birthing* (Andipatin et al., 2019; Lindemann, 2009; Stoyles, 2015), clients can be guided to memorialize what was lost in a way that is meaningful to them. This could include *calling the fetus into personhood* by hanging ultrasound photos, giving a name, or symbolically including the loss in family events. It could include *calling the person into parenthood* by honoring Mother's Day or Father's Day or recognizing their chosen identity as a parent. It could include symbolically honoring a relationship to an ambiguous loss through planting a garden, getting a tattoo, or making art. It could include the construction of an emotional relationship through letter writing or doll-cuddling. These activities are ways for the client to take agency to create meaning of their loss, integrating it into their identity and their personal narrative. This active construction of social relatedness contrasts the neoliberal focus on individualism and hyper-self-sufficiency (Sugarman, 2015).

Recommendations for Future Research

The socio-political landscape of fetal personhood and reproductive rights is changing rapidly. During the writing of this capstone, laws have been passed globally that drastically impact reproductive rights and definitions of fetal personhood. The US state of Alabama has shifted the definition of fetal personhood to embryonic personhood, ruling that frozen embryos are children (Chandler, 2024). The province of British Columbia, Canada has announced public

funding for one round of in-vitro fertilization (Pawson, 2024). France has made abortion a constitutional right (Wright, 2024). In the introduction, I stated that the arguments in the capstone would be made within a particular socio-political-cultural context, according to Wiggins (2017) definition of discursive psychology. This context has already changed since I began writing this capstone, and will continue to change; thus, this research must be ongoing.

My research was primarily focused on desired pregnancies; future research may consider more ambiguously desired pregnancies within the developing political context of abortion rights. I identified the ambiguity in the discursive use of the word *abortion* – this alone requires more research. Future research that examines neoliberalism's impact to womanhood, motherhood, and personhood in greater depth is warranted, as well as research that continues to examine the detriments of neoliberal individualism in an intersectional feminist context. From a philosophical viewpoint, research that challenges neoliberalism's pervasive "common sense" (Sugarman, 2015, p. 103) and provides political and social alternatives would be broadly relevant to the topic of reproductive loss.

Future research may extend and update Layne's (2003) seminal works that normalize unhappy reproductive endings, telling non-linear and non-normative reproductive stories, in particular in LGBTQ+ populations. Research that studies the frequency and risk factors for developing more serious mental health complications such as PGD and PTSD following RL is also needed. Future research should also validate my proposals for a revised PGS (see Appendix). Relevant to this capstone would be future research that examines the potential association between socio-political-cultural hierarchization of RL and the development mental health complications such as PGD and PTSD. Research on the effectiveness of trauma-informed

counselling approaches such as EMDR, somatic therapy, and IFS for RL is almost non-existent and a ripe area for further research.

Conclusions

In this capstone project, I examined RL within a contemporary socio-political-cultural context defined by neoliberalism, liberal feminism, and pronatalism. I used discursive examples from popular media, including celebrity news articles, popular entertainment, and current politics to demonstrate how neoliberalist and pronatalist ideals are reinforced in discourse and how they complicate the experience of RL, particularly for those experiencing discrimination. I reviewed the experience of RL, including the lack of cultural understanding and validation, internalized guilt and shame, assumptive worlds and identity confusion, reproductive stress and trauma, mental health complications including PGD and PTSD, and concepts of fetal personhood and social birth. I considered how the contemporary neoliberal socio-cultural-political context is implicated in these complicated experiences of RL. I examined and critiqued established and emerging counselling approaches to RL, considering how well they address contextual factors.

My research questions were: *How does our contemporary neoliberal socio-cultural-political context shape the RL experience?* and *How do established and emerging counselling approaches to RL consider the contemporary neoliberal socio-cultural-political context?* My research demonstrated that discourses in popular media reinforce neoliberal and liberal feminist constructions of pronatalist domestic feminism, the meritocracy of motherhood, and the essentialized mother. These constructions contribute to RL experiences of internalized guilt and shame, stress and trauma associated with the loss of assumptive worlds based on linear and normative reproductive stories, and stigma related to the conflation of the words *abortion* and *miscarriage* and the moral condemnation of non-linear, non-normative reproductive stories. The

most common current counselling approaches include CBT and Narrative approaches. Emerging trauma-informed approaches include EMDR, somatic therapy, and IFS therapy. Both established and emerging approaches may be enhanced through the inclusion of intentional social birthing activities to construct a relationship to what it is that was lost. From a stance of activism and social justice, counsellors must continue Layne's (2003) work to challenge happy, linear, cis-heteronormative pregnancy stories.

Neoliberalism may be based on freedom and equal rights, but it is a mistake to assume that women's ability to choose can be equated with power to control the subtle mysteries of life and death. Counsellors must work to deconstruct neoliberal ideologies of pronatalism, meritocracy, and essentialism in our discourse about womanhood, motherhood, and pregnancy. While medicine may define biological birth (Andipatin et al., 2019) and the law may define legal personhood (Government of Canada, 2023), only a person in relationship to another can determine their social birth. Counsellors can work with individuals to locate their power, agency, and choice to define their relationships to self and others. Counsellors should consider a trauma-informed perspective when working with RL, given the stark contrast between intersectional lived experiences and social constructions based on pronatalism, meritocracy, and essentialism in our age of neoliberalism.

This capstone research project is limited to this time and this place; the world of reproductive rights, gender rights, and fetal rights is rapidly changing. RL places women on the margins of pronatalism, essentialism, and meritocracy in our contemporary neoliberal socio-political-cultural context, challenging their identities, worth, and purpose. Deconstructing neoliberalism is *personal* and *political* feminist and socially-just work for everyone who experiences RL within this time and place.

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Appendix A

REVISED PERINATAL GRIEF SCALE (Adapted from Toedter et al., 2011)

33 Item Short Version

SCORING INSTRUCTIONS

The total PGS score is arrived at by first reversing all of the items EXCEPT 11 AND 33. By reversing the items, higher scores now reflect more intense grief.

Then add the scores together. The result is a total scale consisting of 33 items with a possible range of 33-165.

The three subscales consist of the sum of the scores of 11 items each, with a possible range of 11-55.

Subscale 1	Subscale 2	Subscale 3
Active Grief	Difficulty Coping	Despair
1	2	9
3	4	15
5	8	16
6	* 11	17
7	21	18
10	24	20
12	25	22
13	26	23
14	28	29
19	30	31
27	* 33	32

* Do not reverse.

PRESENT THOUGHTS AND FEELINGS ABOUT YOUR LOSS

Each of the items is a statement of thoughts and feelings which some people have concerning a loss such as yours. There are no right or wrong responses to these statements. For each item, circle the number which best indicated the extent to which you agree or disagree with it at the present time. If you are not certain, use the "neither" category. Please try to use this category only when you truly have no opinion.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. I feel depressed.	1	2	3	4	5
2. I find it hard to get along with certain people.	1	2	3	4	5
3. I feel empty inside.	1	2	3	4	5
4. I can't keep up with my normal activities.	1	2	3	4	5
5. I feel a need to talk about the loss.	1	2	3	4	5
6. I am grieving for the loss.	1	2	3	4	5
7. I am frightened.	1	2	3	4	5
8. I have considered suicide since the loss.	1	2	3	4	5
9. I take medicine for my nerves.	1	2	3	4	5
10. I very much miss what/who I lost.	1	2	3	4	5
11. I feel I have adjusted well to the loss.	1	2	3	4	5
12. It is painful to recall memories of the loss.	1	2	3	4	5
13. I get upset when I think about the loss.	1	2	3	4	5

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
14. I cry when I think about the loss.	1	2	3	4	5
15. I feel guilty when I think about the loss.	1	2	3	4	5
16. I feel physically ill when I think about the loss.	1	2	3	4	5
17. I feel unprotected in a dangerous world since the loss.	1	2	3	4	5
18. I try to laugh, but nothing seems funny anymore.	1	2	3	4	5
19. Time passes so slowly since the loss.	1	2	3	4	5
20. The best part of me died with the loss.	1	2	3	4	5
21. I have let people down since the loss.	1	2	3	4	5
22. I feel worthless since the loss.	1	2	3	4	5
23. I blame myself for the loss.	1	2	3	4	5
24. I get cross at my friends and relatives more than I should.	1	2	3	4	5
25. Sometimes I feel like I need a professional counselor to help me get my life back together again.	1	2	3	4	5

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
26. I feel as though I'm just existing and not really living since the loss.	1	2	3	4	5
27. I feel so lonely since the loss.	1	2	3	4	5
28. I feel somewhat apart and remote, even among friends.	1	2	3	4	5
29. It's safer not to love.	1	2	3	4	5
30. I find it difficult to make decisions since the loss.	1	2	3	4	5
31. I worry about what my future will be like.	1	2	3	4	5
32. The loss means being a "Second- Class Citizen ".	1	2	3	4	5
33. It feels great to be alive.	1	2	3	4	5