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Norrmann-Vigil, Ingrid Heidi

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Women's narratives of pregnancy loss:

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medical personnel, and YouTube viewers in the interactive organization of loss experience and
its recollection

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Applied Linguistics

by

Ingrid Heidi Norrmann-Vigil

2016

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2016

ABSTRACT OF THE DISSERTATION

Women's narratives of pregnancy loss:

Discursive and multimodal manifestations of the involvement of the self, the interviewer, medical personnel, and YouTube viewers in the interactive organization of loss experience and its recollection

by

Ingrid Heidi Norrmann-Vigil

Doctorate of Philosophy in Applied Linguistics

University of California, Los Angeles, 2016

Professor Marjorie Harness Goodwin, Co-Chair

Professor Charles Goodwin, Co-Chair

Approximately one in four pregnancies are lost; yet, most women are not aware of this high incidence rate until they face a miscarriage or a stillbirth. This research studies 43 narratives collected from interviews and 40 video blogs compiled from YouTube, focusing on the discursive and multimodal manifestations of the involvement of four different actors that play a significant role in shaping the pregnancy loss experience and its recollection. I first explore the role of the self in the loss experience and analyze how, as a means to understand the loss, women attribute blame and responsibility to themselves by discursively detaching their selves from their bodies. Furthermore, I examine how they reconstruct their identities as women and mothers as part of their sense-making process. The second actor that plays a significant role in the women's recollection of their experiences is the interviewer, as a peer who also endured pregnancy losses.

This peer-relationship formed during the interviews often leads to the co-narration of the loss, facilitated through the interaction of non-verbal semiotic resources and the embodiment of the most traumatic moments in the stories. Medical personnel are the third actors analyzed, as they bring the news of the demise to the women and significantly impact their experience and emotional recovery. Studying the direct and indirect reported speech of these interactions elucidates how these two forms are used in combination with other semiotic resources to embed layers of emotional and epistemic stances onto the discourse and to display dissatisfaction with medical personnel. Finally, a pregnancy (loss) community has emerged in the last few years on YouTube, fostering vloggers' and viewers' interactions as members of a community of experience. By exploring the content and the semiotic resources present in the vlogs, I unveil how vloggers establish and maintain a connection with the viewers and how this online community is created and expanded. With this research, I seek to open up a dialogue centered on pregnancy loss as an undesirable but natural part of life. My aim, ultimately, is to change how our society receives the news of an unborn's demise, how medical personnel communicate with the grieving parents, and how mothers grief and overcome the pain of such loss.

The dissertation of Ingrid Heidi Norrmann-Vigil is approved

Christopher Jason Throop

Marjorie Harness Goodwin, Committee Co-Chair

Charles Goodwin, Committee Co-Chair

University of California, Los Angeles

2016

To my son Ryker and my two angelitos I never met

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TRANSCRIPTION CONVENTIONS

The data was transcribed according to the system developed by Gail Jefferson and described in Sacks, Schegloff, and Jefferson (1974). Additionally, I also employed a new notation for illustrating embedded prosody or facial expressions onto the talk. The following are the most relevant features used in this dissertation:

- . Falling of final intonation contour
- , “Continuing” intonation
- ? Rising intonation
- ↑ Rise in pitch reset
- ↓ Fall in pitch
- (0.8) Silence in tenths of seconds
- (.) Hearable micro pause, less than a 0.2 seconds
- : Lengthening of the immediately preceding sound
- .hh In-breath, each h represents a tenth of a second
- hh. Out-breath, each h represents a tenth of a second
- ° Whisper, breathy speech
- word Underlining marks some form of stress or emphasis, signaled by an increased volume and/or change of pitch
- Sudden cut-ff of the preceding sound, a self-interruption
- [] Overlap
- = Attaches continuous speech with no hearable pause
- > < Talk in between is delivered at a faster rate than surrounding talk
- < > Talk in between is delivered at a slower rate than surrounding talk
- (()) Transcriber’s comment

* * Extra layer embedded onto the talk in between the asterisks (e.g., facial expressions, prosody, etc., as described by the transcriber's comment)

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VITA

- 2008 B.A. in Linguistics and French; minor in Spanish Linguistics
University of California, Los Angeles
- 2008 - 2011 Teaching Assistant / Associate
Department of Spanish and Portuguese, UCLA
- 2008 - 2012 Peer Learning Supervisor - Humanities and Social Sciences
Academic Advancement Program, UCLA
- 2010 M.A. in Spanish
University of California, Los Angeles
- 2010 - 2011 Organizing Committee Member
VIII Annual Graduate Student Conference
Department of Spanish and Portuguese, UCLA
- 2010 - 2011 Editor
Mester: "Voices in the U.S.: Spanish and Portuguese"
Department of Spanish and Portuguese, UCLA
- 2011 - 2015 Eugene Cota Robles Fellowship
University of California, Los Angeles
- 2012 - 2015 Teaching Associate / Fellow
Department of Applied Linguistics, UCLA
- 2012 - 2016 Instructor - Spanish
UCLA Extension
- 2013 - 2014 Section Editor
Issues in Applied Linguistics
Department of Applied Linguistics, UCLA
- 2013 - 2014 Organizing Committee Member
2nd Conference of the American Pragmatics Association at UCLA
- 2014 - 2015 Graduate Research Mentorship
University of California, Los Angeles
- 2015 - 2016 Rater, Test of Oral Proficiency (TOP)
Office of Instructional Development, UCLA
- 2015 - 2016 Dissertation Year Fellowship
Faculty Women's Club Fellowship
University of California, Los Angeles

SELECTED PUBLICATIONS AND PRESENTATIONS

Publications

- Norrmann-Vigil, I. (2015). Conceptualizing and articulating pregnancy loss through embodiment in peer interaction. *Language & Communication*, 45(C), 70-82. doi:10.1016/j.langcom.2015.10.002
- Daland, R. & Norrmann-Vigil, I. (2015). Toward a generative theory of language transfer: Experiment and modeling of sC prosthesis in L2 Spanish. *Open Linguistics*, 1 (1), 650-683. doi:10.1515/opli-2015-0024
- Norrmann-Vigil, I. (2012). Accounting for diminutive formation in Porteño Spanish. *Mester*, XLI (01). 99-122
- Daland, R., Hayes, B., White, J., Garellek, M., Davis, A., & Norrmann, I. (2011). Explaining sonority projection effects. *Phonology* 28. 197-234. doi:10.1017/S0952675711000145

Selected Presentations

- Understanding gestures as an invitation to co-construct narratives of trauma. *National Communication Association 101st Annual Convention*. Las Vegas, NV. November 2015.
- Covert blame attribution through (grammatical) agency in narratives of pregnancy loss. *2015 Conference on Language, Interaction and Social Organization (LISO) at UCSB*. Santa Barbara, CA. May 2015.
- “We were pregnant but I miscarried”: How agency informs sense-making in narratives of miscarriage. *American Anthropological Association Annual Meeting*. Chicago, IL. November 2013.
- When gestures complete a story: Audience participation in the co-constructions of narratives of trauma. *American Sociological Association Annual Meeting*. New York, NY. August 2013.
- Lights, Camera, InterAction! Face-to-face interaction features used to build community on YouTube. *The International Institute for Ethnomethodology and Conversation Analysis Conference*. Waterloo, Canada. August 2013.
- Did you suffer like I did? How shared knowledge through personal experiences facilitates and influences the co-construction of narratives of trauma. *Society for Psychological Anthropology 2013 Biennial Meeting*. San Diego, CA. April 2013.
- When the past and the future merge: How embedded narratives give meaning to health expectations. *Western States Communication Association Annual Convention*. Reno, NV. February 2013.
- “I’m sorry for your loss; it happened to me too”: Creating second stories in YouTube video blogs of miscarriage. *18th Annual Conference on Language, Interaction, and Culture (CLIC) at UCLA*. Los Angeles, CA. May 2012.

Chapter One

INTRODUCTION

Even though it's a tremendous loss personally, it's such an invisible loss to everybody else; you know, cause there's nothing to show for it. (Stella)

Background

The ultrasound technician turns the machine on and with the probe begins the vaginal examination of the embryo. In front of me hangs a 27-inch LED monitor. A black blob in the center of the screen with a smaller white blob in it. On the TV it looks quite large, but the small white blob is probably no more than a couple millimeters in diameter. The technician continues to rotate the probe and to click on her keyboard while staring at the small monitor in front of her for what seems an eternity but probably for no more than two or three minutes. Silence. Nobody in the room talks. My husband is sitting to my left, in silence too. Finally the technician turns to me and tells me she will bring the doctor in. This is my first pregnancy; I have never been in that room before or through a routine 8-week ultrasound. I have never met the doctor before either. I am excited to hear what she has to say, to hear about all the dos and don'ts while being pregnant, to learn when my due-date is, to start decorating the nursery, to learn the sex of my baby, to pick a name, to become a mom! I am going to become a mother! I am pregnant and there is life inside of me... I am already a mother! The ultrasound technician comes back in, this time with the doctor. They look at the small monitor for a few seconds and the doctor looks at me, "I'm so sorry." I look at her trying to understand what is happening, why she feels sorry. She hands me a box of tissues, and I keep looking at her quietly. With her hand on my leg, trying to comfort me, she repeats, "I'm so sorry. There's no heartbeat." And in that moment I feel my stomach drop. Something just stole the nursery, the morning sickness, the due-date, the name of the baby, and even motherhood away from me. My dreams and hopes of being pregnant and

becoming a mother, seeing my belly grow, and watching my child grow have been torn into pieces.

Approximately one in five pregnancies are not carried to term, resulting in either a miscarriage or a stillbirth (Fretts, 2014b; Michels & Tiu, 2007; Regan & Rai, 2000; Tulandi & Al-Fozan, 2012; Ventura, Curtin, Abma, & Henshaw, 2012; Wilcox et al., 1988); yet, this is a statistic most women only learn about after they are faced with the shocking news of an imminent loss or their unborn babies no longer being alive. In fact, Abboud and Liamputtong (2002) report, in their study of the experiential and emotional differences between men and women after a pregnancy loss, that several women had heard about miscarriages but “did not know what it involved or they impact it would have” (p. 44). A miscarriage, which is an early pregnancy loss, is the most common type of pregnancy loss with an overall prevalence of “15% to 27% for women aged 25 to 29, increasing to 75% in women older than 45 years” (Kersting & Wagner, 2012, p. 187). According to the United States National Center for Health Statistics, “the majority of individual states in the United States use 20 weeks of gestation as the threshold for distinguishing a stillbirth from a miscarriage” (Fretts, 2014b). Although the gestation time is the determining factor for differentiating between a miscarriage and a stillbirth, other distinctions between them are also crucial medically and legally. One of these medical differences is the method for evacuating the products of conception. In the case of a miscarriage, unless there is an infection or other complications, women can either naturally expel the embryo—i.e., allowing their bodies to evacuate it with or without the aid of medicine—or they can have a surgical procedure—i.e., either dilation and curettage or dilation and evacuation depending on the time of gestation—(Fretts, 2014b). For stillbirths before 24 weeks of gestation, having a dilation and evacuation surgery is also a possibility (Fretts, 2014a); however, after this point in time, if after the demise of the fetus women do not go into labor on their own, they have to be induced into labor, unless for medical reasons a caesarian delivery is necessary (Fretts, 2014a). Being induced can significantly impact the mothers psychologically, as the physical process of delivering a

stillborn vaginally is similar to delivering a living baby since women “still have contractions at the same rate [they] would have in a normal labor” (Czukas, 2014), yet they leave the hospital and return home empty handed. On the other hand, a major legal difference between a miscarriage and a stillbirth lies on the official recognition of the existence and the death of that baby, as death certificates can only be generated after stillbirths (Fretts, 2014b). This distinction carries great implications not only morally but also psychologically for the grieving mother whose child can or cannot be legally recognized as ever existing.

Despite pregnancy loss’ high rate of incidence and the lack of a correlation with any sociocultural or economic factor, pregnancy loss constitutes a taboo topic in the modern American society; most people do not want to talk about it or do not feel comfortable talking about it. Unfortunately, the non-acceptance of this subject often translates into women not being able to find the proper support to overcome the psychological sequelae of the loss. Previous studies on the psychological process of recovery after a pregnancy loss have addressed coping strategies (Abboud & Liamputtong, 2002; 2005), the stigma associated with the loss (Erviti, Castro, & Collado, 2004; Fairchild & Arrington, 2011), and identity reconstruction (Fairchild, 2009) among other topics. Throughout the literature on pregnancy loss and its grieving process, the preferred methodology for collecting data is the administration of questionnaires (Keefe-Cooperman, 2004; Renner, Verdekal, Brier, & Fallucca, 2000) and in-depth interviews (Abboud & Liamputtong, 2005; Erviti et al., 2004; Fairchild, 2009). The latter method has long been used to elicit narratives and study how people make sense of life events through the process of telling their stories (Coetzee & Rau, 2009; Mattingly, 1998a; Ochs & Capps, 2001). Narratives are understood as “one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which (it is inferred) actually occurred” (Labov, 1972, p. 359). Bruner (2002) on the other hand states, “in all its forms [a story or narrative] is a dialectic between what was expected and what came to pass. For there to be a story, something unforeseen must happen” (p. 15), which is a significant element in narratives of

trauma, particularly pregnancy loss. However, one element that is missing from both definitions is the “evaluative hue” (Capps & Ochs, 1995, p. 13) that tellers incorporate into their stories, rendering them not only factual accounts of the losses, but also a mechanism through which they can embed their emotions and make sense of their experiences. Additionally, although not always in a conscious manner, these “stories shape the way tellers see and experience themselves in their worlds” (Capps & Ochs, 1995, p. 13) as narratives constitute a way for the tellers to reveal their selves and their moral constitutions (Capps & Ochs, 1995; Rymes, 1995). This notion of the projection of the self through discourse has been explored in several contexts (Capps & Ochs, 1995; Ochs & Capps, 2001; Rymes, 1995), as the lexical and grammatical analysis of narratives can unveil how “speakers structure their own sense of self and agency” (Rymes, 1995, p. 497), which is particularly relevant in cases of pregnancy loss, where the etiology of the fetal demise can be vague or unknown (Tulandi & Al-Fozan, 2012), deeming the loss an “ambiguous loss” (Boss, 1999).

The definition of trauma slightly varies depending on the field of study. Classical medicine considers trauma as an event that causes physical injury (Erikson, 1994), whereas the American Psychological Association looks at trauma from a different perspective, defining it as “an emotional response to a terrible event like an accident, rape or natural disaster” (A.P.A.). The previous two definitions do not agree on the time frame (i.e., medicine looks at trauma as a moment, while psychology views it as an emotional response with an undetermined duration); nevertheless, they both agree that trauma causes a change in the constitution of a person. From the psychological perspective, trauma is closely related to narrative, as this form of discourse is one of the main ways of formulating and making public such experiences, and it is also widely considered prominent for exposing and making sense of traumatic and past events in general. In fact, several studies have been focused on narratives as they relate to medical issues; they have addressed clinical interactions between occupational therapists and patients who were severely injured or disabled (Mattingly, 1998a), the case of an agoraphobic woman and how she managed

panic (Capps & Ochs, 1995), narratives as the avenue for making sense of past experiences (Mattingly, 1998a; Ochs & Capps, 2001), and the illness experience for chronically ill patients (Kleinman, 1988) among other topics. What all of these narratives have in common, aside from referring to medical problems, is the traumatic element this topic inherently carries, which influences the way in which those events are perceived, interpreted, and how the memories are recalled. Despite the traumatic aspect of a pregnancy loss, the ambiguous nature of most miscarriages and even some stillbirths render this type of trauma much different from other ones where the experiencers can make sense of the events through recounting what happened. The most salient feature of an ambiguous loss is its capability of blocking the recovery process by means of freezing the experience and not allowing the person to understand what, why, or how the trauma came to be. Especially in cases of ambiguous pregnancy losses, most frequently early miscarriages, mothers tend to blame themselves for the loss more so than those women who do know the reason for the loss (Nikcevic, Tunkel, Kuczmierczyk, & Nicolaides, 1999). Overcoming the traumatic experience, understanding and accepting the demise of the embryo or fetus then becomes an arduous task to accomplish, and women sometimes take years to even begin to come to terms with the loss.

Although every pregnancy and demise are different, it is often easier to understand one's own experience through an intersubjective connection with others who have also lived through similar losses. Whether it be by watching video blogs on YouTube of mothers who share their pregnancy loss stories, asking for or giving advice on online forums, sharing stories at a peer-support group, or conversing with another mother who also lost a baby, most women agree that finding others who also had a miscarriage or a stillbirth makes them feel understood, not alone, and less ashamed or embarrassed of what happened to them. Women frequently admit they begin to understand and accept their own experiences by hearing others talk about what they endured and how they began the emotional recovery process. This relationship formed between these women sharing their stories is founded on the pillars of intersubjectivity. As Duranti

(2010) remarks, intersubjectivity does not entail a simultaneous mutual understanding, rather “the possibility of exchanging places, of seeing the world from the point of view of the Other” (p. 21). It is through the connection they create with each other, and through understanding each other’s losses that they are able to see their own losses in a different light and begin to accept them. On the other hand, in sharing the loss experience with others, the emotional “pain can potentiate the most empathic connections [they] have with others. (...) It may compel [them] to act, to help, to be concerned, and to give aid” (Throop, 2012, p. 409). Duranti (2010) explains Husserl’s concept of empathy as “the primordial experience of participating in the actions and feeling of another being without becoming the other” (p. 22). In the context of pregnancy loss, women claim this empathic connection aids in the understanding of the other and most importantly the Self. Therefore, regardless of how deep and private the emotional pain these women experience is, “making sense of it is deeply social” (Buchbinder, 2015, p. 197).

Focus of the Dissertation

This project examines the interactive shaping and organization of pregnancy loss experience vis-à-vis four different actors that are involved in or represented in the narratives of miscarriage or stillbirth. The dissertation is therefore divided into four thematic chapters, each one centered on one of those agents: the narrator as the self, the interviewer and her relationship with the narrator as peers, the medical personnel involved and how their interactions are reported, and finally the relationship between YouTube vloggers and the viewers as they create and maintain a virtual support community.

Chapter three focuses on the women narrating their stories as experiencers and tellers, mothers and women, and agents and patients. Because of the nature of a pregnancy loss, during the grieving process sometimes women put into question different factors such as the self, their bodies, and even their motherhood or womanhood identity. In this chapter I address how women perceive and talk about themselves. As a byproduct of attributing blame in order to

overcome the ambiguous loss, there is often a perceived detachment between the self or mind and the body, understanding the body as the entity responsible for the fetal demise. This disconnection not only affects the women's sense-making process as they attempt to grieve their losses, but also impacts their sense of self, changing the constitution of these women at their core and sometimes shaking or shattering their sense of womanhood, femininity, and even their motherhood identity. Although these changes are within the self and the mind, they manifest through language and embodied action, providing an insight into the psychological recovery after an ambiguous loss.

Chapter four explores the intersubjective dialogical process between the narrator and me as the interviewer, since I experienced two pregnancy losses before carrying out the interviews. This relationship often leads to the co-narration of the narratives, particularly of moments that are too painful to recall and synthesize into words. I examine how the semiotic resources involved in the narratives (e.g., gestures and facial expressions) interact with the oral discourse to create a recipient-oriented narrative that allows for my involvement in the telling and negotiation of meaning. Furthermore, I analyze why face-to-face interaction is important for the sense-making process, focusing on the importance of gestures as narrators create a recipient-oriented discourse.

Chapter five focuses on the reported interactions with medical personnel, paying particular attention at the functional difference between direct and indirect reported speech. Doctors, nurses, midwives, and ultrasound technicians play a crucial part in the emotional aspect of the loss, as they are often the ones who deliver the news of the demise and the first ones to have the opportunity to offer support or not. In an ideal setting, the medical staff is supportive, empathetic, and has the time to devote to the non-medical aspect of a pregnancy loss. Unfortunately, most settings are far from ideal, which is why these women's reports of their conversations with medical personnel are analyzed. The aim of this chapter is to understand how the speech being reported interacts with "the speech doing the reporting" (Vološinov, 1971,

p. 153). In other words, I seek to uncover how the layering of language, prosody, and gestures represents different stances and speakers within the same string of speech. Particularly in these narratives, this complex layering lends itself to portraying manifestations of patient dissatisfaction, which often arises from a misalignment between the patients' needs and the doctors' understanding of those needs (Friedman, 1989).

The last thematic chapter centers on YouTube as a community of experience. In order to cope with the loss and seek support, many women resort to the internet and share their stories with "strangers" in forums, support groups, or YouTube. Although the narratives found on YouTube have similarities with the ones told during interviews, they also have an element of community-formation that is unique to this environment. Women tell their stories to an open virtual community, and in doing so they also have to maintain a connection with the viewers. In the vast context of YouTube, vloggers can belong to smaller communities, one of those being the motherhood and pregnancy (loss) community, which mainly focuses on the journey to and through motherhood. In this chapter I explore the content of the vlogs and the verbal and non-verbal elements in the vloggers' narratives of pregnancy loss—e.g., indexing other videos, pointing at specific parts of the screen, language use, etc.—that influence the creation, perpetuation, and expansion of such community.

As the guiding thread that unites all of these thematic chapters, the intersubjective relationships between the women and other actors is examined as well as the manifestation of pain as an Other that interacts with the women and other actors involved in the experience. Although the physical pain that affects the body plays a significant role in the loss experience, the emotional pain is the most salient and critical form of pain present in these narratives. The centrality of the emotional pain arises from its crucial role in shaping relationships with other actors in the experience as they ignore, understand, or highlight its existence as an Other that affects the women. The invisibility of most miscarriages that Stella speaks to in the epigraph of this chapter is perpetuated as an invisible emotional disruption that hinders many women's

realities after a pregnancy loss, regardless of the type of loss. This emotional pain these women experience becomes an Other they have to fight and conquer in order to rebuild a new identity and a new self that can accept the loss and be at peace with it. Through the empathetic relationships and intersubjective connections with other actors in the pregnancy loss experience, this pain becomes a recurrent theme in the narratives as the women live through pregnancy losses and attempt to recover from the trauma.

By analyzing how these pregnancy loss experiences are shaped and communicated, I seek to open up a dialogue centered on pregnancy loss as an undesirable but natural part of life. My aim, ultimately, is to change how our society receives the news of an unborn's demise, how medical personnel communicate with the grieving parents, and how mothers grief and overcome the pain of such loss.

Chapter Two

METHODS

The data used for this dissertation consist of: (1) interviews of women over 18 years old who have experienced at least one pregnancy loss (study approved by UCLA Internal Review Board: IRB 12-000049) and (2) pregnancy loss vlogs selected from YouTube. The resulting collection of narratives was examined, focusing on language use and content, to understand how women manifest verbally and non-verbally the impact that different actors have in their sense-making process of a pregnancy loss.

Interviews

The first data subset consists of 43 interviews (27 miscarriages and 16 stillbirths) that were collected over a period of two years. Although similar interview/narrative-based studies on other topics have used larger datasets (e.g., Kleinman (1988), Rothman (1993), Mattingly (1998a), Ochs and Capps (2001)), previous works on pregnancy loss have not necessarily used a large number of narratives (e.g., Paton, Wood, Bor, and Nitsun (1999), Harvey, Moyle, and Creedy (2001), and Fairchild (2009), who collected 21, 3, and 24, miscarriage interviews respectively).

To reach potential participants, I contacted people I knew as well as family therapists, support groups, and grief counselors from Ventura, Los Angeles, and Orange Counties and asked them to forward the call-for-participants to those who they believed would qualify and be interested in the study or to post the study's flyer on their websites, blogs, or Facebook pages. This nonrandom method as well as snowball sampling (Atkinson & Flint, 2004; Goodman, 1961), which entails participants referring other potential participants, are recommended when attempting to recruit hard-to-reach populations (Faugier & Sargeant, 1997) as in the case of women who have experienced pregnancy losses. In fact, even when using both methods of data collection several calls-for-participants were needed in order to gather 43 interviews and reach

theoretical saturation (Glaser & Strauss, 1967), at which point no new content or discursive patterns emerged from the data.

The interviews were conducted in person in Southern California and online over video chat with women from anywhere in the United States; table 2.1 represents the distribution of interviews by type of loss and type of interview.

		Type of Loss		Total
		Stillbirth	Miscarriage	
Type of interview	In person	8	16	24
	Online	8	11	19
Total		16	27	43

Table 2.1. Distribution of interviews

To record the in-person interviews, two cameras were used, i.e., one capturing both parties, and a second one capturing a close-up of the interviewee; and to document the online interviews the screen was captured using the software Camtasia, and a video camera was also used to focus on me. An interview guide based on a set of questions proposed by Fairchild (2009) was prepared in case women had trouble telling their stories or did not know how to begin their narratives. For the most part, in order to “get people on to a topic of interest [and] let the informant provide information that he or she thinks is important” (Bernard, 2011, p. 3778) without interrupting them, most interviews were unstructured, using only two prompts. The first prompt was meant to get the women acclimated with the interview environment, feel comfortable about being recorded, and set the background of the loss, elaborating on the circumstances under which they became pregnant. The second one asked the women to narrate their loss(es), giving them freedom to start at any point in the pregnancy, and to expand in any direction in which they felt comfortable. Most interviews lasted around forty minutes, and aside from these two prompts only a few explanatory questions (e.g., requesting expansion on aspects of the narratives that were not clear or clarification of medical terminology, etc.) were needed.

YouTube Vlogs

The second data subset consists of 40 vlogs downloaded from YouTube¹. These videos were posted by women who shared their pregnancy loss stories as part of their usual vlogging. Before posting these particular videos, most of these women had been sharing videos about their lives and pregnancies, and they belonged to what some YouTube users refer to as a “pregnancy community”. Among the videos they regularly uploaded, there were videos on their trying-to-conceive journey (commonly known as TTC videos, e.g., ovulation and basal temperature charts), “finding out” videos where they showed a live pregnancy stick test, early pregnancy symptoms, etc.

A search on YouTube on the subject of pregnancy loss yields over one hundred thousand videos. Since the purpose of this project is to analyze personal narratives of pregnancy loss and determine how a community is built and maintained within the context of YouTube, it was imperative that the vlogs collected represented popular videos that generated enough traffic and interaction to sustain an online support community. The first step to filter out irrelevant videos was to select keywords that encompassed both major categories of pregnancy loss (i.e., miscarriage and stillbirth) and also excluded non-personal narratives. After a preliminary search of different keyword combinations, I decided to combine “my ... story” with the key terms *miscarriage*, *stillbirth*, and *pregnancy loss* in order to obtain the largest possible pool of first person narratives—as of February 2015, the results were approximately 32,800, 7,900, and 66,900 respectively. Among these videos, a large number of them did not include oral narratives (i.e., there was no text or there was written text displayed over a solid color background or a series of images), were related to minors (i.e., either the narrator claimed to be a minor, or the story being told dated back to when the narrator was a minor), were off topic, or had very few views (i.e., less than 1,000 views). Although the chosen number of views might seem arbitrary, the YouTube search showed that roughly the top 50 videos for each keyword used had more than 1,000 views; the remaining relevant videos had on average fewer than 200 views. Since one

of the main reasons for analyzing YouTube stories is to see how a community can be created in this medium, high traffic is necessary to ensure connections are being made between vloggers and viewers. Consequently, a first selection of videos was made by filtering them by view-count and only collecting the vlogs in English with over 1,000 views that included first person oral narratives of women over 18 years of age at the time of the loss, which from all three searches amounted to a total of 60 videos². Although the number of views is the most agreed upon parameter for measuring popularity of a video on YouTube, as a few marketing experts specialized in online media consulted for this project stated, there are other factors for determining ranking and popularity on YouTube, such as number of comments, likes, and subscribers among others (Patel & Patel, 2012), but the metrics on their relevance is not clear.

To determine a proper popularity ranking that included other variables aside from view count and to select the most popular videos as the dataset for this study, I performed statistical analysis of the 60 videos collected. Following what marketing consultants had agreed on was the most important variable for ranking popularity, I considered view-count as the golden standard in the analysis. Additional variables taken into consideration were: subscribers, likes, dislikes, number of comments received, days elapsed since uploaded, and duration of the video; for the latter variable, only the duration of the original video with more than 1,000 views was considered, and subsequent videos that were part of a series were disregarded. A simple visual examination of the data revealed the existence of an outlier, which is “an observation which deviates so much from other observations as to arouse suspicions that it was generated by a different mechanism”³ (Hawkins, 1980, p. 1). A Grubbs test on the dataset reported an outlier value with 99% confidence interval ($p < 0.0001$) for six out the seven variables examined (“days on YouTube” did not include any outliers); two of those outlier values (i.e., those for dislikes and duration of the video) belonged to two different videos, and the remaining four outliers belonged to the same video, which confirmed the initial visual examination. Since outliers are considered “noise that must be eliminated because [they] degrade their predictive accuracy”

(Angiulli & Pizzuti, 2002, p. 15) this video outlier was not included in the subsequent statistical analysis of the data. Table 2.2 illustrates the descriptive statistics of the data and the correlations performed on the data in order to evaluate what variables were relevant for ranking popularity.

Variable	Correlation		Minimum	Maximum	Mean	Std. dev.
	r	p-value				
Views	1.000	0.00000	1025.0	147591.0	14894.3	32336.3
Subscribers	0.245	0.54100	2.0	137625.0	6348.3	19922.2
Likes	0.567	0.00012	3.0	1091.0	136.9	263.0
Dislikes	0.544	0.00004	0.0	101.0	8.6	18.9
Comments	0.668	< 0.00001	0.0	709.0	71.3	131.2
Days	0.166	0.24994	55.0	2593.0	871.8	595.4
Duration	0.061	0.48467	4.8	44.3	14.4	7.4

Table 2.2 YouTube vlogs analytics (excluding the outlier video)

Correlations between the variable “views” and the other ones in the data yielded a statistically significant positive relationship ($p < 0.001$) with likes, dislikes, and number of comments; therefore, these were the variables taken into consideration for the popularity ranking. In order to calculate a comprehensive popularity score, the data from the selected variables was first standardized to obtain comparable scales since, as illustrated in table 2.2, the ranges of the selected variables are very different. With the standardized data, a weighted score was calculated using the significant correlation values, which yielded the following formula to determine the popularity score of each video,

$$\text{score} = (1.000 \times S.\text{views}) + (0.511 \times S.\text{likes}) + (0.543 \times S.\text{dislikes}) + (0.678 \times S.\text{comments})$$

where S.views, S.likes, S.dislikes, and S.comments represent the standardized values of views, likes, dislikes, and comments respectively. Once the popularity score was computed for all videos in the dataset, the 40 videos with the highest score were selected as part of the dataset for this dissertation.

Analytic Approach

The main methodological frameworks used to develop this dissertation were narrative analysis (Bruner, 2002; Labov, 1972; Ochs & Capps, 2001), multimodal discourse analysis (C. Goodwin, 1995, 2013; Kendon, 2000; Streeck, 1993), and conversation analysis (1995a, 1995b). Combining elements of conversation analysis and narrative analysis, an examination of different dimensions in the narratives—i.e., tellership, tellability, embeddedness, linearity, and moral stance—helped unveil how the women make sense of their losses as they tell their stories (Ochs & Capps, 2001; Sacks, 1995a), and how they frame their losses vis-à-vis each relevant actor in their narratives—i.e., the self, the interviewer, the medical personnel, and the YouTube viewers. Moreover, in order to reveal different layers of meaning embedded within the narratives and provide a better understanding of the women’s sense-making process, I performed content analysis and a micro-level analysis of the stories through multimodal discourse analysis, focusing on aspects of delivery—i.e., speech, facial expressions, pitch and intonation, and gestures. By means of this framework I analyzed the intersection between the structure of verbal discourse and the multimodal aspects of the narratives. Some of the discursive features I focused on were transformative operations (C. Goodwin, 2013)—to understand how shared knowledge is recycled through interaction in peer communication of trauma—and format tying (M. H. Goodwin & Goodwin, 1987)—to reveal how syntactic structures are repeated and reused in order to create new meaning. Regarding the multimodal aspects of the narratives, the analysis revolved around gestures and embodiment—following Streeck’s (1993, 1994) and Kendon’s (1994, 1997, 2000) notion that gestures provide information about the semantic content of utterances, thus playing a crucial part in communication—and the interaction between facial expressions and emotions as conceptualized by Darwin (1998) and expanded in Ekman’s (2007; 2003) work.

Notes to Chapter Two

1. The YouTube videos used for this project are considered public since at the time they were collected they were publicly available on YouTube without having to login or use a password or private links to access them. Nevertheless, due to the sensitive nature of the information the vloggers shared, their names have been replaced with pseudonyms in order to protect their identities. On the same token, the screen names of the commenters have been changed, blurred, or deleted to ensure their anonymity.
2. When a video selected in this step indicated it was part of a series of videos posted on the same topic and on the same day (i.e., the title indicated Part 1, 2, etc.), all of the videos in the series were combined regardless of the number of views of the other videos. For purposes of content and linguistic analysis, all of the videos were combined and counted as one; however, only the statistics (e.g., number of views, likes, comments, duration, etc.) of the original video selected were taken into consideration.
3. In the case of this outlier, the different mechanism for generating the data point lies on the method for acquiring viewers. This video belongs to the top fashion vlogger on YouTube, who has approximately 475,000 subscribers, versus an average of 11,000 subscribers for the remaining women in the dataset.

Chapter Three

RECONSTRUCTING WOMAN & MOTHERHOOD IDENTITY: INTERPLAY OF AGENCY, BODY, AND SELF

Those months after [the miscarriage] it was really really hard because I felt so discouraged, and I felt ashamed; I felt like I failed on myself, on Alan, on my family. So I decided not to tell anyone. I decided to keep everything internal, and I didn't tell my friends or family because I felt like I failed. (Chriselle)

Introduction

A pregnancy loss is a unique type of trauma in the sense that a death occurs inside another human being. Unfortunately, this loss sometimes goes unnoticed to those surrounding the mother, and often women have to overcome this experience without any external support, rendering the psychological trauma grueling. The grieving process can be lonely and mentally demanding, causing many women to blame themselves for the loss, to think of their bodies as damaged instruments, and to question their identities as mothers and even women. Studies investigating miscarriage and psychological distress have revealed that self-blame is often present in women with “severe reactions to miscarriage” (James & Kristiansen, 1995, p. 71) and elevated levels of anxiety and depression (Nikcevic et al., 1999). In both studies, participants were prompted through questionnaires to indicate their level of self-blame or responsibility in the losses. This awareness of who or what is responsible for the loss is not always present after a miscarriage. In fact, the cause of approximately 50% to 80% of early pregnancy losses is attributed to chromosomal abnormalities (Babarinsa & Muslim, 2015; Tulandi & Al-Fozan, 2012), which often means the etiology “of a single sporadic pregnancy loss cannot be readily ascertained in the clinical setting” (Laferla, 1986, p. 110). Furthermore, women who experience an early pregnancy loss do not have the opportunity to hold or bury their dead babies. This

inability to determine a medical cause for the demise or to attain closure through the physical contact with the fetus is one of the main factors for problematic grief resolution after a pregnancy loss. It has been determined that an ambiguous loss—i.e., the lack of understanding or closure after a loss—“creates a powerful barrier to coping and grieving and leads to symptoms such as depression and relational conflict that erode human relationships” (Boss, 2006, p. 1), which greatly affects people’s ability of making sense of the experience. In order to overcome this uncertainty, people find something or someone—even themselves—to blame for the traumatic experience. Moreover, those who do not place the blame on themselves or others often accredit their misfortune to chance or bad luck. As Boss (1999) claims, “this is a more functional approach to ambiguous loss than is self-blame. Indeed, attributing the uncertainty surrounding a loss to randomness is in itself a way of making sense of it” (p. 1236). Accepting chance or an external force as an agent and admitting it is not always possible to know why things happen disambiguates an otherwise ambiguous loss. Conversely, self-blame prevents the person from grieving, making sense of the loss, and moving on with her life (Boss, 1999). Regardless of the time elapsed between a pregnancy loss and the recollection of such experience, in an attempt to find a resolution for the origin of the miscarriage or stillbirth, many women blame themselves or their bodies for having failed at carrying a pregnancy to term. Although James and Kristiansen (1995) and Nikcevic et al. (1999) found women admitted self-blame, this attribution is not always overt when women narrate their stories without being prompted to specifically think or talk about blame or the causing agent for the demise. Women who are still processing and understanding a pregnancy loss, are not necessarily aware of their emotional stances, which can manifest linguistically as they articulate their experiences and make sense of the trauma. In these instances, blame can be extracted from the narratives when examining the grammatical agency and the attribution of responsibility for the loss.

It has been widely accepted that the analysis of grammatical markers (e.g., pronoun use, verb tense, etc.) can reveal interlocutors’ social actions (Ahearn, 2001). One of those markers, of

particular interest when studying responsibility and blame, is grammatical agency. All languages incorporate three different relationships: subjects of intransitive verbs, agents—or subjects—of a transitive verb, and objects of a transitive verb (Ahearn, 2001). Furthermore, in English a subject can have different semantic roles aside from agent—e.g., actor, experiencer, instrument, and patient—(Duranti, 1990). This capacity of language to assign different semantic roles depending on the grammatical or discourse strategy used affords speakers to frame events in different ways (Duranti, 1990; Fillmore, 1977). One such way of manipulating discourse strategies takes place in the portrayal of reduced responsibility through mitigated agency (Duranti, 1990, 2004). For instance, the following three sentences roughly describe the same event: (1) the police chased the thief; (2) the thief ran from the police; and (3) the thief saw the police running towards him. However, *the thief* has three different semantic roles. In sentence (1) the thief is the patient of the chasing event. In sentence (2) the thief is the agent of the running event. Finally, in sentence (3) the thief is the experiencer of the seeing event. Although these three phrases describe the same event, they frame the chase differently and introduce different levels of agency for each one of the actors involved. Consequently, through grammatical agency speakers can express—purposely or not—issues of responsibility, blame, and self-blame, even when the speaker is not consciously attempting to attribute fault to one actor or another. These actors who receive blame or responsibility through the discourse strategies in play do not necessarily need to be persons, especially when narrating an ambiguous loss. Blame can be assigned to objects, to external forces, and even to one’s physical body as a separate entity from the self.

In order to comprehend how the physical body can constitute a different entity from the self, it is first necessary to understand the concept of self. From a Heideggerian perspective, Ochs and Capps (1996) remark that “although many societies celebrate the notion of an individual thinking ego, the development of self-awareness in all human beings is inextricably tied to an awareness of other people and things (p. 30). From this perspective, our selves are

created through our past, present, future, and imagined involvement with others. Thus, the constitution of the self “is always, and at the same time, openly shared and deeply personal” (Zigon, 2007, p. 135). Along “a continuum of perceived completeness”(Ochs & Capps, 1996, p. 31), the past and present play a significant role in constituting a person’s self-identity, which is developed through the stories being told, thus creating a “complex, fluid matrix of coauthored selves” (p. 32). As Wynn Leonard (1989) further elaborates in her analysis of Heidegger’s concept of self, these interpretations of the self surface “in our linguistic and cultural traditions and make sense only against a background of significance” (p. 47). Because of the fluidity of the constitutions of our selves, people can construct and reinterpret their selves at any given moment “without necessarily having the explicit concept of the meaning of Being at [their] disposal” (Heidegger, 1927, p. 481). Therefore, when individuals blame themselves for an ambiguous loss, they can construct a particular entity of self on which they place the responsibility for the loss. Although this entity for the most part conceptualizes the self as the mind, this self can include or exclude the physical body. “While the dispositions are indeed embodied, being-in-the-world should not be thought of as bodily. In fact, we should not think of being-in-the-world as a static thing that is located anywhere” (Zigon, 2007, p. 135). This division between the mind and the body has been examined for centuries in philosophy. In fact, Descartes (1641) maintains “it is certain that I, (that is, my mind, by which I am what I am), is entirely and truly distinct from my body, and may exist without it” (p. 1023). This detachment of the body from the mind can be observed in the discourse of patients of serious or chronic conditions as they often refer to their bodies as machines or damaged instruments. In their study of high-tech modern medicine in advanced heart failure, Raia and Deng (2015) connect Heidegger’s concepts of *Zuhandenheit* (ready-to-hand) and *Unzuhandenheit* (unready-to-hand) with bodily experiences. *Zuhandenheit* represents the relationship we have with objects we use everyday (e.g., tools, equipment, or even a shoe), as we use them without even thinking about them or their involvement in our lives. On the contrary, when something that is ready-to-hand

malfunctions, is broken or is missing, a breakdown occurs and our relationship with the object becomes *Unzuhandenheit* (Raia & Deng, 2015; Zigon, 2007). Heart transplant patients conceptualize the body as a tool that becomes prominent when there is a problem with it, which results in interpreting the body as a malfunctioning tool—*Unzuhandenheit*. As Kleinman (1988) acknowledges, in Western societies people think of their bodies as things or discrete entities, “machinelike and objective, separate from thought and emotion” (p. 11). Once pain is felt, for instance in my arm, every arm movement is conspicuous and distinct from the rest of the body, which remains “*transparent* to my perception” (pp. 557, emphasis in original). Advanced heart failure patients experience their bodies as machines that decay into damaged instruments, which translates into experiencing there is something wrong with themselves. “Going to the doctor and learning about [their] malfunctioning heart has now brought to the forefront the function that each body part has in allowing [them] to live” (p. 567). Although the perception of the malfunctioning body as detached from the self is not always present at the conscious level, in most cases this disconnect emerges linguistically as patients narrate their stories.

By examining pregnancy loss narratives collected from interviews and YouTube vlogs, this chapter attempts to generate a better understanding of the sense-making process following an ambiguous loss, particularly as it pertains to the reconstruction of womanhood and motherhood identity. The first section explores the notion of self-blame and mitigated responsibility through the grammatical agency present in the discourse, considering pronoun use and lexicon among other linguistic resources. The second section analyzes the presentation of the self as a separate entity from the body, as women attempt to find an agent responsible for the fetal demise. The third and final section combines the elements previously analyzed to understand how these women reshape their identities as women and mothers after a pregnancy loss.

Grammatical Agency

In English, the intransitive verbs *to be pregnant* and *to miscarry* require a subject that carries out the action. A woman can be pregnant, but a man cannot, and the same applies to miscarrying. Despite what is biologically possible and grammatically prescribed, in recent years in the U.S. it has become increasingly common to hear a woman say “we are pregnant”, implying the involvement of her partner in the emotional and biological process of creating life beyond conception. In fact, there is currently an ongoing debate on online blogs about men “trying to take credit for all the work that being pregnant can be” (LoveESky, 2010) when they say “we are pregnant”, as LoveESky rages in a parentsconnect.com forum, which Weiss (2013) confirms. When the pregnancy is lost, however, the issue of agency becomes more consequential as it carries a sense of responsibility and even blame for the loss, as illustrated in figure 3.1.

Grammatical Agency	Pregnancy	Miscarriage
Self	70%	48%
Self + Partner	22%	7%
Null	8%	45%

Table 3.1 Distribution of grammatical agency

In the data collected, most women (70%) referred to their pregnancies with the verb *to be pregnant* in the first person singular. The second most popular form (22%) was the first person plural, which involved their partners or significant others in the process of being pregnant. Finally, eight percent of the instances mentioning being pregnant did not include an agent for the pregnancy in the formulation. Utterances in this category contained phrases such as *being pregnant* or *to get pregnant*, e.g., “I think to get pregnant again so quickly would be dangerous.” On the other hand, when women referred to losing the pregnancy due to a miscarriage, the grammatical agency involved was much more equally distributed. The form mostly used to referred to a miscarriage (48%) connected the loss with the first person singular.

Whether these women used the verb *to miscarry* (e.g., “I miscarried in June 2004”) or the noun *miscarriage* (e.g., “I had the miscarriage”), the grammatical agency for the loss was placed on themselves. Although grammatical agency does not necessarily entail attribution of responsibility, most cases of self-blame correspond to narratives where the grammatical agency is placed on the self. Contrasting with the low percentage of null grammatical agency to refer to a pregnancy (e.g., to get pregnant), a significant number of instances (45%) included a reference to the miscarriage by using a noun without attributing its causality to any particular person or entity (e.g., “as a result of the miscarriage” or “the miscarriage happened”). These cases where there was a reference to the miscarriage but an agent responsible for the loss was not involved in the utterance were considered as null grammatical agency. In these cases, the miscarriage was presented as something that happened, without it necessarily being anybody’s fault. Most of these women understood the probability of occurrence of chromosomal abnormalities, which is the most frequent etiology for early miscarriages (Babarinsa & Muslim, 2015; Tulandi & Al-Fozan, 2015). Accepting chance as factor in the loss plays a significant role in these women being able to grieve and overcome the loss, as Boss (1999) points out happens with ambiguous losses. Finally, a small percentage of the women (7%) involved their partners in the recollection of the loss (e.g., “we miscarried” or “we had a miscarriage”). Although in these cases blame attribution is not evident, what is salient is the lack of self-blame attribution. By involving their partners in the narratives, these women accepted the demise as a shared loss, without necessarily attributing any responsibility. Furthermore, in these cases the traumatic event is framed as centered on the demise and its aftermath, rather than the women themselves as the cause for the demise. Although the difference in distribution of grammatical agency between the narration of the pregnancy and the loss are strikingly different, most women did not mention both the pregnancy and the loss within their discourse in order to produce a quantitative analysis comparing grammatical agency side-by-side. Nevertheless, a qualitative analysis of selected

narratives can yield significant information regarding the role grammatical agency plays in the sense-making process after a miscarriage.

Taking into consideration that in the data collected only a small portion of the women (22%) produced the inclusive form of *to be pregnant* in the first person plural, and that not all of them mentioned their losses with an attached grammatical agency, the number of cases left for comparing a relationship between grammatical agency, self-blame, and understanding the loss is quite small. Nonetheless, a few instances were found that highlight the importance of language used as part of the sense-making process of an ambiguous loss, which are analyzed in the remainder of this section.

Contrasting Grammatical Agency in Pregnancy vs. Loss

Julie agreed to be interviewed for this project because we knew each other for several years before I even started this project. Prior to our meeting, however, she warned me that she had miscarried 24 years ago and was not able to recall much from the event. In fact, during our encounter, I had to ask multiple follow-up questions in an attempt to elicit a complete story, to what Julie repeatedly replied she could not remember much of what had occurred. Surprisingly, towards the end of the interview Julie became very emotional about the experience of having lost a child, and even acknowledged she had probably hidden those feelings for all those years. These emotions surface in the language used during the interview, particularly when she refers to the pregnancy with the pronoun *we* and the loss with the pronoun *I*. The following excerpt belongs to the beginning of their meeting when I first prompted her to talk about the loss.

Excerpt 3.1: We were pregnant and I miscarried (Julie's interview)

- | | | | |
|---|--------|---|------------------------------|
| 1 | Inter: | So how- how- how did you find out. | |
| 2 | Julie: | That >I-< we were pregnant or that I mis carried. | personal pronoun
contrast |
| 3 | Inter: | Both. | |
| 4 | | How- how was it when you found out you were pregnant | |
| 5 | | and then_ | |

6 Julie: You know, I remember with my daughter, (.)
7 I don't really re(h)me(h)mbe(h)r wi(h)th my(h) so(h):n(h)
8 hehe .hhh=
9 Inter: =Okay.
10 Julie Uhmm, But I (.) remember: (0.4) when I miscarried.
11 (.) Uhmm (1.4) And the thing that was actually
12 I thin:k (1.2) has always been (1.2) confusing to me,
13 (1.0) is (1.2) how little I (.) didn't (0.8) understand
14 what was going on.
15 (1.2) Uhm, (0.4) you know.
16 (1.2) I consider myself (1.0) relatively intelligent,
17 Inter: Yeah
18 Julie: And I wasn't naive or anything,
19 Inter: Yeah
20 Julie: ((clears throat)) and yet, (1.2)
21 I really (1.4) didn't know what was happening.

unsuccessful
reformulation repair
highlights charged
emotional state

Julie replies to my question regarding how she found out by asking for clarification as to whether I am referring to the pregnancy or the miscarriage. At this point, she makes a critical distinction in the grammatical use of the verbs *to be pregnant* and *to miscarry*. Both should be prescriptively conjugated in the first person singular since Julie is the experiencer and subject of the sentence, the one who was pregnant, and the one who miscarried. In line 2, after uttering a brief cutoff “I-”, Julie self-repairs this conjugation and produces instead “we were pregnant”, conforming with the trend of involving one’s partner in the narration of a pregnancy. However, this grammatical trend does not extend to the loss of pregnancies, which is illustrated in Julie’s speech when she says, “I miscarried” also in line 2. Aside from the grammatical contrast of these two utterances, her discourse also involves the presentation of the self vis-à-vis the loss. Julie suggests a shared responsibility of the pregnancy with her husband, yet she describes herself as the sole agent for the loss. This structure, implying herself as the agent, is further reiterated in line 10. In this instance she prefaces the story of finding out about the miscarriage as the one episode she can recall “I (.) remember: (0.4) when I miscarried”, contrasting the memory of this moment with not remembering how she found out about the two subsequent pregnancies. The use of the verb *to remember* in this phrase presents her current effort to piece the story

together and present it to her audience, but it does not necessarily reflect the act of recalling what happened during the miscarriage. In fact, this effort is clouded by her low epistemic stance as she later admits having never fully understood what was happening at the moment of the loss (lines 11 through 21). She prefaces this explanation by qualifying the lack of understanding as confusing (line 12). This bafflement can be observed through the content of her discourse and also linguistically in lines 13 and 14, by means of the reformulation repair that reflects her low epistemic stance and also her current emotional state. In the midst of long pauses, she utters “how little I (.) didn’t (0.8) understand what was going on” (lines 13-14). After an initial hesitation following “how little I” she attempts to repair the utterance with the negating auxiliary “didn’t”. The 0.8 second pause at this moment, suggests hesitation—probably caused by the mismatch between the utterance produced and the intended discourse. She then attempts to repair what was said by formulating “understand what was going on”, resulting in two different formulations of the same idea within the utterance. The final utterance can be rephrased as “how much I understood”, which is the opposite of the intended meaning—which is confirmed in line 21, “I really didn’t know what was happening”. Although this mismatch problem occurs only once in her narrative, the long pauses and hesitations continue throughout her discourse (lines 11-16 and lines 20-21). Furthermore, by repeating in line 21 how she “didn’t know what was happening”, she reinforces her current emotional state as a reflection of the confusion she felt at the moment of the loss. Although it had been 24 years since the loss and Julie prefaced the interview by stating she did not recall much about it, the hesitations in this excerpt as she attempts to make sense of what transpired during the loss reflect her current emotional stance and an unresolved sense-making process. The loss, its meaning, and the emotions surrounding that day had been put aside, left unattended for several years. Yet as she attempts to recall details of what happened and how the miscarriage affected her or not, she unveils all the unresolved emotions and grief. This is clear towards the end of the interview

when Julie becomes visibly emotional and sheds a few tears, as she expresses—quite surprised—she does not know where the tears are coming from.

Taking into consideration how the trauma affected her and she never made sense of the loss or grieved it, it is possible to interpret the contrast between “we were pregnant” and “I miscarried” as more than just attributing the responsibility and blame for the loss to herself. Not only did she physically experience the miscarriage, but the loss also left a hidden psychological imprint on her that even after 24 years surfaced as unexplained emotional pain for the child that could have been. It is through language then, that these unresolved feelings after trauma can manifest themselves even when the experiencers are not aware of their existence. The next case also illustrates how verb conjugation can reflect the emotions that surface during the retelling of loss.

Grammatical Agency as a Reflection of a Changing Emotional State

Laurie, a 41 year-old mother of twins, battled infertility for a few years and lost two pregnancies conceived via in-vitro fertilization (IVF) before giving birth to her two healthy boys. Similarly to Julie’s case, Laurie and I knew each other for several years before the interview took place; however, we found out about each other’s losses after I sent out a call for participants for this research. This personal connection played a significant role in the interview since Laurie admitted she only accepted to be interviewed because of our shared similar lived experience. She had originally refused to participate in the study; nevertheless, after I explained to her the reason behind this project was to understand my own losses, Laurie decided she wanted to be part of it. On the other hand, our shared similar lived experiences yielded a more personal dialogue throughout the interview. The following four excerpts are presented in the order they occurred during the interview, and they display the emotional changes Laurie experienced as she narrated her story.

Similar to excerpt 3.1, at the beginning of the interview Laurie was asked how she found out about the loss, to which she briefly mentioned it was after she was bleeding and went to the emergency room. In order to elicit a richer description of the events, I asked for more details. The next excerpt illustrates Laurie’s response, my request for clarification, and Laurie’s follow-up answer.

Excerpt 3.2: Finding out I had miscarried (Laurie’s interview)

1 Laurie: The standard, (0.8) uhh you know.
 2 Like you find out your’re pregna:nt,
 3 they do (0.8) uhh (0.6) blood test, and things like that,
 4 and then 8 weeks you go see your doctor, you see the heartbeat,
 5 everything’s great, a:nd (0.2) about,
 6 (0.4) say ten to eleven weeks it’s °when I had the miscarriage.° 1st person sg.
pronoun
 7 Inter: So, how was it at the e-
 8 e:verything happened at the emergency room that they told you?
 9 Laurie: Mmhmm
 10 Inter: Did they- was there a tech that told you or
 11 they had to bring a doctor in?
 12 Laurie: It was actually a doctor that saw me
 13 Inter: Oh okay
 14 Laurie: It was a- It was a young doctor that was really nice.
 15 I have, (0.4) kinda weird, but I have (.) good memories of him.
 16 Because he: (0.2)
 17 he took it you know very- it was- took it very simple. 3rd person sg.
(impersonal)
pronoun
 18 (0.2) He was like, (.) we don’t know, (0.6) but let me check,
 19 (0.4) and then: when he couldn’t find the heartbeat he said
 20 I’m- I’m really sorry but yes it is a miscarriage.

Laurie’s answer begins with the enumeration of the major steps of finding out of a pregnancy, i.e., the first tests and doctor appointments she had to go to. Between lines 1 and 5 she enumerates these episodes and concludes in line 6 by saying that around weeks 10 or 11 she miscarried. The utterance “I had the miscarriage” is one of the most commonly used expressions of early pregnancy loss in the data. Women use it to narrate their own experiences and also to report the medical staff’s speech; therefore, Laurie’s utterance in line 6 is not salient among the data collected. However, as she proceeds to describe in more detail how the doctor in the

emergency room discovered the embryo had no heartbeat and revealed it to her, she switches the subject pronoun to *it*. The report “it is a miscarriage”, in line 20, contrasts with the most common form of reported speech in the dataset, “you had a miscarriage”. Although it could be possible that Laurie reported verbatim what the doctor had told her, this is quite unlikely because no other similar cases were found in the data collected¹. Although bleeding in early pregnancy could be an indication of an imminent miscarriage or one that has already taken place, the temporality of both events is not comparable; bleeding is ongoing whereas a miscarriage is an instantaneous action. Therefore, it would be grammatically and contextually awkward to join the bleeding and the miscarriage by means of a copulative verb if the pronoun *it* indexes the bleeding in “it was a miscarriage”. This leads to the postulation that Laurie transformed the doctor’s speech as she reported her encounter with him in the emergency room. Following this notion, it is possible to observe how her grammar use switches with her emotions as the interview progresses and she recalls painful events. If it is the case indeed that Laurie substitutes the doctor’s presumably second person pronoun with *it*, then similarly to Julie’s case seen in excerpt 3.1, this agency detachment is done in part to embed her emotions of the loss experience. The hypothesis of the pronoun *it* indicating Laurie’s detachment of the loss is further emphasized as she later repeats this exact phrase in a different context. A few minutes later in the interview, after Laurie elaborates on her emotions, on the medical care she received at the emergency room, and on the follow-up visit with her doctor, I request clarification regarding the timeline of the events mentioned. The next excerpt illustrates how she recapitulates the events that transpire during her first loss.

Excerpt 3.3: Sequence of finding out of the loss (Laurie’s interview)

- 1 Laurie: This first- so I went to the emergency,
- 2 found out that it was a miscarriage,
- 3 The doctor was nice,
- 4 The second day I had to go back (0.4) to see what was the option.

3rd person sg.
impersonal
pronoun

Because Laurie was initially admitted for the miscarriage at the emergency room, she had to return to her regular OB/Gyn doctor for a follow-up visit the day after. At this visit, she received different options for evacuating the products of conception, which is what she refers to in line 4 when she says, “I had to go back to see what was the option”. In this excerpt, similarly to the previous one, it is possible to interpret the use of the third person neuter pronoun as Laurie’s detachment from the loss. She is not insensible to it, but she uses this grammatical form to manifest the loss as something that happened to her as opposed to her having any active agency in it. When looking at this phrase in line 2, it is clear that from a grammatically prescriptive standpoint, the pronoun *it* is still indexing the bleeding and the episode in general. However, as it was previously mentioned, this is not a common way of referring to a miscarriage in English. This recurrence in the substitution of the first person pronoun with the neuter pronoun *it* further emphasizes the agentive dissociation in her discourse, which can also be found in excerpt 3.4 where she talks about her experience at Planned Parenthood.

As a result of the loss, Laurie had to undergo surgery to remove the products of conception, which was performed at Planned Parenthood. This clinic is well known for their pro-choice support and for performing surgery mostly for abortion cases, although some women who spontaneously lose their pregnancies are also treated there since the surgery needed for the extraction of the remains is the same. After Laurie’s surgery, the medical personnel that was overseeing her recovery failed to notice in her medical chart that she was not there for an abortion and asked her which method of contraception she wanted in order to avoid another pregnancy. The following excerpt illustrates Laurie’s retelling of her response.

Excerpt 3.4: I’m not having an abortion (Laurie’s interview)

- 1 Laurie: And then- And I’m like- I went- I was(h) rea(h)lly b(h)ad.
2 .hhhh I was like (.)
3 I am not having an abortion. — abortion & negation of agency
4 This was a miscarriage, — non-agentive
5 I am trying to have a baby. — miscarriage

Although the context and the grammar are different from the previous two examples, in excerpt 3.4 there is also an agency dissociation regarding the loss. In this case, Laurie contrasts an emphatic rejection of an abortion (“I am not having an abortion”, line 3) with the resignation of the loss (“This was a miscarriage”, line 4) and the implicit refusal to the contraceptives (“I am trying to have a baby”, line 5). The structure of her clarification of not having an abortion follows the grammatical norm previously mentioned for a miscarriage, which also applies for abortions (i.e., to have + miscarriage/abortion). By not contracting the conjugated verb *I am* and producing an emphatic negation *not*, she not only affirms and stresses her agency as a non-abortive one but also portrays herself as someone who is the minority in the surgery floor at Planned Parenthood. Following this emphatic presentation of herself as a post-surgery patient in line 3, she introduces more evidence for why she uses such a strong tone. The reason given in lines 4 and 5 for her elevated and angry tone complete the presentation of herself as a pregnancy loss patient who has just been mistreated when asked if she needed help avoiding a future pregnancy. A recurrent theme in the narratives collected that recall medical encounters is the lack of empathy received from medical personnel. The misunderstanding between the nurses and Laurie bring about her cruel reality that she cannot successfully carry a pregnancy while there are other women who voluntarily choose to end their own pregnancies.

Laurie’s grammatical and lexical choices in excerpt 3.4 distinguish between her rejection of being considered an abortion patient and the sense of defeat regarding the miscarriage. The verb tense change from present continuous in line 3 to past tense in line 4 marks the loss as something that has already taken place and is irreversible. Conversely, as she utters “I am trying to have a baby” in line 5, the present continuous tense highlights her agentive stance as actively trying to carry a pregnancy to term. Moreover, this last tense switch reinforces the anger towards the question of contraception and the intentionality of becoming a mother vis-à-vis the loss of the pregnancy. On the other hand, the lexical choice in the phrases “I am not having an abortion” and “This was a miscarriage” yield a difference in the agentive subjects of each phrase.

The verb *to have* contrasts with *to be* as the first one requires an agentive subject in the sentence and the latter does not. Whereas *to have* is conjugated in the first person singular to remark the rejection of the abortion, she employs a neuter pronoun for the miscarriage, presenting herself as the unwilling recipient of the loss and someone who went through this type of surgery involuntarily.

The combination of grammatical and lexical choices coupled with the content of her narrative unveil her emotional stance towards the loss and the poor bedside manners at Planned Parenthood. Throughout the interview Laurie attempts to overcome the dichotomy of producing a complete description of her losses and not delving too deeply into her emotions and the lived experience. This attempt to detach herself from the losses and the trauma that the experience at Planned Parenthood caused her is illustrated in excerpts 3.2 through 3.4 and continues in several occasions as the interview progresses. Nonetheless, as the story of the losses comes to an end and she transitions into the last pregnancy, that she was able to carry to term, the grammar used once again switches to reflect her change in emotional stances. At the beginning of her last pregnancy, Laurie one more time found out she was bleeding and went to the emergency room, but this time she found out the bleeding was due to implantation of two eggs in her uterus, as described in excerpt 3.5.

Excerpt 3.5: Happy ending (Laurie's interview)

- 1 Laurie: It kind of closed my- m(h)y visit at the emergency,
2 because I started seeing some bleeding again.
3 Inter: At the same time?
4 Laurie: No earlier. I just knew I was pregnant, but we hadn't seen the doctor,
5 we didn't seen any heartbeat. (0.4) But I was like oh no. (0.4)
6 I was sure. (0.2) I was sure it was another miscarriage. 3rd person
impersonal
pronoun
7 It's like this is it, (0.4) This is it, this is the last time,
8 I'm not doing this again, I'm not going through with that again,
9 and Peter was the same,
10 and we got to the emergency and there like (0.6)
11 well we don't know. You're not bleeding that much.

((several lines omitted))

21 Laurie: And so the doctor instead of thinking
22 I was having a miscarriage was like no. I think she's having twins,

((several lines omitted))

38 Laurie: We were leaving thinking I was having a miscarriage,
39 and we came back home (0.6) twins:
40 Inter: with twins.
41 Laurie: hhh. .hh So it was kind of like the- (1.0)
42 the happy ending of the visit at the: (2.2) emergency.

Indexes loss again with
1st person sg. pronoun

She begins narrating the story of the last pregnancy by prefacing it provided her with closure regarding the visits to the emergency room. Until this point going to the emergency room for her meant a miscarriage, which changed for the last pregnancy. Nevertheless, as she tells in lines 5 through 10, the idea of a third consecutive loss was unbearable and would have probably resulted in her last time trying to conceive. The recollection of this traumatic event brings into the present the distraught past emotional stance, which, as in the previous three excerpts, is reflected through her use of the neuter pronoun *it* in order to detach herself from the possible loss. This sorrow dissipates as she explains how the doctors were performing several tests at the emergency room to determine the cause of the bleeding, which was probably due to the implantation of two eggs in her uterine lining. As she reports her interaction with her doctor and what she presumes was the doctor's mental process when finding out about her elevated hCG levels², she uses once again the more common form "I + have + miscarriage" in line 22. This time, the report also includes him thinking Laurie was having twins. This combination of the topic of miscarriage with the good news of being pregnant with twins explains why her emotional stance at this point is not as somber as before and is able to link miscarriage with the first person singular. This grammatical form is later in her discourse reiterated in line 38, when again she contrasts the idea of a possible miscarriage with the actual outcome of being pregnant with twins, which she was able to carry successfully to term.

Duranti (2004) defines agency as “the property of those entities that have some degree of control over their own behavior [and] whose actions are the object of evaluation (e.g. in terms of their responsibility for a given outcome)” (p. 453). Taking into consideration the narrative as a whole, and examining excerpts 3.2 through 3.5, it is possible to understand Laurie’s grammatical detachment from the first person singular as an attempt to stress her inability to control the situations that led to both miscarriages. Although grammatical agency does not constitute semantic agency, by removing herself from the agent position within the utterances that indexed the miscarriages, she presents herself as the recipient of the action rather than the responsible party. This aligns with Laurie’s emotional state at the time of the telling as she relives the past experiences and expresses how she felt victim of the mistreatment at Planned Parenthood and how the bleeding took her by surprise in all pregnancies, not allowing her to revert the situation. The language used then becomes a “mode of experiencing the world” (Ochs, 2012, p. 149) as it reflects the transition of Laurie’s current emotional stance vis-à-vis the trauma experienced.

Detachment of the Self from the Body

Disengagement between the loss and the grammatical agency, presented in the previous section, is only one of the resources women have available to reveal through language their affective stance towards the loss and the sense of helplessness many of them feel. This section focuses on the attribution of semantic agency to the body, as a separate entity from the self, in an attempt to cope with miscarriage and stillbirth as an ambiguous loss.

The lack of a clear etiology for most early miscarriages, and even for the loss of some more advanced pregnancies, inhibit women from understanding and accepting the loss and beginning to cope with it. The absence of definite reasons for the demise results in an ambiguous loss, difficult to overcome (Boss, 1999). A natural and common mechanism for coping with this ambiguity, be it a pregnancy loss or any other type of ambiguous loss, is to place blame on the

self or an external agent. In fact, “determining that ambiguous loss is often caused by an external force and not one's own shortcomings is at the same time tragic and freeing” (Boss, 1999, p. 1243). The majority of early pregnancy losses are not preventable and are caused by chromosomal abnormalities (Tulandi & Al-Fozan, 2015) which cannot be specified. This leads to a great number of women blaming their physical body. This dissociation between the person's mind and her body happens also to patients with other conditions, where the body is conceptualized as a broken machine, separate from the mind or self (Kleinman, 1988; Raia & Deng, 2015).

The Body as a (Broken) Machine

Most of the narratives incorporating the notion of detachment between the body and the self are found in cases of early miscarriage. Women refer to their bodies in the third person, disconnected from themselves, and even report talking to and addressing their bodies as if carrying on a conversation with it. The first example of this dissociation was recorded in Stella's interview. She was 32 years old at the time of the interview and was still in the process of making peace with the idea of never being able to bear a child. At the age of 25, after being married for about three years, she became pregnant but miscarried at ten weeks. Since she was not trying to conceive at the time and was still very young, she was able to overcome the loss and move on. Two years later, when she and her husband decided to try to have children, she found out she had unexplained infertility issues and underwent fertility treatments for the following five years. Doctors finally came to the conclusion she could only defeat her infertility with IVF treatments, but she was not willing to go through this process. At this point she realized that the pregnancy she had lost was the closest she would ever be to becoming a mother. Although that miscarriage had been quickly overcome when it happened, several years later, after trying to conceive for five years, the memory and the idea of that pregnancy took on a different meaning and the wound that had already closed opened up again. The rollercoaster of emotions she

experienced for five years of enduring fertility treatments come to light very clearly during the interview, particularly as she recalls how the miscarriage occurred, illustrated in excerpt 3.6.

Excerpt 3.6: My body rejecting the baby (Stella's interview)

1 Stella: So we went home that night a:nd then the next da:y
2 while I was at work (1.0) uhh (0.4)
3 was when I could feel like my body rejecting (0.2) uhm the baby
4 and uhh (1.0) everything started cramping up_
5 and uhh (0.4) >it was really painful.<
6 .hh uhm hhh. and >it was< really hard cause I was-
7 uhhh (1.4) I was at work you know.
8 I was teaching.
9 so I was like trying to (.) be present to the kids,
10 and it wasn't that- it was a half day.
11 So I- I only had to kinda bear through it for like half an hour
12 so that's why I (0.2) stayed at work, and,
13 on the way ho:me .hh uhm (1.2)
14 I just- I knew it was happening
15 (0.2) uhm and I was:: (0.6) really (1.2) emotional about it,
16 uhm .hh And I just (0.2) was like telling my body
17 No, n(h)o, n(h)o, do(h)n't d(h)o this you know.

"the body" as the agent in the loss

highlights state of consciousness

pretend dialogue between her and her body

At around 10 weeks pregnant, Stella noticed light vaginal bleeding and went to the emergency room. After being examined, she was told that at that moment everything seemed fine and was discharged, which is why she went home that night and returned to work the following day (lines 1-2). The next day, the symptoms of miscarriage began while she was teaching. More than the physical pain and the cramps, she highlights in her discourse a dissociation of the body from herself. In line 3, with "I could feel like my body rejecting (0.2) uhm the baby" she formulates through the language of rejection the thematization of the body as the agent, responsible for creating and hosting the pain, while she becomes a passive recipient and experiencer of the miscarriage. By characterizing the body as its own entity capable of provoking the embryonic demise, she brings the body into the focus of the telling, which progressively becomes more dissociated from her and her mind. This detachment reaches a climax in lines 16 and 17 when she reports talking to her body as an overtly separate entity from

herself. Most likely the miscarriage was caused by a chromosomal abnormality and could have not been prevented. Nevertheless, as she looks back into the experience, taking into consideration all the acquired knowledge of her body since then—i.e., the loss and the subsequent infertility—she blames the body for rejecting the baby. This presentation of the body as the one who caused the loss prefaces the bodily experience of the cramps and the physical pain. Through this organization of the narrative she highlights this dissociation between her and her body, subjugating any other possible relationships with her body—e.g., through the physical pain experienced—to this disconnection. The sense of dread and betrayal felt is exacerbated by the surprise factor, as she was clearly not expecting this loss to happen after being discharged from the emergency room. In fact, despite having bled vaginally she returned to work and resumed her normal life, not suspecting anything bad would happen.

Excerpt 3.6 begins with the location where the main events took place, which is repeated in line 7 (“I was at work you know”). This repetition serves a dual purpose in Stella’s narrative. On the one hand, it emphasizes the idea of unexpectedness as she probably would have remained at home if she knew she was in any danger of losing the baby. Resting would probably have not prevented the loss since she had already started bleeding the night before; nevertheless, in the data collected most women who experience bleeding and think there could be a problem with the baby resort to bed rest to avoid aggravating the situation. Moreover, since there is nothing medically that can be done to stop a miscarriage once the process has begun, resting gives the women peace of mind, knowing they did everything in their reach to keep the baby alive. On the other hand, the repetition of the location becomes particularly relevant when Stella tells how despite the physical pain she was keeping her composure in front of the children in class. Highlighting the setting within her story helps the audience understand the reason behind her emphasis on maintaining her social presence in front of her students. The onset of the physical pain took place in a classroom, a public space where she constituted an authority figure and where it was inappropriate to demonstrate the personal feelings related to this

experience. Moreover, her students were children who were too young to understand the trauma she was enduring. This setting is what motivates Stella's state of consciousness as she was keeping her composure and "trying to be present to the kids" (line 9). She was attempting to control the pain and her body, suppress her emotions, and portray the illusion of a normal life to others, while at the same time she was aware the bleeding and the cramps most likely implied a miscarriage.

As Stella retells her story, the frequent restarts and pauses denote how sensitive she still is to this experience. However, the physical and emotional restraint she experienced at the moment of the loss are no longer present in her narrative, since several times during the interview she lets the tears flow without attempting to wipe them off or to stop to compose herself. Through the content of her discourse—as she reiterates a detachment of herself from her body—and through the grammar used, Stella incorporates an affective stance onto the discourse. In excerpt 3.6, Stella claims she stayed teaching and enduring the pain of the loss silently because she only had to be in the classroom for half an hour. It is in the manifestation of this battle and struggle with her body and the pain, in order to consciously preserve a teacher facade, that the bifurcation of the pain into emotional pain and physical pain become apparent. As in most cases of pregnancy loss, the physical pain was finite; Stella recalls experiencing physical pain in the classroom and trying to conceal it and separate herself from it. Throop (in press) examines this notion of pain as a separate entity that inhabits the body but comes from elsewhere, claiming the pain "does not belong to me. I did not create it, nor do I control it. My pain escapes me. And yet, it is still of me" (p. 312). Understanding pain as an Other explains Stella's struggle in front of her students. She felt at the mercy of her body and the pain, and not matter how much she tried to mentally push them away, their presence was still interfering with her Self as a teacher. As she drove home from school, however, she no longer needed to suppress herself and became very emotional when she realized she was having a miscarriage (lines 13-15). At this point, she reports how her state of awareness of the loss resulted in her talking to her

body and imploring it to not do this (line 17). Similarly to the beginning of this excerpt, here Stella clearly distinguishes between herself as the recipient of the loss and her body as the one causing it, presenting her body as a broken machine who provoked the demise of the embryo. Furthermore, the laughter laminated onto line 17, as she reports the words she uttered to her body, further depict the notion of her as the unwilling experiencer, denoting an affective stance of defeat and the presence of the emotional pain at the time of the telling. Another component that illustrates her emotional stance as attempting to remain distant from the miscarriage is the grammar used. As it was discussed in the *Grammatical Agency* section of this chapter, *to miscarry* or *to have a miscarriage* are the most common forms of referring to an early miscarriage. In the subsection *Grammatical Agency as a Reflection of a Changing Emotional State* it was analyzed how Laurie switched the language and grammar used throughout her narrative, which corresponded with her shifting emotional stance as she narrated different moments of her journey to motherhood, and she used the neuter pronoun *it* to distance herself from the loss. In a similar manner, Stella in excerpt 3.6 refers to the loss with the pronoun *it*, as she mentions for the first time that she became aware of the miscarriage but without overtly stating it (“I knew it was happening”, line 14). Although in this context this form is not as awkward and grammatically salient as the forms Laurie uses in excerpts 3.2 through 3.5, the grammatical structure chosen marks Stella distancing herself from the miscarriage. The impersonal form used indexes the loss, but in her discourse Stella does not provide an explicit referent for the pronoun *it*. Her distancing is even greater than Laurie’s because not only does she refrain from attributing any grammatical agency to herself, but also she seems to not even want to explicitly mention the miscarriage. This distancing from the miscarriage and her body later in her discourse turns onto blame, and at one point she even mentions feeling betrayed by her body, as illustrated in excerpt 3.7.

Excerpt 3.7: I blame my body (Stella's interview)

1 Stella: I think it- (1.0) getting pregnant and: .hh uhm (1.2)
 2 and having a life inside of me even for a short time, .hh uhh (0.4)
 3 kind of (2.6) made me see my body differently? you know? connection with
 4 uhm (0.4) Connect to that part of myself, uhh (2.0) uhm (2.0) her body
 5 I think I also (1.0) now (0.4) after (.) looking back on that experience,
 6 And .hh uhm (2.4) the infertility like see my body's been broken? body as a
 7 .hh uhm Especially: you know my- (1.2) my female (0.2) parts to me broken
 8 like my uterus and my ovaries and stuff like that. machine
 9 I have (0.2) the sense that they're broken:?
 10 And that they're: uhh deficient. .hh uhm And that (.) you know (0.4)
 11 My femininity is: deficient as a result of that? uhh (1.2)
 12 Because there's this part of my womanhood that (1.2) uhm (2.0)
 13 I can't live into or I can express:: uhh (1.2) .hh
 14 Because I think you know
 15 motherhood is such a: (2.8) definitive sign of (.) womanhood, (0.2)
 16 in my mind and also in our culture, in:- in our world,
 17 uhm .hh s:o:: hhh. so I do think it made me feel more- "me" as
 18 (0.8) yeah more broken. uhm (2.2) after (0.2) that (.) experience. broken
 19 Inter: After that experience or- I just find like-
 20 I find surprising that you would refer as broken. (0.2) I don't know. body as a
 21 Like by listening to you talk. Why- why would you say broken? broken
 22 Stella: .hhh Uhm hh. Because it (.) didn't work the way it was supposed to,
 23 you know. Like, (1.0) uhh (1.4) I dunno I feel like my b- (.)
 24 I- I have this sense like wanna blame my body for .hh (0.2) blames
 25 the miscarriage and also for the: (.) infertility. the body
 26 uhh (0.8) That (1.0) there's something wrong with it, you know.
 27 Or something that (0.2) uhh made it reject (.) the baby or
 28 (0.2) made it inhospitable for (.) life, uhm and makes it still.
 29 .hhh uhm (1.0) So:: yeah. it feels like there's something (0.2) wrong.

Stella launches an in-depth recount of her emotions and her relationship with her body by indicating how the loss experience helped her see her body differently and “connect with that part of [her]self” (line 4). However, it is unclear if the part of herself she mentions refers to the physical or the identity aspect related to the pregnancy. If this phrase indexes the physical component, then although she was able to connect with her body, this bond resulted in a negative interaction as she spends the remainder of excerpt 3.7 explaining how she felt betrayed by her body and how she sees it as a broken tool. If, on the other hand, she refers to the identity built as a pregnant woman, she also feels disappointed as she conceptualizes the ideal woman as

one who can successfully carry a pregnancy to term, which she is not able to do. Regardless of what “that part of [her]self” is indexing, it is clear in this excerpt that at the time of the telling, Stella is still coming to terms with the loss, trying to understand her relationship with her own body, and attempting to reconstruct her identity as a woman and mother. The narrative process is commonly “used to rebuild the individual’s shattered sense of identity and meaning” (Crossley, 2000, p. 527) particularly after trauma, understanding identity as “the linguistic construction of membership in one or more social groups or categories” (Kroskrity, 2000, p. 111). This interview was the first time in those seven years post-loss that Stella was able to tell her entire story without any interruptions or fear of being judged, and she was also able to verbalize her emotions towards the experience, her body, and herself.

In excerpt 3.6, Stella denotes a detachment between herself and her body when she indicates how the body was rejecting the baby (line 3) and how she was imploring her body to stop the miscarriage (lines 16 and 17). Likewise, in excerpt 3.7, she further emphasizes this distancing from the physical body when she deconstructs it as a broken machine whose parts—i.e., “[her] uterus [her] ovaries and stuff like that” (line 8)—rendered her incapable of becoming a mother and affected her as a woman. This escalating expression of the body as a broken machine is a reflection of the accumulation of her experience through the miscarriage and also the infertility, which she mentions in line 6. As she continues ruminating on the state of her physicality, her emotions evolve from sadness and frustration to anger and defeat. After expressing the sadness felt while she became aware of the miscarriage, in excerpt 3.6, these emotions evolve into frustration and anger in the first half of excerpt 3.7 when she qualifies her body as deficient. The notion of broken is first attributed to her body in lines 6 and 9 and is later transferred onto Stella in lines 17 and 18 when she says “it made me feel more broken”. There is an emotional escalation that denotes the increased sense of defeat felt as she re-lives the experience of the miscarriage and the infertility through the narrative; the broken body becomes the more broken self that cannot fulfill her role as a woman or mother. Until this moment in the

interview, Stella had made every possible attempt at distinguishing between her mind and self from her physical body as two separate entities. Nonetheless, it is by analyzing and understanding the influence of her body on her identity—performed in lines 11 through 17—that Stella admits to feeling broken. At this point, I enter the space by acting on the term *broken*, which seems particularly problematic for Stella. In my request for elaboration, I do not attach *broken* to either the body or the self, “I find surprising that you would refer as broken” (line 20), forcing Stella to disambiguate my phrase by selecting a noun that the adjective *broken* can modify. Indeed, to my question “why would you say broken?” (line 21), Stella replies “because it didn’t work the way it was supposed to” (line 22), indexing the body as the broken element in the story. In this section of the narrative as she continues to elaborate on her understanding of the state of her body, her emotional stance shifts from the anger and frustration that she had been denoting so far to defeat and sorrow.

In the remainder of excerpt 3.7, as Stella elaborates on her emotions towards her body, the loss, and infertility, she shifts the semantic agency of the loss away from the body. She begins her response by attempting to blame her body for the loss and the infertility, which is already a downgraded sense of responsibility from her body “rejecting the baby” (line 3, excerpt 3.6). As she continues her description of the body and its role in the loss and miscarriage experience, she pulls away the semantic agency from the body, while at the same time the sense of defeat vis-à-vis her body escalates. This upgrading-downgrading process is accomplished through the grammatical organization of the discourse, by means of a series of format-tying utterances (Du Bois, 2014; M. H. Goodwin & Goodwin, 1987), as illustrated in excerpt 3.8.

Excerpt 3.8: Manipulating semantic agency and sense of defeat through format-tying

22 Stella: .hhh Uhm hh. Because it (.) didn’t work the way it was supposed to,
23 you know. Like, (1.0) uhh (1.4) I dunno I feel like my b- (.)
24 I- I have this sense like wanna blame my body for .hh (0.2)
25 the miscarriage and also for the: (.) infertility.

26 uhh (0.8) That (1.0) there's something wrong with it, you know.
27 Or something that (0.2) uhh made it reject (.) the baby or
28 (0.2) made it inhospitable for (.) life, uhm and makes it still.
29 .hhh uhm (1.0) So:: yeah. it feels like there's something (0.2) wrong.

One of the main characteristics of miscarriage as an ambiguous loss is the lack of a clear etiology. After experiencing such a trauma, women seek to find answers and the reason or entity responsible for the loss, in order to understand and accept the embryonic demise. Excerpt 3.8 illustrates how Stella navigates through this ambiguity and attempts to make sense of the loss as “the need to place blame is common in people facing a loss or other traumatic experience” (Boss, 1999, p. 1236). Through a web of format-tying utterances, she searches for the cause of the miscarriage and the infertility. She begins by claiming “there’s something wrong with [her body]” (line 26), but immediately transforms *something* into a different entity that made the body reject the baby, taking the semantic agency away from the body and transferring it to an unknown agent. The sense of defeat portrayed escalates as this new external entity made her body reject her baby and rendered it inhospitable for life (lines 26 and 27). Through another series of format-tying she upgrades the temporality of the inhospitality of her body from the past to the present (“makes it still”, line 28). Claiming an external agent made her body inhospitable for life contrasts greatly with the beginning of excerpt 3.7 where she recalls having had life inside of her for a short time. Although she still has access to the memory of that experience, it was an incomplete experience that this agent, implied in lines 26 through 29, took forever away from her. She finally concludes her explanation in response to why she says broken by recycling the phrase “there’s something wrong”, originally uttered in line 26, but this time without the agentive role attached to it, leaving an unresolved ambiguity regarding who or what caused the miscarriage and the infertility. Through her discourse and the intricate format-tying fabric of blame and responsibility Stella denotes a very conflicted self, inhabiting a ruthless body that caused her great pain, whether it be through its own volition or forced by an outside unknown entity. Moreover, she conceptualized this pain as a separate entity from her body or her Self. She

unsuccessfully attempted to control the physical pain, and the emotional aspect of the pain was still present, years later, at the moment of the interview. The need to find an agent responsible for physical problems is particularly salient in cases like Stella's, where despite having been able to become pregnant once, they can no longer conceive naturally. As Stella narrates her experience, she brings this series of events into a vivid consciousness, which carry with it a series of emotions and memories. This process of recreating these experiences make this heightened forms of traumatic experiences present to her at this point, as she retells her story and ruminates on what the role of her body is and how it impacts her as a woman and as a mother.

The Body and its Influence in Identity Reconstruction

Aside from affecting her sense-making process of the miscarriage, Stella's notion of her body as broken also constitutes a significant factor in the reconstruction of her identity as a woman and a mother, illustrated in excerpt 3.9.

Excerpt 3.9: Stella's body's influence on her identity reconstruction

7	Stella: .hh uhm Especially: you know my- (1.2) my female (0.2) parts to me	body's influence on her identity
8	like my uterus and my ovaries and stuff like that.	
9	I have (0.2) the sense that they're broken:?	
10	And that they're: uhh deficient. .hh uhm And that (.) you know (0.4)	
11	My femininity is: deficient as a result of that? uhh (1.2)	perception of herself
12	Because there's this part of my womanhood that (1.2) uhm (2.0)	
13	I can't live into or I can express:: uhh (1.2) .hh	
14	Because I think you know	perception of the norm
15	motherhood is such a: (2.8) definitive sign of (.) womanhood, (0.2)	
16	in my mind and also in our culture, in:- in our world,	
17	uhm .hh s:o:: hhh. so I do think it made me feel more-	perception of herself
18	(0.8) yeah more broken. uhm (2.2) after (0.2) that (.) experience.	

The previously examined concepts of detachment between the body and the self, and the conceptualization of the body as a broken machine, greatly influence Stella's perception of herself as a woman and a mother. She defines her body as broken and deficient for not being

able to carry a pregnancy to term and for being infertile. In excerpt 3.9, this qualification is also transferred to herself as a woman when she defines her “femininity is deficient as a result of that” (line 11). The pain connoted in Stella’s discourse does not stem from her “confusion about [her new] identity, but from knowing too well what [she] has become” (Goffman, 1963, p. 133). Up until this point in the narrative, it seemed as though contemplating the body as the semantic agent for the loss was part of Stella’s psychological process of grieving and accepting the loss. Nevertheless, the detachment and the blame attributed to the body have much deeper consequences in Stella as a woman, as she feels her womanhood is lacking an instrumental element by not being fertile. This perception arises from her idea of what constitutes the norm for a woman, which she defines in lines 14 through 16. She equates motherhood with womanhood, and if the first one is unattainable, she characterizes the latter as deficient. This identity problem arises from a collective definition of womanhood that stigmatizes childlessness (Miall, 1986; Remennick, 2000) and stereotypes infertile women and those who are involuntarily childless as unfulfilled (Callan, 1987; Lechner, Bolman, & van Dalen, 2006; Letherby, 1999, 2002). The criteria for class-membership for biological man, woman, animal, or even deviant categories, such as homosexual or juvenile delinquent, are fairly straightforward and shared by most (D. E. Smith, 1978), but *woman* and *womanhood* refer to two distinct concepts. A woman is defined as an adult female human being; on the other hand, womanhood denotes the characteristics of a woman and her identity, and it does not constitute a universal category (Bailey, 1999). Womanhood is a concept socially and culturally constructed that can vary greatly even within a community. To justify the notion that motherhood is a significant component of womanhood, Stella expands the roots of her definition from her mind, to “our culture” and also “our world” (line 16). If, according to her, the ideal norm of a woman is universally defined as one who can procreate, then her perception of herself as deficient and broken is not an overly dramatization of her infertility but a reasonable qualification of herself as an incomplete woman. This, however, is her definition of a real woman, and by no means a

universally accepted concept. The miscarriage she experienced seven years before the interview could have been an isolated incident and momentary state; however, introducing the infertility as a trait of who she is now marks in her discourse a part of her womanhood that she cannot get passed and believes renders her deficient. As Stella attempts to reconstruct her womanhood identity—post pregnancy loss and post-infertility—the language used points towards her emotional state of deep sadness, as she knows she can never become a mother unless she resorts to assisted fertilization. She transfers the notion of her body as being deficient to her as a woman being deficient (lines 10-11), which she later upgrades to “more broken” (line 18). While she attempts to build her womanhood identity through her narrative, the language used is insufficient to portray her emotional state of deep grief and sorrow.

Stella was never able to have children, which is what drives her to consider herself deficient and broken. Nevertheless, other women who had living children and subsequently lost a pregnancy also share this understanding of a failing body as a synonym of a failing woman; such is the case of Sara, illustrated in excerpt 3.10. Sara had two children in her early thirties and decided she wanted to expand her family, but unfortunately lost three consecutive pregnancies around 11 to 15 weeks. Particularly the second pregnancy loss was severely traumatic as doctors had to perform an emergency D&E³ on the live fetus at 15 weeks of gestation in order to save Sara’s life. The fact that the surgery performed was similar to an abortion—since the baby’s heart was still beating—deeply traumatized Sara; although the baby had no chance of surviving since Sara’s water had already broken, and the fetus was too young to survive outside the womb. Towards the end of the interview, she commented on the loss experiences and how she felt after deciding her and her husband would not be able to have a third child, which is reflected in excerpt 3.10.

Excerpt 3.10: What's wrong with you? (Sara's interview)

1	Sara:	As women (0.4) and (0.2) you know dads	women/mother norm
2		but moms in partic- >you know<	
3		our- our- our job is to take care and protect our child	
4		and we couldn't even do that.	contrast between her and the norm
5		We couldn't even get it out the gat-	
6		We couldn't even .hh give birth.	
7		Like what an ultimate failure.	body as a separate entity
8		Like I was so mad at my uterus for so(h)m(h)e- I (h)wa(h)s like	
9		*what is wrong with you.* ((higher pitch, looks at her stomach))	
10		you know. I felt like a failure you know.	

Although Sara is a mother and was already the mother of two boys when she experienced her losses, the grammatical organization of her discourse and the connection between motherhood and womanhood are very similar to the ones found in Stella's narrative. Sara defines the norm for what a parent is by invoking women first (line 1), subsequently involving fathers, and finally shifting from women to mothers (line 2) and claiming "our job is to take care and protect our child" (line 3). Analyzing this shift from *women* to *moms* and considering the interaction of the lexicon with the structure of her discourse, it could be argued that both terms are used interchangeably. After introducing women and dads, in order to remove *dads* from the equation, she requires an equivalent noun, which is why "but moms in partic-" (line 2) appears as a repair. Looking further down excerpt 3.10, she corroborates the plural pronouns *our* and *we* refer only to females, as in line 6 she refers to *we* as the ones giving birth. Therefore, Sara's equation of women to mothers—whose job is to take care and protect our children—mirrors Stella's ideal form of women. Another similarity between Stella's and Sara's discourses is the grammatical structure. Sara uses a series of format-tying utterances in order to contrast the ideal woman with her concept of herself, illustrated in excerpt 3.11.

Excerpt 3.11: Format-tying in Sara's discourse

1 Sara: As women (0.4) and (0.2) you know dads
2 but moms in partic- >you know<
3 our- our- our job is to take care and protect our child
4 and we couldn't even do that.
5 We couldn't even get it out the gat-
6 We couldn't even .hh give birth.
7 Like what an ultimate failure.
8 Like I was so mad at my uterus for so(h)m(h)e- I (h)wa(h)s like
9 *what is wrong with you.* ((higher pitch, looks at her stomach))
10 you know. I felt like a failure you know.

Sara's contrast between the ideal woman and her lower perception of herself is softened by including in her narrative all women who have experienced pregnancy losses, through the use of the first person plural pronoun *we*. "We couldn't even do that" (line 4) places directly at the center of attention the contrast between the ideal concept of a woman/mother and her reality. Subsequently, she recycles the structure "we couldn't even" through lines 5 and 6 to define what the pronoun *that* in line 4 indexes, which is to "give birth" (line 6). Although the sense of defeat is present throughout this discourse, it is not as poignant and dramatic as in Stella's interview. Sara refers to the first person in the plural form, thus including others and not pointing the finger directly at herself, and she expresses "like what an ultimate failure" (line 7) without a grammatical agent who is attributed the defeat. Nevertheless, in lines 8 through 10 she connects the sense of defeat with herself and her body, as she reports her questioning why her body would not work properly. The structure and mode of presentation of this report are very similar to Stella's report in excerpt 3.6, lines 16 and 17, but this notion of detachment is only mentioned superficially in Sara's discourse. By incorporating the dialogue with her body as a separate entity, she is able to place blame on it and advance her sense-making process, which Boss (1999) suggests often is the case when facing an ambiguous loss. To counteract the uncertainty of an unknown etiology for the fetal demise, Sara implicitly places the responsibility for the loss on her body, more specifically, her uterus. This helps her cope with the unpredictability of the

situation and make the overwhelming experience more understandable to her. Although in most cases of pregnancy loss the mother is at no fault for the demise, which doctors tend to stress during medical consultations, women tend to conceptualize their body's failure as their failure as women. This sense of disappointment can be observed in Sara's discourse as she continues the contrast between the ideal woman and herself by recycling the expression of failure, first introduced in line 7, into "I felt like a failure" (line 10), incorporating herself in the narrative as the experiencer. Consequently, Sara's reconstruction of her identity as a mother and a woman originates on her interpretation of her broken body that provoked the fetal demise. A pregnancy loss is a traumatic experience that yields many changes in women's lives, but not all women have to interpret their bodies as machines or broken tools in order to (re)construct their identities as women or mothers, as it is examined in the next section.

Reconstructing Motherhood and Womanhood Identity

When a woman finds out she is pregnant, she also comes to the realization that her body will change, new life will grow inside of her, she will give birth to that baby, she will become a mother, and hopefully she will see that baby become a toddler, a child, a teenager, and an adult. The life of that woman changes the instant she sees that positive pregnancy test. During the following nine months, she will prepare herself to give birth to that child and to welcome that person into this world. Part of this preparation entails contemplating who she will become as a mother and as a woman, what changes she feels necessary in her life, and how she envisions the child will change her life. This process of constructing a motherhood identity interjects with the reconstruction of her womanhood identity. For some, however, a pregnancy loss truncates the possibility of motherhood while highlighting the imminent need for a new womanhood identity. Whether women lose their babies from a miscarriage with an unknown etiology and resort to blaming their bodies for the demise, as examined in the previous section, or from a stillbirth with clear causes, they question who are themselves as mothers and as women. While some

women have a positive outlook on the situation and count with the support of family and friends to overcome the loss and move on with their lives, this is not the case for all women. The following three examples illustrate how women deal with the reconstruction of their identities after a miscarriage or a stillbirth.

The first example belongs to Melinda's YouTube vlog. Although her channel does not focus on parenting or family, through other social media outlets followers requested that she devoted one video to pregnancy and pregnancy loss. At the time Melinda recorded the vlog it had been eight years since she had a miscarriage; nevertheless, she was still able to recall the emotions and sense of doubt she experienced short after her loss, as illustrated in excerpt 3.12.

Excerpt 3.12: I wasn't a woman enough (Melinda's vlog)

1 Melinda: And you know after I had the miscarriage- >you know<
2 it made me f- and also made me feel like I wasn't a woman enough.
3 Like (0.2) >I was-< you know I can't carry a child?
4 I can't .h give birth to a child? (.)
5 But (0.2) know you- you- you'll be alright.

womanhood identity reconstruction
characteristics of the ideal woman

Melinda introduces the reconceptualization of her womanhood identity as a consequence of the miscarriage. She does not incorporate her body in her discourse as the agent for the loss, nor does she attempt to place the blame on anyone, as she understands and accepts the cause for the loss is undetermined. Nevertheless, the loss affects her perspective of herself as a woman. In line with Stella's and Sara's discourse, examined in the previous section, she interprets a woman as one who is able to carry a pregnancy to term without medical assistance. Format-tying, as in previous examples, is used to enumerate and expand on the characteristics of the ideal woman that she lacks. In line 3 she states "I can't carry a child", which she recycles in line 4 by replacing the main verb ("I can't give birth to a child") to emphasize her unsuccessful pregnancy experience and justify why after the miscarriage she felt she was not "a woman enough" (line 2). Her presentation of this past emotional stance, however, contrasts with the content of these

utterances. Since she miscarried she was able to give birth to two healthy children, and with time she overcame the loss. Her emotional stance at the moment she recorded this vlog seems to be serene and collected, which contrasts with the reported experience of distress and desolation when she questioned her womanhood identity. Her composed demeanor also gives meaning to her encouragement words in line 5. If only focusing on the discourse and ignoring the emotional state embedded onto the narrative, line 5 seems contradictory. Before then, she just expressed how she questioned herself as a woman after her loss, yet she promises the viewers they will be alright. However, the implicit message embedded through her calm emotional state indicates that she was able to overcome her shattered womanhood identity. She denotes that despite the identity crisis she experienced, she coped with the loss, had children, and resumed a normal life. Therefore, the implied message carried within her discourse and the embedded emotional stance is that if she was able to overcome the miscarriage and the emotional trauma after that experience, so can the viewers.

Melinda's fiancé played a significant role in her emotional recovery; he encouraged her to take time to herself to grieve and not bury the emotional pain of the lost pregnancy with a new one. Unfortunately, not all women have the needed emotional support from friends and family. Even when those who are close share well-intended words of encouragement, often they rush the grieving woman to cope with the loss and move on, hoping she can leave the sadness behind and resume a normal life. This was the case for Karla, who lost her son Joel immediately after birth. At 19 weeks pregnant, Karla found out her son had alobar holoprosencephaly, a rare congenital brain malformation which is lethal (Monteagudo & Timor-Tritsch, 2016). She carried the pregnancy to 23 weeks, and after being in labor for 21 hours, she delivered Joel, who lived only for one minute. As she reported during the interview, her family and friends were very well intended after the loss; however, they did not want to see her sad and encouraged her to move on and not think about him. Karla's reaction at the time was to seclude herself in her home and avoid social gatherings; she developed an anxiety disorder and often experienced panic attacks.

As she reflects back on those interactions with her friends and family, she points out how their reactions would probably have been different if Joel would have died later as a baby or a child, since he would have had time to bond with them. Nonetheless, she had developed a bond from the moment she found out she was pregnant, and the wound for her was as deep as if he would have died later in his life because he was already her child. The next excerpt illustrates how Karla describes her interpretation of motherhood as it relates to the loss of her son.

Excerpt 3.13: Becoming a mother vs. being a mother (Karla’s interview)

1 Karla: >you know< My feeling is-
 2 is the moment you find out you’re pregnant you become a mother.
 3 (0.2) And you have hopes, and you have dreams, Motherhood
 4 and (.) you mother that baby. (0.2) From that moment. identity
 5 (.) And so: it doesn’t matter how old your child is,
 6 it is always devastating. Truncated
 7 Because you (.) lo:se (.) your dreams of (.) being a mother. motherhood
 8 And you lose your: dream of having a child. experience

Karla defines the starting point of motherhood as the moment a woman is aware she is pregnant. She includes the hopes and dreams of being a mother as what constitutes the first experiences of motherhood. Whether the woman is taking care of her body or planning for the baby’s future, she is actively mothering that child and conceptualizing his future and the development of her new identity as a mother. Through the differentiation between conceptualizing and actively doing mothering, Karla presents in her discourse a contrast between identity and experience. For her, a woman becomes a mother “the moment you find out you’re pregnant” (line 2), whereas the experience of being a mother can be truncated if the pregnancy is lost (line 7). This opposition between motherhood identity and motherhood experience is one that many women face post-loss. Most people who have no connections with pregnancy loss consider a woman becomes a mother when she gives birth to a live child; conversely, those who have faced pregnancy loss often argue they become mothers the moment they become pregnant. In fact, as part of the data collection for this project, women were asked

to fill out a brief demographic questionnaire that included the question “Do you have any children?”. Participants had to fill this out in front of the researcher and often requested clarification as to whether this included their deceased children—from miscarriage or stillbirth—or not. In all cases the researcher responded participants were free to answer as they felt was more appropriate, which led to them including the children lost to miscarriage or stillbirth as part of their total number of children. In excerpt 3.13, Karla speaks to the construction of a motherhood identity after a pregnancy test, and she highlights that regardless of the child’s age—whether the demise occurs in-uterus, immediately after or several years after birth—the pain for a mother is always shattering. Since even the early stages of pregnancy provide a woman the possibility to “invoke her future mother self” (J. A. Smith, 1999, p. 294), the broken dreams and interrupted imagined future result in the devastating pain that Karla refers to in lines 5 and 6. Aside from the physical trauma that miscarriage and stillbirth cause, the collapse of an idyllic envisioned future creates the psychological trauma that many women have to confront, and not all of them have the tools to cope with. This understanding that the future no longer holds what one had planned unravels a series of questioning. Women find themselves searching for a reason for such loss, attempting to find an agent who caused it, and ultimately having to reconceptualize who they are as mothers and women, since they no longer exist within the present and future envisioned self.

In the data collected, women who suffered a stillbirth had a stronger stance towards their motherhood identity compared with those who experienced a miscarriage. All of the women who spoke about motherhood identity post-stillbirth considered themselves mothers and did not doubt their identity as mothers, regardless of whether they had living children or not at the time of their narratives. The next excerpt illustrates one of these cases; Heidi had lost a pregnancy at 24 weeks, and 5 months later she recorded her story to share on YouTube.

Excerpt 3.14: I am a mom (Heidi's vlog)

1 Heidi: .hhh And I just wanna say: like .hh
2 (0.2) I'm really grateful for Adelaide.
3 Even if I never have any other children. .hh Uhm
4 (0.4) I got to feel her kick. construction of
5 (1.6) And I got to hold her and some moms never get that. motherhood identity
6 (0.2) Some women never get to be moms. .hh
7 And I am a mom. And I will always be a mom. (1.0) Uhm (2.6)
8 And so:: (2.8) I'm gonna try and make a little brother or sister.

The physical contact with the child—i.e., being able to physically feel the baby in the womb and having the possibility of holding the baby after birth—is one of the main differences between a miscarriage and a stillbirth, and it also constitutes a key player in the women's reconstruction of their motherhood identity post-loss. The inaccessibility to physical closure is crucial in deeming a miscarriage an ambiguous loss (Boss, 1999). Women who experience a miscarriage normally pass the products of conception on their own or through a surgical procedure. Given the embryos' or fetuses' small size and method of extraction, women seldom have the possibility of seeing them as fully developed babies by the end of the first trimester—which is the period when most pregnancies are lost (Tulandi & Al-Fozan, 2012; Wilcox et al., 1988). This situation is further aggravated when the baby's existence is denied or dismissed, which leads to the woman's "rapid de-construction of her motherhood" (Lovell, 1983, p. 760) and subsequently questioning of her womanhood identity, as examined in the previous section. In excerpt 3.14, Heidi speaks to this lack of physical contact with a baby as she shows gratefulness for having felt the baby kick and being able to hold Adelaide after she was born. "Contact with a dead baby [is] an emotional but positive action and seen as important in helping to face and accept the loss" (Lovell, 1983, p. 759). It is through this manifestation of Heidi's brief physical experience as a mother that she constructs a strong motherhood identity, denoted in lines 7 and 8. The restating and tense shift in "And I am a mom. And I will always be a mom." (line 7) confirms that Heidi, regardless of the brevity of the physical experience, conceptualizes

herself as a mother. This is reiterated as she concludes saying she will “try and make a little brother or sister” (line 8), implying Adelaide is her first born daughter and any subsequent children she births will be her siblings.

Heidi, Karla, and the many other women who consider themselves mothers after a pregnancy loss, regardless of whether they have any living children or not, contradict Mead’s (1934) proposition that our own selves can exist only in so far as the selves of others exist and enter as such in our experience. The relational and symbiotic relationship between a mother and her child determines that for there to be a mother, there has to be a child. Yet the women in this project illustrate how this relationship can be born out of hopes and dreams during pregnancy and not necessarily constructed on concrete conscious experiences. Pregnancy is an “image-making stage” (Galinsky, 1987, p. 14) where women prepare themselves for a change in their sense of self and learn to bond with their babies. For many women after a pregnancy is lost, the imagined motherhood identity is torn. Many others, however, like Karla and Heidi, fight to preserve their motherhood identity and empower those whose identity has been shattered for never having met their babies.

Conclusion

This chapter examined the role of narratives in women’s attempts at making sense of their pregnancy losses and at understanding how these losses affect them as mothers and women. In order to unveil how women achieve the linguistic construction of their identities, particular attention was paid to three separate components of their stories: the interaction between grammatical agency and semantic agency role as it pertains to blame and responsibility attribution of an ambiguous loss, the linguistic resources used to portray a detachment between the body and the self when recollecting the loss experience, and the grammatical organization of the reconstruction of their motherhood and womanhood identity.

The vast majority of pregnant women begin to create an ideal future mother self from the moment they find out they are pregnant (J. A. Smith, 1999). Galinsky (1987) supports this notion of pregnancy as an “image-making stage” (p. 14) where men and women prepare for parenthood and a new sense of self. This preparation is both physical and emotional. While the pregnancy progresses, women experience physical changes as their organs shift positions to make room for the growing baby, and at some point during the second trimester they begin to feel the baby move inside the womb. Likewise, hormonal changes can affect women emotionally. When a pregnancy fails, the physical readjustment to non-pregnant status slowly begins, sometimes even before the woman is aware of the loss. This physical temporality contrasts with the immediacy of the emotional shock. The preparation for motherhood stops abruptly, and women are left in the midst of understanding and building their new identities and futures. The unexpectedness of the loss leaves most women adrift without knowing how to recover a sense of normalcy and reconstruct their womanhood identity and their still-not-fully-conceptualized motherhood identity. Unlike any other type of death, even the death of a living child, many women feel a part of themselves dies when they find out the pregnancy was lost or its imminent loss is irreversible. As Heidegger (1927) explains, the death of Others “is not something which we experience in a genuine sense; at most we are always just ‘there alongside’ [and by no means we can grasp the] loss-of-Being as such which the dying man ‘suffers’” (p. 7961). Nevertheless, when the Other is inside the woman and still physically connected to her through the umbilical cord, the conscious division between the Other and the Being becomes unclear. This inability to separate the Other from the self leads to a death experience that is part of the woman’s self experience, leaving many women feeling guilty for not having been able to foresee the loss. Although this remorse is often not apparent at the conscious level, it can surface in the women’s narratives through the linguistics resources used, such as grammatical agency.

Women often employ non-prescriptive grammatical constructions to reflect their emotional stances vis-à-vis certain traumatic moments in their pregnancy loss experiences. In

the data collected, grammatical agency can be generally associated with attribution of blame and responsibility, particularly in cases of early miscarriage when women are searching for a concrete reason for their losses. Knowing exactly what caused a pregnancy loss can have beneficial psychological effects, even months after the loss (Nikcevic et al., 1999); however, most miscarriages are lost due to chromosomal abnormalities (Tulandi & Al-Fozan, 2012), which constitutes a vague etiology. Women try to overcome the psychological burden of the ambiguity in early pregnancy loss, and even sudden or unexpected stillbirths, by finding a responsible agent for the loss. Most of the time, in an attempt to resolve this ambiguity they place the blame on themselves or their bodies, as separate entities from themselves. This sense of responsibility or blame can be manifested overtly as women sometimes “express feelings of blame of themselves or having others imply that the woman was to blame for the [pregnancy loss]” (Abboud & Liamputtong, 2002, p. 47). Nonetheless, the voicing of guilt and responsibility is not always overt, but it does frequently surface in narratives through non-prescriptive grammatical agency, which was the case for Julie and Laurie in the first section of this chapter. Alternatively, blame can emerge in the discourse through the personification of the body, as was the case for Stella or Sara, who reported talking to their bodies in the second section of this chapter. This separation of the self as a separate entity from others affecting the experience and the constitution of the person can often be seen with regard to the body and also the pain experienced. Stella, Sara, and many other women on the data reported imploring or begging their bodies to not lose the baby. In their narratives they portrayed their bodies as agentive entities capable of the fetal demise and of causing them devastating physical and emotional pain. In a similar way, when referring to the pain this dissociation from the self was also present as they had no control over the pain, and often attempted to obstruct it, diminish it, or even forget it to no avail. Throop (in press) emphasizes that “pain experienced as “mine” often evokes a sense that my body is no longer now precisely my own” (p. 312). It is precisely this conceptualization of the body and the pain experienced—both physical and emotional—as two

external forces, strangers to the Self, that acts upon a woman and renders her powerless, hindering the psychological recovery after a pregnancy loss.

In all these instances examined, narratives are used for more than just recalling stories. Women analyze their experiences by piecing the traumatic events together, which helps them understand the loss and begin to overcome what they have endured. In psychotherapy sessions, the production of narratives is encouraged, as they provide an opportunity for those who have lived through trauma—and are still attempting to make sense of what they endured—to rebuild their sense of self (Crossley, 2000) and create meaning from the lived experience. As they retell their stories, women who have experienced a pregnancy loss have an opportunity to reconstruct the mother-to-be identity they had began building while pregnant. Whether the pregnancy loss occurred weeks or months after conception, most women had already begun conceptualizing themselves as mothers. For new mothers, the pregnancy meant the opportunity of giving birth for the first time and having their first child; for those who already had living children, it meant expanding the family and seeing their children grow together and become best friends; for those who had previously lost a child, this new pregnancy meant a new opportunity at rebuilding a motherhood identity. For all those women, the lost of a pregnancy brought a shattered identity as well as dreams and hopes. Although several women in the data collected pointed out that once a woman carries a child she becomes a mother, the truncated possibility of physically becoming a mother and mothering that child leaves a whole in their sense of selves. They become childless mothers, which is not the identity they had envisioned. As they narrate their stories, many of them for the first time take the opportunity to define how they see themselves, who they are as women and mothers.

Notes to Chapter Three

1. YouTube and Google were also searched in order to find out the frequency of “it is a miscarriage” versus “you had a miscarriage” or a similar form involving the second person pronoun. When searching for “It was/is a miscarriage”, no identical hits appeared on the first page of either search engine. On the other hand, when searching “You had/are having a miscarriage”, all of the results in the first page included either the phrase “You had a miscarriage” or “You are having a miscarriage”. These findings then confirm that it is not common to say “It is a miscarriage”, and it is therefore reasonable to believe Laurie’s doctor did not express himself in those exact words either.

2. The earliest method available for diagnosing a pregnancy is assessment of the serum human chorionic gonadotropin (hCG) in blood or urine (Lockwood & Magriples, 2015). The hCG concentration rises as the pregnancy progresses during the first 10 to 11 weeks of gestation. A slower than normal rise suggests the possibility of an abnormal pregnancy (eg, ectopic, threatened miscarriage, etc) (Bastian & Brown, 2014). On the other hand, an elevated hCG concentration could be indicative of multiple gestation (Urbancsek et al., 2002).

3. Dilation and evacuation is a surgical procedure performed early during the second trimester to terminate a live pregnancy or to manage a spontaneous abortion (Hammond, 2015; Tulandi & Al-Fozan, 2015).

Chapter Four

LOSS EMBODIMENT IN NARRATIVES¹

And so you sit in a room with other women; some women had lost the babies to SIDS and lost their seven-week old. And then there were moms who lost seven-week pregnancies and it didn't matter; it didn't. We didn't judge each other based on who carried the baby the longest. It was just... we were all in this shitty club of we-were-supposed-to-have-babies-and-none-of-us-do. (Karla)

Introduction

Grief support groups constitute safe places created to share the traumas experienced, generally focusing on a particular type of trauma, where people from all walks of life meet, share their pain and sufferings, and give each other comfort and the strength to accept what happened. Depending on the topic and the setting, they can be led by family members, friends, peers, members of the clergy, or mental health professionals. With the exponential growth of Internet accessibility, online support groups and discussion boards are becoming more popular, which means more people have access to peer support; unfortunately this also means that for certain populations in-person support is not as easy to find, which is the case for pregnancy loss. For those who are not affiliated with any religion, the number of secular pregnancy loss support groups is quite small even in large cities, and in general those groups encompass miscarriages, stillbirths, and perinatal loss, as Karla mentions in this chapter's epigraph. Nevertheless, those who do have access to these groups report how sharing their stories with peers without being judged impacts significantly their emotional and psychological recovery. Talking to others who have experienced similar losses and who are also grieving facilitates the sense-making process; this relationship between peers is the focus of this section. At the center of this chapter lies the relationship between the interviewees and me, as the recipient of the stories and as a peer who

experienced two pregnancy losses. This chapter analyzes the recipient-oriented discourse of trauma formulated in the presence of a peer who listens without judging and who can empathize with the trauma endured. The focus lies on the embodiment aspect of the narratives to understand specifically how representational gestures (Kita, 2000; McNeill, 1992) help make sense of the losses and advance the grieving process in the context of peer communication.

Following a miscarriage or a stillbirth, women often face silence or blank stares when sharing the news with others. Pregnancy loss is still considered a taboo topic in modern American society (Layne, 2000); furthermore, it revolves around the death of a being that nobody other than the mother knew, and most people avoid talking about death. Family and friends may have known the woman was pregnant, and they might have even seen her stomach grow as the weeks went by, but they never met the baby. They never touched him or felt him, and they were not able to create a “we-relationship” (Schutz, 1967) with him; nobody other than the mother bonded with him. When he died, others did not mourn his loss for long. However, this loss brought the mother’s life to a grinding halt, and in many cases she felt alone, as nobody knew how to face that death. Nobody wanted to talk about it or hear about it (DiMarco, Menke, & McNamara, 2001). To overcome this silence, many women resort to peer support found online or in person. Although not every woman in this study had participated in a support group, over half of them did and reported positive results. Particularly those who attended in-person support groups expressed how the interaction with peers helped them feel validated and understand their own losses, as Carla explains when asked if she contacted any support groups after losing her daughter at 23 weeks.

Excerpt 4.1: You can tell all your dark thoughts (Carla’s interview)

- 1 Carla: I found one uhm (0.2) in Ronca City
- 2 which is about an hour away from Stailweather,
- 3 I live in Stailweather Oklahoma, (.) uhm
- 4 and I was able to go there, (0.2) uhm
- 5 and I was pretty angry after- after she passed away,

6 uhm and so they definitely helped a lot. uhm you know
7 because these are all people who lost children and
8 .hh just being able to talk with them, and be like you know
9 I'm angry at everything and you can tell all your dark thoughts
10 and like they don't judge, they- they thought those same things.
11 so (.) uhm that was really helpful.

Although Carla in the previous excerpt emphasizes the idea of support groups as a judgment-free setting, where those present have experienced similar anguish, many women steer away from face-to-face support groups in fear of “feeling immediately judged by others” (Gold, Boggs, Mugisha, & Lancaster Palladino, 2012, p. e71) and turn to online message boards and other more anonymous forms of support instead. This paired with the convenience of accessing an online message board around the clock plays a significant role in why only approximately 30% of the women interviewed reported sharing their stories in face-to-face support groups. As Carla points out, the closest support group she found was an hour away from her hometown. Even in larger cities support groups are scarce and often meet at times when it is difficult for mothers who work or those with young children to attend. Nevertheless, the power and benefits of sharing stories with peers has been studied for pregnancy and perinatal loss, revealing it helps lessen traumatic stress symptoms (Cacciatore, 2007), and provides long-term benefits and new coping strategies (Cacciatore, 2007; Côté-Arsenault & Mason Freije, 2004). In fact, not only did most of the women in the dataset praise their support groups and expressed how they played a key role in beginning to cope with the loss and resume a somewhat normal life, but they also formed strong relationships with other members of the groups, and some women even became facilitators of new support groups themselves, as Olga describes.

Excerpt 4.2: Incredibly healing (Olga's interview)

1 Olga: It's total peer support. (0.2) .hh uhm so: (0.2)
2 having had somebody: (0.8) be there for me. (0.2) you know
3 uhm (1.0) I had to be there for somebody else because (0.2) uhm
4 (1.0) because I knew what it was like in all ways shapes and forms
5 and .hhh true to the day I mean. (1.6) the experiences are so alike.

6 .hh but (0.8) because I'm a communicator?
7 you know that's always worked for me
8 whether it was writing, or even listening or reading
9 in communicating in that very (0.2) one to one way
10 with text or literature, (0.4) audio, .hh you know. (0.2)
11 ha- b- but being with another human being. (0.2)
12 and speaking and communicating. .hhh uhm it's incredibly healing.
13 (0.6) you know. (0.2) it really is.
14 And (0.2) you know also (0.4) speaking helped me: (0.4) realize things
15 I didn't even realize. you know.
16 Because (0.2) you're looking at that mirror image
17 and it's (.) >you know< kind of a reflection of yourself.
18 Even though we all experience things differently so,
19 .hhh you know just to (.) let people know that they're not alone.
20 And that's it.

In the previous excerpt Olga touches on several key aspects of this chapter. As Carla had already mentioned, Olga points out the importance of understanding and having lived through similar experiences as “you’re looking at that mirror image and it’s kind of a reflection of yourself” (lines 16-17, excerpt 4.2). This idea of shared knowledge as an aid in the recognition and understanding of each other’s loss and grief is present in the discourse of most women who have experienced a pregnancy loss; in most cases, they feel a lack of empathy and misunderstood by those who have not experienced a similar loss. Nevertheless, empathy as “the suspension of the self to take the place of the other” (Frank, 1985, p. 190) does not require a shared lived experience; it is an asymmetrical experience as one can never experience the Other’s experience, only experience the Other as she is living through the experience. In fact, the projection of one’s emotional state onto another person often results in misunderstanding and evidence of lack of empathy (Hollan, 2008). As Hollan (2008) remarks, empathy involves the intersubjective processes of understanding another and being understood, and it is through this exchange that “there are moments of possibility in which another may perceive aspects of my own self-experience that I am not yet aware of myself” (Throop, in press, p. 326). By listening, empathizing, and letting “people know that they’re not alone” (Olga, line 19, excerpt 4.2), the act

of sharing their stories becomes the act of making sense of their own losses and the beginning of the emotional healing process.

Traditionally in peer-support groups, a facilitator moderates the floor so everyone has an opportunity to participate. Although attendees do not necessarily tell their full stories as they can do in a one-on-one interview, they share excerpts of their experiences and hear other people's narratives. By means of this interaction, they identify themselves with others in similar situations, which can create a sense of belonging and a support system beyond the scope of the meetings (Ussher, Kirsten, Butow, & Sandoval, 2006). Conversely in an interview, the interviewer rarely has the opportunity to share her own experience. Despite the unidirectionality of the narratives in this setting, interacting with a peer can also bring out healing and a sense-making narrative. Unlike in interviews where the researcher has no commonalities with the participants outside of the research setting, in this study all participants knew of my story with pregnancy losses before they agreed to share their own stories. This openness can lead to a setting in which the interviewer is able to develop a rapport with the participants (Elliott, Watson, & Harries, 2002) and not be seen as a threat or someone who would judge the stories being told (Staley, Buckland, Hayes, & Tarpey, 2014). The practice of involving peers as interviewers to access hard-to-reach populations is widespread (Bengtsson-Tops & Svensson, 2010; Elliott et al., 2002; Noland, 2012; Staley, 2013; Staley et al., 2014). Furthermore, having a peer conduct interviews has proven to be valuable for creating a better understanding of the experience (Elliott et al., 2002) and "to improve the quality of the data and the depth and validity of the analysis" (Staley, 2013, p. 186) because interviewees feel more at ease during the interaction. In fact, several women interviewed for this project mentioned they accepted to participate solely because I had introduced myself as someone who's identity had been shaped by pregnancy loss; moreover, they even thanked me for the opportunity to freely tell their stories, many of which had never been told from beginning to end before the interview took place. They believed this shared experience would result in a greater possibility of

understanding during the interview, which was necessary for them to truthfully and openly narrate their losses without the fear of being judged. Other pregnancy loss studies involving interviews do not mention that lack of a shared experience between the interviewer and the interviewee could hinder the collection of detailed stories. Nevertheless, some studies acknowledge a low rate of acceptance to participate in interviews (Fairchild & Arrington, 2011; Paton et al., 1999), which could be attributed to a difference in “loss identity” between the research team and the potential participants. Excerpt 4.3 below, clearly illustrates the cathartic effect on Sandy for sharing her loss as she comments on it towards the end of her narrative.

Excerpt 4.3: It’s always helpful to tell the story (Sandy’s interview)

- 1 Sandy: It’s helpful to talk to you so thank you. hehehe
- 2 Inter.: Well thank you for sharing.
- 3 Sandy: It’s always helpful to (.) tell the story
- 4 I don’t know why. but it really is.

Similar to Olga’s comment on how being and communicating with another person is “incredibly healing” (Olga, line 9, excerpt 4.2), Sandy in the excerpt above acknowledges how telling her story to others is helpful. How narratives aid in the sense-making process and coming to terms with difficult or traumatic experiences has been extensively studied (Garro & Mattingly, 2000; Mattingly, 1998a; Ochs & Capps, 1996, 2001). By voicing inner thoughts and constructing a narrative of the experience, the person who suffered has to analyze her own feelings and emotions, and piece together the chronology of the main and surrounding events. It is through this process of collecting, analyzing, and presenting the account to an audience that she begins to understand what took place; and by sharing these stories with peers in a supportive setting, she can also begin to accept the traumatic events as part of her new being and constitution. What makes the interviews in this study unique is that the women recognized me as a peer who could understand the embedded connotations in their speech and other non-verbal parts of discourse such as gestures, particularly iconic gestures (McNeill, 1992). This parallel to a

judgment-free support group environment resulted in an uncensored recipient-oriented discourse, where the women felt free to pause and cry, and where they continued their coping journey as they wove gestures and language to give an insight into their thoughts and “inner mental processes” (McNeill, 1992, p. 109) and to even invite the co-construction of their narratives.

Embodiment of Trauma

When telling a personal story of trauma to someone who has experienced a similar event and has access to shared knowledge, the language used does not need to be as explicit as when narrating for those who have not lived through similar events (Holler & Wilkin, 2009); words can be left unsaid, understanding that the audience can make an attempt at filling in those unspeakable moments with what they have learned from their own experiences. One resource commonly used to complement, supplement, and even substitute verbal discourse is gestures, particularly representational gestures such as iconic ones (McNeill, 1992). Their use in face-to-face communication has been widely analyzed, particularly focusing on its interaction with language in different contexts (C. Goodwin, 1995; Hydén & Peolsson, 2002; Kendon, 2000; Kita, 2000). As McNeill (1992) states, “jointly, speech and gesture give a more complete insight into the speaker's thinking. [Both] refer to the same event, but each presents a somewhat different aspect of it” (p. 13). To this, Kendon (1994) adds that gestures “provide information to co-participants about the semantic content of utterances” (p. 192). Meaning is always made by bringing together a set of semiotic resources with different properties that can mutually elaborate each other; thus, the gesture invokes the ability of the recipient to fill in what was projected by the talk (C. Goodwin, 2000). This notion of semiotic resources interacting with each other, in this case gesture and speech, is particularly relevant in narratives of trauma, pain, and suffering. Referring to how gestures and speech are connected when people talk about pain, Hydén and Peolsson (2002) explain how the experience of pain can block a person's capacity to

translate it into ordinary language as pain does not have to be cognitively analyzed for someone to endure or perceive it. That pain experience not only makes difficult the use language to distinguish its quality but even more difficult its communication, as it “shatters language and evades representation” (Buchbinder, 2015, p. 191). In order to transmit these experiences and feelings, “pain is not only communicated with verbal descriptions, but it is also expressed through (...) nonverbal means like gestures” (Hydén & Peolsson, 2002, p. 327). Moreover, Rowbotham, Holler, Lloyd, and Wearden (2011) report that “some gestures represented information [about the pain experienced] that was hardly represented in speech at all” (p. 1). Just as pain is “impossible to define [and] difficult to express to anyone who has not experienced [it]” (Schott, 2004, p. 209), so is recounting a traumatic experience beyond a mere recollection of chronological events. To include the psychological and social ramifications of the episode can result in an unfathomable task achieved only through a rich combination of speech, gestures, and other semiotic resources.

In order to understand how the women in this study orient their discourse to a peer, and what role the gestures used play within the narrative as a sense-making process, this chapter only focuses on iconic gestures, as they “bear a close formal relationship to the semantic content of speech” (McNeill, 1992, p. 12). Because of differences in camera positioning in the YouTube vlogs, it was not always possible to see the vlogger’s torso, arms, and hands in the videos; on the other hand, most of the interviews conducted online only captured the head of the interviewee up to the bust line, rendering it impossible to determine whether they produced gestures or not. Consequently only the iconic gestures found in the in-person interviews were descriptively transcribed, coded, and analyzed in this chapter.

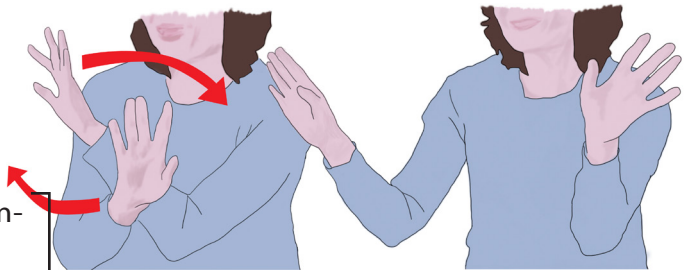
Inviting Recipient Participation

Some women find talking about the diagnosis and management of their pregnancy losses to be cathartic, despite entailing re-living the experience and painful emotions. Excerpt 4.4

involves Laurie, a woman who lost two pregnancies before she had twins. Although in her narrative she voices accepting the losses, she did not come to terms with the dilation and curettage procedure (D&C) that was necessary to extract the products of conception. Because of the coverage of her health insurance, this procedure took place at Planned Parenthood, a government-funded agency mostly known for performing abortions. D&C is frequently recommended for miscarriage patients who do not expel the embryo naturally, but it is also performed as an abortion technique. In fact, Laurie in her interview explains how the day of her procedure she was waiting among women who were having abortions, and she describes how they were all lined up in their gurneys next to each other waiting for their turn to go into the operating room. To aggravate the situation, one of the nurses in the facility confused Laurie for an abortion patient and offered her the necessary resources to prevent a future pregnancy. This unresolved conflict led to Laurie not being able to remember the name of the procedure on several occasions as she was retelling her story during the interview. The following excerpt illustrates the last instance in her narrative when she requests my help to recollect the term *D&C*.

Excerpt 4.4 - The term D&C (Laurie's interview)

- 1 Laurie: Because the doctor who did the- the- ((tongue click))
 2 I can never remember the word.
- 3 see, I don't- I'm-
 4 Inter.: [D&C]
 5 Laurie: I'm just [blanking]
 6 Inter.: [the surgery]
- 7 Laurie: The surgery. Yeah. That's better. I think I had such a bad memory
 8 of that that, I'm like haha p(h)ushing it away from me. .hh Uhh
 9 the surgery, I never met the doctor who did it? it's rea::lly (0,2) it's:
 10 kind of a factory to be honest the way they do those things.



At the beginning of excerpt 4.4, the repair in line 1 followed by a tongue click in place of a noun provide the first clue that something is problematic in the story. Laurie then proceeds to pause the narrative and comments on the recollection process as she says, “I can never remember the word” (line 2). This side note continues in line 3 as she attempts to explain what is happening in her thinking process, but stumbles again (“I don’t- I’m-” in line 3), which she overcomes by embodying “blinking” at the end of that line. This gesture is later translated into words in her following utterance (“I’m just blinking” in line 5), completing the commentary on forgetting the term *D&C*. The hesitations in lines 1 through 3 invite my participation as I overlaps with Laurie in line 4, “D&C”. Furthermore, I interpret the discourse between lines 1 and 4 as a problematic memory lapse in the narrative. Thus, to resolve the obstacle the term represents for Laurie, I subsequently substitute it with the noun phrase *the surgery*, since the procedure is a surgical one. As Laurie explains why *D&C* is problematic (lines 7-10), as she associates it with the abortions performed at Planned Parenthood, she accepts the proposed more neutral term “the surgery” as a preferred one. However, in line 10 she downgrades it to “those things”, confirming through the language used the traumatizing effects of the factory-like procedure.

Although the embodiment presented in excerpt 4.4 does not refer to the past experience being narrated, since Laurie is articulating at the moment of the telling how she cannot recall the past, it does represent the intersection of her current emotional state with the lived trauma. This conflict results in a memory bias that prevents her from recalling the emotionally loaded term *D&C*. There is evidence that extreme levels of emotion at the time of an event impair memory (Brewin, 2001), and this incompleteness associated with distress is often what prevents people from recovering from their traumatic experiences (Wigren, 1994). In this case, Laurie is able to articulate a very detailed narrative of both of her losses but cannot recall the name of the procedure. Given the setting where her *D&C* procedure took place, she associates the term with abortion rather than miscarriage. This particular memory block associated with the *D&C* takes

place several times during the interview, even after I provide the term for her each time, and Laurie explicitly acknowledges the issue as her “pushing it away” (line 8) given how traumatic the experience was. In the midst of the memory lapse displayed in excerpt 4.4, her emotional state is heightened as she is about to describe what she recalls about the procedure at Planned Parenthood, which renders her unable to recall the term and also to explain what is happening internally to her. With the aid of the “drawing-a-blank” gesture—depicted in line 3 in excerpt 4.4 and reiterated in figure 4.1 below—she is then able to portray her internal struggle and retrieve the appropriate words to finish her utterance.

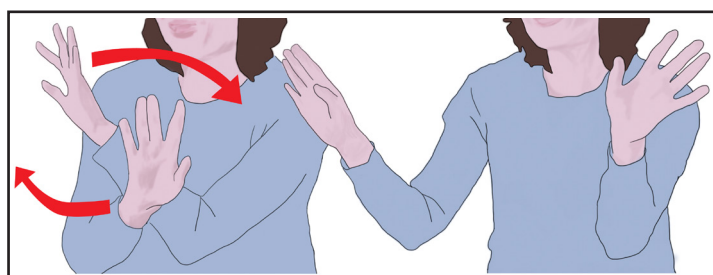


Figure 4.1 Laurie’s drawing-a-blank gesture

There is a strong connection between embodiment and narration as gestures “are part of the speaker’s ongoing thought process” (McNeill, 1992, p. 245). When producing non-conventionalized gestures, speakers are free to articulate their thoughts in any way their bodies deem necessary and do not have to follow any preexisting rules or conventions; they can create new gestures and incorporate their entire bodies if necessary to convey meaning. Conversely, when producing language speakers have to abide by predetermined grammatical rules and pre-existing lexicon. The limitation of language is particularly salient in cases similar to Laurie’s where heightened emotion or other psychological factors affect accessibility to language. Gestures then not only facilitate language processing, but a person’s inability to produce them can actually affect people’s language use (Rimé, Schiaratura, Hupet, & Ghysseleynckx, 1984). In the previous excerpt, as Laurie’s emotions intervene in her ability to elaborate her story

successfully, she is unable to clearly articulate her thoughts (“see, I don’t- I’m-“ in line 3); however, her hands move freely crossing in front of her to the sides as if erasing a slate, signifying her blank mind. After she successfully conveys her thought through this gesture she is able to continue with her narrative, which leads to her explaining how the trauma affects her current state (“I’m just blanking” in line 5). Because narrating pregnancy loss entails re-living those past experiences and resurfacing painful emotions, the shock experienced often is present during the interviews as well. This heightened emotional state can bring about the women’s inability to articulate those experiences, even when trying to embody the trauma.

It is widely understood that narratives aid in the sense making process, particularly of traumatic events (Ochs & Capps, 2001; Zigon, 2012), and within those narratives different semiotic resources intersect to create a complex layered web of meaning. As women recall and narrate their experiences, they shape them as they interconnect different memories, actions, actors, and physical and emotional sensations in the stories by means of a rich combination of semiotic resources. One of those resources previously discussed is gestures, which facilitates the cognitive processing of emotions and bodily experiences in order to communicate them through language to an audience who have not experienced the events being reported before. Nevertheless, women who are still in the midst of understanding their own experiences sometimes cannot articulate those past traumas beyond representational gestures, and it is up to the audience to analyze and translate them; such is the case of Candra in excerpt 4.5. For over a year she struggled with infertility and was trying to conceive through in-vitro fertilization (IVF) with a donor’s eggs; two rounds of IVF resulted in successful implantation, but unfortunately she lost both pregnancies in the first trimester. The lack of a precise etiology for the losses, very common in early pregnancy losses, resulted in depression and Candra questioning the possibility of ever becoming a mother. At the time of the interview, she still had not been able to carry a pregnancy to term, and the losses were still present in her everyday life. In a similar manner to Laurie in the previous excerpt, Candra is in a very emotional state throughout the

interview, particularly as she narrates the most traumatic scene of bleeding and passing the embryo during her first loss, at which point in the narrative she resorts to gestures and my participation as a co-narrator to complete the story. The following excerpt represents how Candra responded when I asked her how she found out about that first loss.

Excerpt 4.5: It was just bleeding and bleeding (Candra's interview)

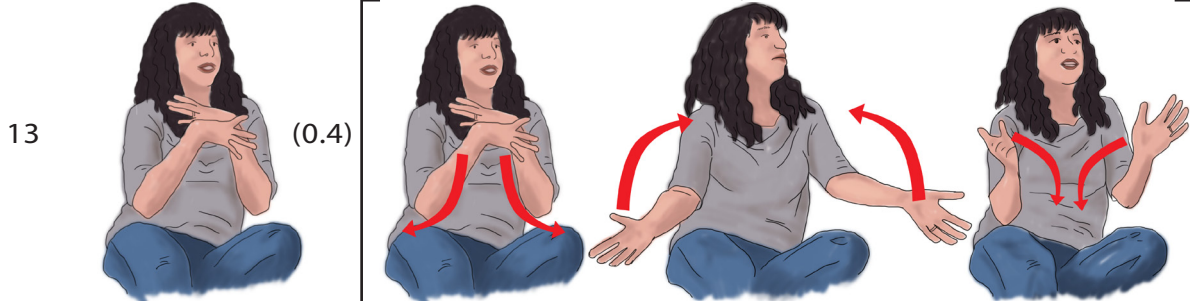
1 Candra: Uhh I found out I think the- the most traumatic-
 2 I don't wanna say the most traumatic, uhm
 3 because I'm thinking of your story when
 4 you just didn't see the heartbeat.

Understanding
of the shared
experience

5 I found out uhm a few days before I was supposed to go in
 6 for the scan of the heartbeat,
 7 .hhh uhh I found out because I: uhh woke up bleeding,=
 8 Inter.: =oh::

9 Candra: An:d I thought that well some blood can be natural,
 10 like especially with [IVF] of the implantation bleeding,
 11 Inter.: [Yeah]

12 Candra: and I went to the bathroom, and >it< just- (.)



14 Inter.: [It was like period it wasn't-]

15 Candra: It was everywhere. It was worse than (.) a period.



17 Inter.: [Bleeding bleeding.]

18 Candra: It was just bleeding and bleeding a:nd
 19 (0.4) I screamed and I woke up my husband,

Before the interview took place, Candra mentioned she had accepted to participate in the study because I had also suffered pregnancy losses. She felt the similar lived experiences would ensure my understanding of her experience and would also automatically afford empathetic alignment between us, generating a safe environment where she could be vulnerable and open about her losses and fears. Several of the women interviewed for this project manifested this same idea of empathy as a product of shared similar experiences; nonetheless, relatively homologous lived experiences can in fact “hinder our abilities to gain insight into one another’s lived realities” (Throop, 2010, p. 772). To become more comfortable about sharing her own story, as she was signing the consent forms, Candra briefly asked me about my miscarriages. With this information in mind, she connected her own story to mine as she began her narrative (lines 3-4). Bringing into the present mine and her stories created a unique emotional atmosphere for the interview. We were emotionally attuned to our own past similar traumas at the same time we were experiencing the others’ emotional stance that emerged from recollecting our losses. This empathetic alignment impacted our interaction during the interview, as the exchange between the two of us turned into a dialogue rather than the traditional question/answer format of an interview. Excerpt 4.5 represents this understanding of a similar shared experience as Candra invites me to co-construct her story.

In excerpt 4.5, Candra begins her response by connecting her own loss to mine. In lines 1 through 4 she repairs her initial position, “I found out I think the- the most traumatic-“ and retracts the qualification of her story by bringing in my story, implying Candra’s loss is equally or less traumatic than mine. In doing so, she places her positionality towards the importance of understanding the other person’s experience at the center of her own account. Prefacing her story with an acknowledgement of the severity of my loss creates an invitation for me to reciprocate this understanding, and it also implicitly introduces Candra’s wish of being understood. Hollan (2008) and Throop (2010) highlight the importance of this duality of understanding in building an empathic rapport; empathy is “as much about one’s efforts at

understanding another as it is about another's desire to be understood" (Throop, 2010, p. 75). Candra's concept of empathy differs from the phenomenological view of empathy as an asymmetrical experience, since she earlier voiced she believed a shared a similar experience would afford empathy. Nevertheless, Candra's grammatical organization of the introduction of her narrative speaks to the former interpretation of empathy, highlighting the importance of understanding and being understood despite never being able to experience the other's experience. Following this preface of her story and the connection with my own story in lines 1 through 4, Candra continues the telling by returning to her story, and in lines 5 and 6 she establishes the time and setting for her narrative. Because typically the first ultrasound during a pregnancy is performed around eight weeks of gestation, a few days before then would establish the time of the miscarriage at about seven weeks pregnant. Moreover, she sets her home as the location since she references waking up and does not indicate being away from home. The phrase "I: uhh woke up bleeding," in line 7 also indicates the unexpectedness of the event, and her sudden realization that her hope of becoming a mother might be in danger. She reinforces the idea of still hoping for a successful pregnancy when in lines 9 and 10 she recollects thinking the bleeding could be from implantation². It is not until she goes to the bathroom that she realizes the amount of bleeding is not normal; she makes this contrast in the epistemic stance in line 12 "and >it< just-" followed by a brief pause and her gesture in line 13. At this point, different semiotic resources come into play for me to be able to co-construct the resolution of the story with Candra. My utterance in line 14 occurs after the onset of Candra's gesture, simultaneously with its main motion, so the embodiment is not what invites me to participate in the formulation of the meaning. Instead, what triggers my utterance are Candra's emotional stance, her previous talk, and most importantly, my shared knowledge from my own experience with pregnancy losses.

Although not depicted in the transcript, Candra was very emotional to the point of tears in several occasions during the interview. Her slight hesitations throughout the excerpt also

show her emotional stance towards the dense topic and reliving the experience. The manifestation of her emotional suffering at the moment of the telling tied with her previous talk (i.e., in line 12 “>it<”, indexing the bleeding, and the interrupted adverb “just-”), help me project Candra’s future talk. After the self interruption in line 10, as Candra makes a brief pause, she also breaks eye contact with me and gazes towards her bottom right as she raises her hands towards her chest—depicted in the first image in line 13. These non-verbal cues prompt me to verbalize what I project would be the outcome of what happened when Candra went to the bathroom, which I do in line 14 concurrent with Candra’s embodiment in line 13. This story is clearly interactively organized; in the sense that it has been constructed taking into consideration I have access to similar experiential knowledge. Therefore, aside from these resources, what makes the projection possible is my monitoring of Candra’s current affective stance and shared knowledge from my past lived experiences. I had already lived through two pregnancy losses and understood the emotional difficulty that recalling the experience entailed. This helped me not only understand Candra and help her when she was at a loss for words, but furthermore, I was able to engage emotionally with Candra by projecting onto Candra’s loss my own experience with my losses.

My first attempt at projecting Candra’s talk appears in line 14 in overlap with Candra’s gesture. After a brief pause in line 13, Candra crosses her hands in front of her chest and holds them there why she deeply inhales, after which she makes two consecutive outward circles with her hands, signifying the bleeding and expelling of the products of conception. Concurrently with this embodiment, I qualify the bleeding as equivalent to a period, which is much heavier than the spotting that could occur during implantation. Thus, on the one hand I upgrade Candra’s initial guess of the cause of bleeding, and on the other hand I foreshadow the imminent miscarriage. To this, Candra responds by first describing the bleeding, and immediately after upgrading my qualifier to “worse than (.) a period”, which is followed by an incomplete phrase “It was just-” and a gesture in line 16. This second gesture carries within much more emotion

that the one in line 13. This difference in emotional stance is visible not only by her closed eyes and her pressed lips denoting resignation and deep sadness (2007; Ekman & Friesen, 2003) at the beginning of the gesture, but also by the sharp trajectory of the hand motion in front of her chest, implying there was nothing left. Given my previous understatement when depicting the bleeding, this time I do not overlap my speech with Candra's gesture and wait until the end to interject "Bleeding bleeding" in line 15, upgrading Candra's previous description even further. She interprets "worse than a period" as heavy bleeding, and by duplicating the term *bleeding* and placing emphasis on the first item of the pair, she categorizes the quality of bleeding as truly bleeding and an ongoing action with a continuous flow, as opposed to "spotting" or even "a period" which has a beginning and an end, and a certain normalcy quality to it. Candra's gestures are therefore glossed as profusely bleeding, similar to how an open wound would bleed, which is not normal for the case of vaginal bleeding during pregnancy, although it is common in cases of miscarriage. It is then through my previous experience of having miscarried that I can comprehend Candra's despair and co-construct her narrative by helping her formulate the lived experience.

Candra is aware of this shared knowledge and she clearly talks to me as a peer. Although anyone else who has never suffered a pregnancy loss could empathize with the teller, not everyone would be able to differentiate the nuances of bleeding or to fully understand and tend to the imminent necessity for someone else to fill in the words that are too difficult to utter when talking about the actual moment of the loss. In this excerpt, the narrator is clearly articulating with me what happened and accepts my involvement in her own recollection of the experience. I then becomes more than just a witness when she brings up both of our body knowledge into play. This results in me attempting to see beyond what is being said and projecting what has not been said yet, thus actively participating in the co-construction of Candra's loss. In order to accomplish this successful analysis and manifestation of the embodied bodily experience, Candra and I engage in an intricate format-tying exchange (Du Bois, 2014; M. H. Goodwin &

Goodwin, 1987). We each systematically transform the previous utterance to co-construct the quantification and qualification of the bleeding, which is illustrated in excerpt 4.6.

Excerpt 4.6: Format tying in Candra's interaction with the interviewer

- 12 Candra: and I went to the bathroom and >it< just- (.)
13 ((gesture))
14 Inter.: [It was like period it wasn't-]
15 Candra: It was everywhere. It was worse than (.) a period.
16 It was just- ((gesture))
17 Inter.: Bleeding bleeding.
18 Candra: It was just bleeding and bleeding a:nd
19 (0.4) I screamed and I woke up my husband,

Candra is the first one to attempt to qualify the blood at the end of line 12, but is unable to find the appropriate words and instead indexes it with the third person neuter pronoun *it* and the adverb *just-*. After the onset of Candra's gesture in line 13, by recycling the pronoun *it* I provide my interpretation of the quality of the bleeding, and within the same utterance I also introduces a contrast with how the blood was not what Candra first thought to be implantation bleeding. However, I stop before finishing the phrase "it wasn't-", inviting Candra to continue with the description. The structure "it was + quantifier/qualifier" acts as the tool both of us employ to build on each other's utterances and jointly determine how to appropriately describe the episode; thus, the blood is transformed and systematically upgraded from similar to a period (line 14, interviewer) to profusely bleeding (line 18, Candra). Within this exchange, two other structures are also transformed to advance the description. In lines 12-13 and 16 Candra reuses the adverbial structure "just- + gesture" as a call for help and an invitation for me to cooperate in the construction of the narrative. In both cases, the term *just* acts as a hedge, marking Candra's uncertainty in her speech; this notion of language as problematic is marked by its substitution with a gesture in both instances. Because their interaction takes place face-to-face, I have the ability to interpret these gestures and help Candra analyze and communicate through language her past experience. Candra's inability to depict and effectively communicate with

words the act of miscarrying reveals how language is crucial but inadequate for the description needed. On the subject of describing physical pain, Hydén and Peolsson (2002) explain that people can “use gestures to show and demonstrate pain by the configuration of their body; this is based on a figurative similarity between physical pain contexts and gestures. Verbal comments are almost completely subordinated to gestures” (p. 336). In this case, the emotional pain brought forth through the retelling and mentally reliving of the experience acts in conjunction with the lived physical pain to disrupt Candra’s ability to verbalize the experience. At this intersection, the emotional and physical pain exceed verbal forms of expressibility and become an Other to Candra, as an experience that is never fully captured. Candra lived through the physical pain during the miscarriage, and as she recalls the event she experiences the emotional pain associated with the loss, yet she has no control over the past or present pain, subjugating herself to this Other as she attempts to narrate the experience, understand it, and overcome it. To begin this process of making sense of the loss and the pain, Candra portrays with gestures what her body felt at the time of the loss and her mind still cannot grasp to formulate an accurate description, and by systematically performing operations on the previous language used, both women advance the co-construction of Candra’s bodily experience. The third structure to play a crucial role in this transformative interaction is introduced in line 17; the duplication of the present participle *bleeding*, as previously mentioned, qualifies the bleeding as truly bleeding, greater and graver than the bleeding of a period. In this sense, I recycle the content Candra expresses in line 15 “It was worse than (.) a period.” and move into a new category of bleeding. In the following line, Candra ties together all of the structures used thus far with her final description of the bleeding “It was just bleeding and bleeding”. By transforming “bleeding bleeding” into “bleeding and bleeding”, she accepts the quality previously provided and upgrades it to an ongoing flow, implying an uncertainty for its end. On the other hand, she recycles one last time her previous structure “it was just”, but this time the adverb switches from displaying uncertainty to displaying her powerlessness vis-à-vis the

imminent and irreversible loss. Although I shared a similar loss experience, each episode is completely different; the interplay between the two embodied actions and the structural transformations in this exchange illustrate how the co-construction of the experience allowed Candra to ultimately transport to the present her past experience and describe the bleeding.

During the interview, Candra analyzes her past vis-à-vis her present and current emotional state, and she formulates a description of the events. As she undertakes this complex process, she embodies the past experience of bleeding and brings it to the present by talking about the past in terms of what is happening to her as she retells the story. When analyzing the re-enactment of symptoms during medical consultations, Heath (2002) states that “the inner and the subjective are overlaid on the outer surface of the body and rendered visible and objective. Moreover, through gesture and bodily conduct patients take symptoms experienced on another occasion and transpose them to the present” (p. 603). This presentness of the story is visible in the emotional layer Candra adds onto her narrative as she relives the entire experiential process by embodying the moment of the loss and turns me into a co-experiencer. By bringing together all of these semiotic resources, the narrator shifts the center of the story from the string of events that happened during her first miscarriage to the experiencing agent, who is placed therefore at the center of the experience as it is being relived. This in turn ties with her moving away from the structure of the story and moving into the embodied organization of the experience, thus putting not only her experience but my own experience at the center of the story through the co-construction of the narrative.

This section revealed how through embodiment, interlocutors can seek out the recipient’s aid to co-analyze and interpret past and present emotions and experiences. Gestures play a significant role in the sense-making process of unresolved events as they can convey meaning prior to presenting to an audience a cohesive or complete thought. Thus, gestures can serve as a first attempt at analyzing past experiences from where a person can then build upon to produce a verbal account of the events. Furthermore, the richness and sense of freedom of

gestures can also enhance speech if embodiment and language occur simultaneously, which is the focus of the next section of this chapter.

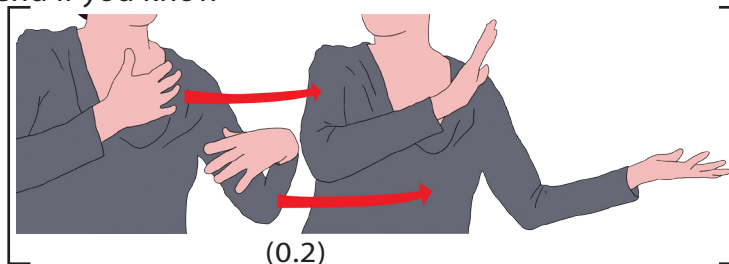
Facilitating Language

Making sense of past traumatic events is central to human experience (Park, 2013) and is associated with reduced distress if accomplished during the first year after a loss (Davis, Nolen-Hoeksema, & Larson, 1998).; however, in some cases it can be an ongoing process that can last years or even never be achieved, particularly in cases of unresolved or ambiguous losses (Boss, 1999, 2006). Although the sense-making process is internal and people often cannot pinpoint how they overcame past traumatic experiences, making sense of a loss—e.g., understanding the loss or finding its meaning (Davis & Nolen-Hoeksema, 2001)—is accomplished through language and narrative and can also be detected in the language used. The previous section illustrated how when coping with loss, language is not always accessible; women resorted to representational gestures to communicate their thoughts and with my intervention were able to begin building an oral discourse representative of their experiences. Although not every person has difficulty coping, understanding, and accepting a loss, most of the women interviewed for this study expressed not having fully moved on. In fact, most of them indicated that accepting the loss as such did not entail leaving it in the past and forgetting it ever happened. The presentness and sensitivity of this topic can be observed in the narratives through the emotions displayed (e.g., crying or deep in-breaths at certain points in the narratives), the speech patterns (e.g., long and frequent pauses in the discourse), and also through non-verbal cues (e.g., facial expressions and gestures). Particularly representational gestures depict, as seen in the previous section, the inadequacy of language alone to fully render the lived experiences in oral narratives, even after the stories have been told multiple times. This phenomenological process of making sense and construing multiple semiotic resources in ways that can be made present and

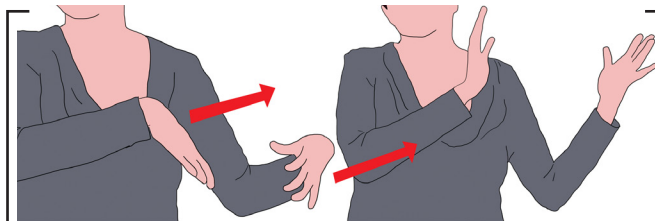
understood by others, when not able to construct a narrative exclusively through language, is illustrated in excerpt 4.7, where Olga describes her inner experience during her second loss.

Excerpt 4.7: I was disposing it (Olga's interview)

- 1 You know it was very primitive.= And it was very (.) real but you know (0.2)
- 2 .hh I (0.4) kind of equate it to: (0.2) the natural process of giving birth.
- 3 Well this was a natural process of miscarriaging. Except I was on the- (0.4)
- 4 the non receiving end if you know



- 5 what I mean, I was (0.2)



- 6 dis- disposing it if you will .hh (0.2)
- 7 I don't wanna say that. but uhm (0.2) So it felt- it- I felt very primitive and
- 8 in that sense it felt really uhm like women have been going through this and
- 9 I'm not dismissing it trust me but since the beginning of time. On their own
- 10 whether it was a cave. or a hut. or a mansion. since the beginning of time. and
- 11 I'm gonna guess that other than comfort I- I felt no differently than they did.
- 12 you know that a lot of them did. .hh Very (.) very (0.2) uh private. very alone.

Before the miscarriage described in excerpt 4.7, Olga had already lost a pregnancy at 9 weeks. She had resolved the first loss with a D&C and this second time chose to pass the embryo at home with no medical intervention. She secluded herself in a dark area in her home, and waited for the embryo to pass and the bleeding to subside. As she recounts this experience during the interview, she focuses more on her emotions and the internal process of miscarriaging than on the string of events. This introspection, present in the examination of her feelings before passing the embryo, is manifested lexically when she describes the moment as primitive and real. Furthermore, she elaborates on her emotional experience of the miscarriage structurally

through format tying (M. H. Goodwin & Goodwin, 1987), as she transforms “the natural process of giving birth” into the “natural process of miscarriaging” (lines 2 and 3). Olga had already given birth to a healthy boy, so she understood that although the processes were similar, the end results were opposite of each other, which is why she places herself as the one in the “non-receiving end” (line 4) to contrast the joy of birth with the trauma of loss. By replacing “giving birth” with “miscarriaging” in the phrase “the natural process of...”, she highlights the contrast between these two events. She had chosen to miscarry naturally at home to be an active participant in the loss experience, as opposed to a passive recipient of a status change (from pregnant to non-pregnant), as it had occurred when she underwent the D&C surgery with the previous loss. Although women during the passing of the products of conception do not have an agentive active role, since there is no forced pushing involved as during birth, the uterus does contract causing severe periodic pain. Many women believe this grueling bodily experience can help them obtain closure for the lost pregnancy and facilitates the beginning of the grieving process. In recalling the loss, Olga concentrates on clearly articulating the emotional experience of miscarriaging by contrasting it with birth and describing the rawness and solitude that women across cultures and classes face in that moment; yet similar to Candra, she has difficulty expressing the actual moment of passing the embryo, from the end of line 3 through line 6.

The utterance at the end of line 3 begins with a non-agentive stance of being in the ‘non-receiving end’ of the miscarriage process. However, as she attempts to clarify the contrast between birth and miscarriage, Olga places herself as a possible agent with ‘I was (0.2) dis-posing’ (lines 5-6) at the same time she gestures throwing something away. This complex structure is built by layering language and gestures onto each other. Olga begins the phrase with *I + was*, which does not entail grammatical agency on its own. Nevertheless, the phrase in combination with the embedded gesture that immediately follows it yields *I + was + gesture*, which could be interpreted as *I + conjugated verb*. Given the gesture’s outward motion from the body, this would correspond to a verb that carries agency. As an attempt to explain her

embodiment, she hesitantly continues by saying, ‘dis- disposing it’ (line 6), and one more time embodies throwing something away, confirming the notion of herself as the agent in the miscarriage. As opposed to Candra’s embodiment in the previous section, where she invites the recipient participation in the construction of her narrative as she cannot produce the appropriate words, Olga continues her discourse with no restarts and does not seek help for a repair. Nevertheless, she does acknowledge that what she just uttered is not appropriate for the intended description, but continues regardless and shifts the focus of the narrative away from the expelled embryo and back to her natural and primitive inner experience.

Turning attention to the imagery of throwing something away, embodied in lines 4 and 5, in combination with the phrase “I was (0.2) dis- disposing it”, Olga’s discourse reveals insight into her mental processing of the loss. The verb *to dispose* requires an agentive subject, and as it was previously mentioned, the gestures could carry a degree of agency given their placement within the spoken utterance. By choosing to miscarry on her own instead of undergoing a D&C, she became the agent in the process of evacuating the embryo as she took command of her phenomenological experience. This decision is probably what originated her feeling of disposing the embryo mentioned in excerpt 4.7. The act of passing an embryo after a miscarriage, on the other hand, is agentless. Once the process of miscarrying starts, it is not possible to stop it since the embryo or fetus no longer has a fetal pole or cardiac activity (Tulandi & Al-Fozan, 2012), and the products of conception have to be evacuated through surgery, medication management, or expectant management (Tulandi & Al-Fozan, 2015) regardless of whether the mother wants the process to happen or not. Eight years after the loss, Olga’s grief is still visible through her gestures, indicating how she is still making sense of the loss and unable to fully articulate the entire experience. When describing the moment of passing the products of conception vaginally, those who have trouble conveying with words the experience tend to gesture some sort of circular motion around the abdomen area (as illustrated in figure 4.2).

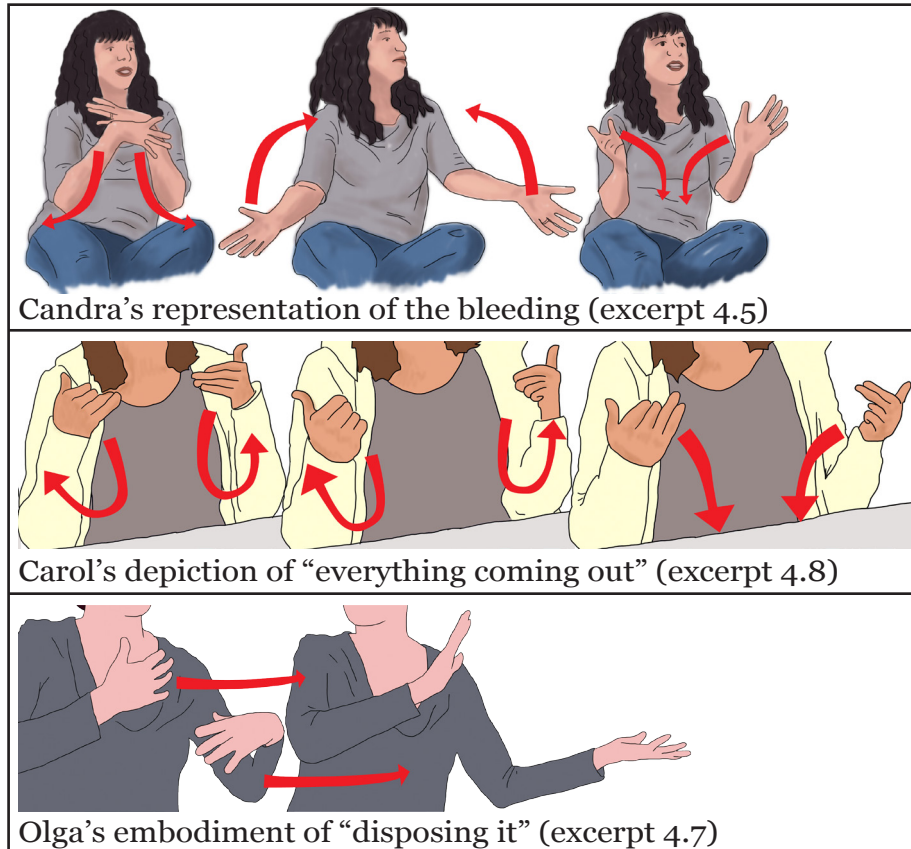


Figure 4.2 Gestures for describing passing the products of conception

Olga's gestures contrast with this trend since on the one hand, her gesture is not circular, and on the other hand, instead of an inward and downward motion, she gestures outward and towards her upper left. One possible interpretation for this difference is that, contrary to what was argued earlier, her gestures do not place any agency on herself. Instead, they could be analyzed as depicting the importance of spirituality³ in her life and her sense-making process, where her hands symbolize the embryo rising to Heaven as opposed to the physical evacuation from her body. If this were the case, her speech would be in discordance with her gestures. Since making sense of trauma is not an overt process, and even those actively grieving are not aware of how they overcome a loss, it is not possible to pinpoint exactly which interpretation is accurate. Nevertheless, the significance of this excerpt does not lie in the interpretation given to the

language and gestures as separate entities, but to the interdependence of the semiotic resources as a manifestation of the complicated mental process of grieving and making sense of a loss.

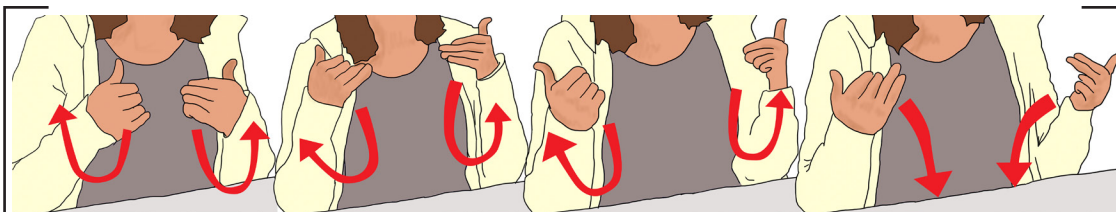
Early pregnancy losses are very frequent (Regan & Rai, 2000; Ventura et al., 2012) and easy to diagnose with the technology readily available these days (Norwitz & Shin Park, 2012; Tulandi & Al-Fozan, 2012), but in the majority of the cases the etiologies remain uncertain (Babarinsa & Muslim, 2015; Brier, 1999). For women with no known risk factors (as was the case for Olga) up to 80% of miscarriages are attributed to chromosomal abnormalities (Babarinsa & Muslim, 2015), leaving the women facing uncertainty since the specific anomaly is not revealed in most diagnoses. This unknown turns the loss into an ambiguous loss, which is “inherently characterized by lack of closure or clear understanding” (Betz & Thorngren, 2006, p. 359), leaving people not knowing how to cope or make sense of the trauma due to its baffling and undetermined nature (Boss, 1999). As Boss (2006) points out, “ambiguity coupled with loss creates a powerful barrier to coping and grieving and leads to symptoms such as depression” (p. 1). The ongoing attempt to gain meaning from a pregnancy loss emerges in women’s narratives; in the process of articulating their stories, women engage in analyzing and recreating what they experienced emotionally and physically. Since coping and finding closure is not always attained, different stages of grieving transpire in the interviews collected. This also reveals the importance of face-to-face interaction as gestures play a significant role in the sense-making process. Although there is a debate as to whether gestures are produced for the recipients or not (Jacobs & Garnham, 2007; Krauss, 1998; Krauss, Dushay, Chen, & Rauscher, 1995), my presence plays an important role in their interpretation, as it was illustrated with Candra’s interaction in excerpt 4.5. Even though not all participants were in the early stages of making sense of their losses, the vast majority of them resorted to gestures at some point in their narratives to either substitute, complement, or enhance their speech.

Complementing Language

So far the excerpts in this chapter illustrated how gestures were embedded within the narratives to aid the language processing and gain meaning from the losses; Laurie, Candra, and Olga were not emotionally able to select the appropriate lexicon to continue with their narratives, resorting to embodiment to fill in those gaps. In contrast with these cases, in the following excerpt Carol is at a different stage in her grieving process, and although she has no difficulty selecting the appropriate language to represent her experience, she still incorporates embodiment in her story to enhance her speech and embed a layer of epistemic and emotional stance onto the string of events she is narrating.

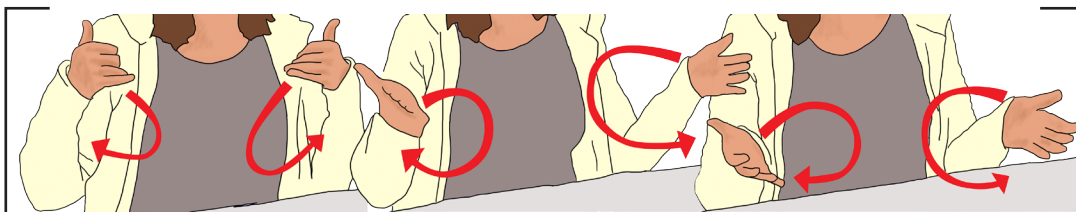
Excerpt 4.8: Gushing in front of my students (Carol's interview)

1 During my first class (.) I all of the sudden

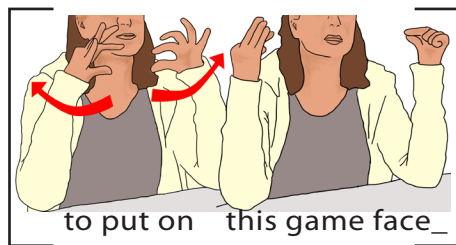


2 felt myself start gushing. (.) Cause I was spotting? (.) I felt myself gushing

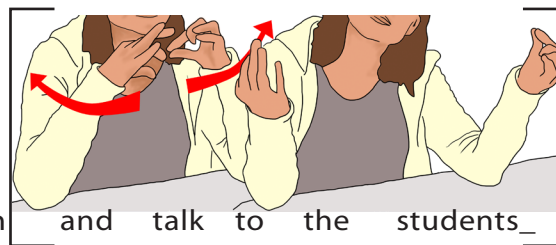
3 I (0.4) miscarried for the entire six hours.= I was standing in front of students on
4 my feet, (.) my very first day of class. (0.2) .hh



5 And I could just feel (.) everything (0.4) just coming out and I



6 had to put on this game face_.hh



and talk to the students_

7 (.) and I knew what was happening in my body and I had to excuse myself at
8 one point 'n (0.2) go to the restroom and try to get a- (0.4) a pad off of someone.

Carol had three living children and experienced a total of five miscarriages before, in between, and after the live births, the last miscarriage being the one described in excerpt 4.8. In spite the losses still being emotional for her, after a few episodes, they turned into systematic and almost mechanical situations. This cyclic quality to her pregnancies—i.e., losing a pregnancy after a successful one and understanding the losses as an inevitable routine—emerged after her fifth pregnancy when although the circumstances for the embryo’s demise were different from previous miscarriages, she still foreshadowed a problematic pregnancy that resulted in a loss. In all but the case portrayed in excerpt 4.8 she managed the losses surgically through a D&C or D&E, but unfortunately this was not the case for the last miscarriage. As with previous losses, she knew the pregnancy was not viable, but was not aware of the imminence of the loss; Carol describes how the bleeding took her by surprise (“I all of the sudden felt myself start gushing”, lines 1-2) while she was teaching the first of three back-to-back classes she had that day. Unlike the previous excerpts seen in this chapter, Carol shows minimum hesitation while recounting the circumstances under which she passed the products of conception, most of her pauses are less than 0.2 seconds, with no repairs and only one restart at the end of line 8 when incorporating secondary details in her story. Nevertheless, she incorporates two distinct gestures within her narrative to embed an epistemic stance and an emotional stance.

As she describes the act of bleeding, the language indicates the intensity of the flow with “gushing” (repeated twice in line 2), but does not indicate a time dimension until line 3, “I (0.4) miscarried for the entire six hours.” In order to anticipate the continuity of the bleeding, she produces three consecutive downward oblong circles in front of her torso, similar to Candra’s initial description of the bleeding, to depict the outward motion of the blood from her body. She later repeats the form of this embodiment in line 5 when after providing the setting of the episode she continues the description of passing the embryo: “I could just feel (.) everything (0.4) just coming out”. However, this time the gestures are produced with more emphasis as the bottom of each ellipse coincides with emphasis in her speech, marked as underlined syllables in

line 5. In both instances through language she clearly describes the flow and insinuates the contents of what she was expelling; “I could just feel (.) everything” (line 5) implies sensing not only liquid blood but also lumps of tissue, which I am able to comprehend by accessing my own knowledge from my experience with miscarriages. By adding a layer of gesture to the spoken discourse in lines 2 and 4, Carol’s embodiment of continuity places the time dimension at the forefront of the story, making the phrase “I (.) miscarried for the entire six hours” (line 3) much more salient. Emphasizing the uninterruptedness of the situation also highlights the systematicity that miscarrying entailed for her. Instead of going to the emergency room like most women would do when faced with heavy bleeding during a pregnancy, Carol continued with her normal life uninterrupted. Aside from the moment when she excused herself to go to the restroom and search for a pad to avoid soiling her clothes, there are no clues of any disruption in her teaching routine. Nevertheless, the normal appearance she portrayed to her students did not match her inner emotional state, embodied in line 6.

The power of this embodiment lies in the visual contrast between the exterior presented to her students, portrayed with the smiles in her hands, and her emotional stance embedded in her facial expression. Although not visible in the transcript, throughout the entire utterance her facial expression denotes sadness by the slight pulling down of the corner of her lips and the minimal raise of the inner corner of her eyebrows (Ekman, 2007; Ekman & Friesen, 2003). As she explains how she put on a game face and talked to the students while experiencing heavy bleeding (line 6), she reiterates this emotional contradiction between her outer-image and the self. Accepting the systematicity of the miscarriages does not imply a lack of emotions towards each individual loss. Her miscarriages were not considered recurrent miscarriages (RM) medically because in between each one of them she was able to carry a pregnancy to term successfully; however, as she was still trying to have a fourth successful pregnancy, the grieving process evoked during her interview resembles that of other women in the study who faced RM. Recurrent miscarriages are defined as three or more consecutive losses (Stirrat, 1990) and

impact only approximately 1% of couples trying to conceive (Rai & Regan, 2006), a much smaller fraction of the population than sporadic miscarriages. As with any early pregnancy loss the etiology is often unknown, which coupled with lower probabilities of success after each loss (Rai & Regan, 2006) results in higher rates of depression (Bagchi & Friedman, 1999). On the other hand, women with RM start conceptualizing the miscarriages as a bodily process and not as death, thus, avoiding grieving and becoming very factual instead of overtly emotional about their pregnancies. In fact, one of the women in the study who experienced eight losses was so emotionally disengaged from the process that she limited her discourse to facts and showed no signs of feelings or distress at all during her interview. Nevertheless, further analysis of her discourse revealed she had avoided grieving but had not fully coped with the situation. She could not remember significant information (e.g., weeks of gestation for each loss or dates) or secondary details of the losses, which is normally associated with unresolved grief and an incomplete recovery from a traumatic episode (Brewin, 2001; Wigren, 1994). Regardless of how the losses are medically labeled, whether RM or sporadic miscarriage, those who experience more than one pregnancy loss share traits in their narratives. They try to make sense of exceptional misfortune and channel grieving through factual dominant narratives, attempting to suppress emotions that, nevertheless, seep into their stories through their uncensored bodies.

Conclusion

The chapter has attempted to unveil the importance of sharing stories of pregnancy loss with peers in a face-to-face setting as a means of making sense of the trauma, particularly focusing on the role embodiment plays in those interactions. In the United States the vast majority of women who experience a miscarriage or stillbirth have access to the necessary medical care to manage the loss and avoid serious health complications, yet most of them receive minimal or no emotional support after the loss (Brier, 1999). Often medical professionals disregard the psychological facet of the fetal demise and focus exclusively on the

medical aspects; however, the psychological complications of these losses could be agonizing, at times leading to severe depression and even post traumatic stress disorder (PTSD) (Engelhard, van den Hout, & Arntz, 2001). The immobilizing nature of an ambiguous loss (Boss, 1999) lies in the uncertainty behind the etiology of the interrupted pregnancy and the undetermined possibility of ever becoming a mother. It is human nature to attribute causation to events in our lives (Boss, 1999); without this foundation, making sense of the trauma and the loss experienced becomes a cumbersome task. Those who learn to accept uncertainty are more likely to accept the loss and cope with their new reality; however, without the proper emotional support a woman will spiral down a black hole without successfully grieving the death of the unborn child. The stigma associated with pregnancy loss leaves many women fearful of talking about it with family or friends, which leads to their shutting down the painful emotions associated with the loss instead of embracing and overcoming those feelings (Randolph, Hruby, & Sharif, 2015). Following the medical resolution of a miscarriage or a stillbirth, most women have no guidance as to how to recover emotionally from what they have experienced, and those few who do often express dissatisfaction with the resources available (Conway, 1995), e.g., counseling, online forums, or support groups. Although counselors can be trained in grief, the women interviewed in this study who did resort to counseling sessions indicated how most professionals were not specialized in pregnancy loss, leaving them feeling they could not connect with them or be fully understood. This lack of connection or empathy could be attributed to a misleading preconception that unless someone has experienced a pregnancy loss, they cannot understand or empathize with a mourning woman. By attending counseling sessions with this biased idea that they will not be understood, these women closed the possibilities to actually being understood. As Hollan (2008) remarks, empathy is an intersubjective process that involves understanding another but also allowing and welcoming the other's understanding. Attending a counseling session in disbelief that a connection can be created blocks the possibility for an

empathic relationship, creating the sense of dissatisfaction and unfulfillment some women felt after counseling sessions.

This popular idea that mutual understanding is a natural consequence of shared lived experiences has influenced the way people share stories and communicate online. These days online forums are very popular and also readily available at all times of the day, giving women an immediate and private outlet to share their sorrows or to chat with a stranger about the experience of losing a pregnancy (Gold et al., 2012). However, due to the large number of women present in these forums communication tends to be anonymous, and in fact several women in this study indicated that long-term relationships built on trust and the comfort of actively grieving with a peer are rarely achieved. Finally, face-to-face peer support groups are the resource women in this study mostly agreed on as the best place for sharing their stories and feeling they were not alone in this journey, without being judged. Unfortunately, support groups devoted specifically to pregnancy loss are scarce even in large cities across the United States. There is an extensive amount of research on the benefits of peer support groups in the recovery from trauma or medical conditions such as chronic illness, addiction, or cancer among others (Funk-Brentano et al., 2005; Rowe et al., 2007; Steiner, 2006; Ussher et al., 2006). Particularly for pregnancy loss, the importance of interacting face-to-face with a peer relies on the temporality of the past experiences. Although members of a support group cannot experience others living through their trauma, they bring into the present their past lived experience and can, therefore, experience each others' recollection of trauma simultaneously, allowing mutual monitoring of emotional stances and an openness for being understood and understanding the other.

Articulating the past and building a narrative of the lived experience are crucial to understanding, accepting, and making sense of the trauma lived (Ochs & Capps, 2001; Zigon, 2012). Through storytelling, people analyze and categorize their experiences as they tell what they lived through. The severity of these episodes can sometimes result in a narrative rich in a

range of semiotic resources that invokes the shared experience of another, rather than simply describing events, in order to convey the lived experience. This was evident in this chapter as the women attempting to convey their past to me supplement their oral narratives with gestures. The freedom that embodiment entails allows them to communicate more organically with me and tap on our shared knowledge to advance their stories. As McNeill (1992) indicates,

gestures “are not forced, as is speech, to include features solely to meet standards of form. Thus they can limit themselves to what stands out. Not only are gestures free in this way to incorporate the relevant dimensions in thought, but they also cannot avoid incorporating these dimensions” (1992, p. 132).

Because conceptualizing trauma related to loss could be difficult, the use of a rich array of meaning making practices (e.g., gestures, prosody, hesitations, etc.) to convey thoughts towards a loss affords people a larger semantic field, particularly in cases of pregnancy loss where not only the woman has to accept the loss of their unborn child but also accept her powerlessness and the fact that in most cases there is nothing she could have done to prevent the loss. This larger semantic field is salient in the creation of new grammatical constructions by means of interconnecting different semiotic resources, e.g., language and gestures. In this study, as Olga attempts to articulate her miscarriage experience and searches for the appropriate lexical item, she introduces the structure *I was* + *gesture* in line 5 of excerpt 3, which can be understood as *I* + *conjugated gesture*. Although immediately after this embodiment she presents the verb *disposing* as a candidate to replace the gesture, this term is in turn replaced with a repetition of the previous gesture. This concatenation of embodiment and language indicates her inability to produce the appropriate language to describe her experience; in addition, her metalinguistic comment that follows the second gesture reinforces this notion, ‘if you will .hh (0.2) I don’t wanna say that.’ in lines 6 and 7. Not only she admits she is unable to access the appropriate lexical item given the circumstances, but moreover she accepts the gesture as an adequate representation of her emotional and physical experience. The multidimensionality and freedom

of gestures (McNeill, 1992) is present in all of the examples presented in this paper. Women embody their traumatic experiences to complement or enhance their oral narratives, which allows them to render a more accurate representation of their psychological and physical experiences.

The lamination of layers of embodiment and language results in structures that ‘mutually elaborate each other to create a whole that is greater than any of its parts’ (C. Goodwin, 2010, p. 389). By employing these interconnected structures, women are able to implicitly request my help to co-articulate their narratives, which facilitates the women’s conceptualization of their traumas. In this way, Candra shares her physical experience by incorporating verbal and non-verbal communication into format-tying when she repeats the adverbial structure *it (was) just + gesture*. She first introduces this structure in lines 10 and 11 of excerpt 3 to convey how she was bleeding. Candra’s failed attempt at verbalizing the bleeding scene results in the articulation of the experience through embodiment. In this instance, through dialogic format-tying involving me, Candra is able to negotiate the adequate lexical term to express her physical experience. The success of this exchange is marked by Candra concluding the format-tying sequence with ‘It was just bleeding and bleeding’ (line 16) and continuing with her narrative. On the other hand, women in the data are able to construct richer, more detailed narratives by embedding onto their oral discourse the embodiment of emotional and epistemic stances that they cannot convey otherwise in the moment of recalling their losses. Furthermore, through the interaction with a peer these women are able to re-live their past experiences, analyze them, and process their losses without any fears of judgment or censoring. This speaks to the importance of sharing these stories in a safe environment with peers who are at different stages in their grieving process and who can openly empathize and give hope for an emotional recovery.

It has been argued that despite the positive experience most women have in pregnancy loss in-person support groups, there are still those who find those groups unsupportive or judgmental (Gold et al., 2012). This negativity can be avoided by confiding stories to anonymous

readers in online support forums. In those forums, stories are created as they are typed. The urgency of a continuous flow in the speech is not present as narrators can pause, re-write, and edit as frequently as needed before posting their stories. For this reason, the flow of the narration and the recreation of the past could be interrupted if the woman feels she is not able to conceptualize and verbally communicate her experience, which hinders the sense-making process. Another nonjudgmental setting for women to make sense of their losses through narrative is psychotherapy. A counseling setting offers the ability to combine semiotic resources as deemed necessary, thus enabling the woman to embody what she cannot verbalize. Nevertheless, those gestures could potentially be ignored or misinterpreted if the counselor cannot create a connection between the gaps in the spoken narrative and the embodiment. A third option consists of face-to-face peer support groups, whether run by professionals or laymen. Generally in this setting, all members are prepared to welcome understanding and attempt the understanding of others, placing the importance of an empathetic connection with others at the center of the sessions. In a similar manner to the accounts presented in this paper, participants are able to involve any semiotic resource to share their experiences, which is crucial when making sense of past misfortunes. Although this environment might not be suitable for those “people sensitive to the stigma or judgments encountered in face-to-face social situations” (Gold et al., 2012, p. e71), when the respect, mutual support, and understanding of those attending is present, this settings is optimal for beginning a successful journey of reconstructing, accepting, and coping with a past trauma.

Notes to Chapter Four

1. Excerpts 4.4, 4.5, 4.7, and 4.8 are updated versions of those printed in “Conceptualizing and articulating pregnancy loss through embodiment in peer interaction” (2015) *Language and Communication*, 45(C), 70-82, doi:10.1016/j.langcom.2015.10.002. Reproduced with permission from Elsevier.
2. Although vaginal bleeding during early pregnancy could signify a miscarriage, approximately 22% of women experience some bleeding and carry their pregnancies to term without any complications (Strobino & Pantel-Silverman, 1989). Implantation bleeding is not a matter of concern and does not require any sort of medical intervention; it is characterized by a small amount of spotting or bleeding typically around two weeks after fertilization, presumably due to the implantation of the fertilized egg on the lining of the uterus (Norwitz & Shin Park, 2012).
3. The notion of Olga being a spiritual person is not extracted from this excerpt, but from the interview in its entirety as she mentions a few times being a spiritual person. It by is taking her narrative as a whole that this excerpt can be analyzed as embodying her spirituality in the midst of the loss.

Chapter Five

REPORTING MEDICAL INTERACTIONS

So then the doctor came in at that point and told me that she had no heartbeat. And I looked at the nurse; I said but you just said there's a heartbeat. She's like "No, I told you there was a heartbeat; I didn't tell you it was your baby's" (Linda)

Introduction

The medicalization of pregnancy in the second half of the twentieth century (Barker, 1998) resulted in a greater inclusion of outsiders in the journey through pregnancy and childbirth (Cahill, 2001). Doctors, nurses, technicians, and other medical personnel became active participants in women's lives during the months leading to the birth of their children. This increased participation also entailed accepting those outsiders in the joyous moments of birth or the miserable moments after discovering a fetal demise. This chapter analyzes how the interaction with medical personnel shapes women's experience and impacts the way in which they frame their losses. The focus lies on how the reported interactions intersect with "the speech doing the reporting" (Vološinov, 1971, p. 153). In other words, by studying how the layering of language, prosody, and gestures represent different stances and speakers within the same string of reported speech, this chapter attempts to unveil how these women display dissatisfaction and (dis)alignment towards the care received.

One of the main reasons for patient dissatisfaction and noncompliance in medical consultations rises from conflicting explanatory models of sickness, as clinical models do not account for differences between doctors' disease model and patients' illness model of sickness (Kleinman, 1978a, 1978b, 1988; Kleinman, Eisenberg, & Good, 1978). As Helman (1981) remarks, *disease* is medically defined as "a deviation from [medical] normal values, and accompanied by abnormalities in the structure or function of body organs or systems" (p. 548),

which does not take into account social and cultural factors that influence the patient. Conversely, (Helman, 1981) defines *illness* as the “subjective response of the patient to being unwell; how he, and those around him, perceive the origin and significance of this event” (p. 548), which includes the patient’s experience, her perception of being unwell, and the influence of social and cultural factors. Although pregnancy loss does not constitute a disease or disorder, conflict between patients’ expectations of treatment versus medical care provided still arises. In fact, Abboud and Liamputtong (2005) point out how even terminology can bring about conflict; what doctors often refer to as *product of conception* is a baby for the woman and her partner. Medical personnel play a crucial role throughout a pregnancy as they care for the baby and the mother-to-be. Although in most instances the interactions between both parties take place during a joyful time in the lives of these women, when issues with the pregnancy are detected, the relationship with medical personnel can become troublesome, not necessarily because of the news being delivered but because of how they are delivered. These negative interactions are problematic as they can affect psychological recovery from the loss (Harvey et al., 2001). Dissatisfaction is often triggered by a perceived detachment and insensitivity on the part of the physicians and nurses (Brier, 1999), which emerges from conflicting explanatory models of sickness (Kleinman, 1978a, 1978b; Kleinman et al., 1978). Friedman (1989) acknowledges “the doctor may view miscarriage as a common clinical problem [whereas] the woman and her partner may view miscarriage quite differently” (p. 457), representing the loss of a child or the hindered possibility of becoming a parent. Moreover, after the miscarriage or stillbirth has been managed and the woman’s uterus is empty, there is no longer need for medical care. Nonetheless, at this moment the grieving parents need the most support and guidance on how to overcome the loss and continue the journey to parenthood. This crossover between the conclusion of medical care and the beginning of need for support from the patient’s emotional perspective is particularly salient in cases of early pregnancy loss, given that 20% of pregnancies end during the first trimester (Kersting & Wagner, 2012; Regan & Rai, 2000). As a result of this

high rate of miscarriage, doctors treat early pregnancy loss as an everyday procedure and do not tend to the possible emotional suffering linked to the miscarriage. This disconnection between the medical and emotional aspects of the loss leads to the highest rates of patient dissatisfaction among all types of pregnancy loss (Cuisinier, Kuijpers, Hoodguin, de Graauw, & Janssen, 1993).

Perceiving the healthcare received as subpar can significantly affect the women's loss experience (Abboud & Liamputtong, 2005; Tsartsara & Johnson, 2002) and even influence the decision of conceiving again in the future (Abboud & Liamputtong, 2005). Often negative experiences resurface during storytelling as part of the sense-making process (Mattingly, 1998b; Ochs & Capps, 2001; Zigon, 2012). When women report communication with medical personnel within their pregnancy loss stories, they can embed different layers of emotional stances that reflect their perception of quality of care received. In this regard, Clark and Gerrig (1990) highlight how spoken reported speech can depict a number of emotional stances and include aspects such as "delivery: voice pitch, (...) emotional state (anger, sarcasm, excitement), [or] accompanying gestures (pointing, smiling, frowning)" (p. 775). Thus, when a speaker reports someone else's speech, she can perform two actions at the same time; on the one hand, she can retell discourse, and on the other, she can embed affective stances through what Vološinov (1971) calls "the "auctorial" context surrounding the reported speech" (p. 153). Particularly in storytelling, reported speech "has the specific function of conveying evaluation since narrators use their own voices or the voices of others to implicitly highlight elements of the story" (De Fina, 2003, p. 95). This incorporation of the reporter-speaker's affective stance as a comment on the reported content or the reported speaker has been extensively studied (Besnier, 1993; De Fina, 2003; Günthner, 1998; Li, 1986; Niemelä, 2005) and it can be accomplish through direct or indirect discourse (Günthner, 1997). Nevertheless, seldom research has been performed on the functional differences between direct and indirect discourse, focusing on when or how speakers use one method over the other. De Fina (2003) notes in her study that immigrant chronicles favored the use of direct reported speech and no chronicles included only indirect

reported speech, indicating a limited use for indirect discourse from a quantitative and a qualitative perspective. She indicates that direct discourse was mainly used to highlight certain actions and convey “characters’ reactions to events” (2003, p. 105). This chapter elaborates on De Fina’s functional distinction between indirect and direct speech by analyzing reports that convey dissatisfaction with medical personnel within narratives of pregnancy loss. Furthermore, the focus lies on the content of direct and indirect speech, how they two forms are selected to convey dissatisfaction, and how the reports interact when they follow each other in the discourse. Finally, in an attempt to understand how the gap between doctors’ and patients’ explanatory models of sickness can be narrowed in the context of miscarriage and stillbirth, this chapter aims to determine how interaction with medical personnel, in cases of reported dissatisfaction, shapes the women’s loss experience.

Data

For this chapter the entire dataset was analyzed, i.e., 43 interviews and 40 YouTube vlogs, to extract and study instances of direct or indirect reports of interaction with medical personnel. Given that the majority of the reported speech present in the interviews concerned negative interactions with doctors, nurses, or ultrasound technicians, it could be argued that the participants were biased after reading the recruitment flyer. Figure 1 shows how the call-for-participants highlighted an interest in interactions with medical personnel and a negative experience with them on the researcher’s part.

My name is Ingrid Norrmann-Vigil, and I'm a Ph.D. student in the Department of Applied Linguistics at UCLA. I'm currently studying narratives of trauma, medical communication, and how women who have experienced a pregnancy loss recall their experiences and their interactions with medical personnel.

The idea for this study started from my own experience; I miscarried on September 2011 and again on May 2012. And after noticing the lack of emotional support not only from medical personnel, but also from some people close to me, I started researching on the subject.

Figure 5.1 Recruitment flyer

The possible bias lies in the fact that participants knew about the researcher's interest on miscommunication, dissatisfaction, and lack of support from medical personnel. This could have affected prospective participants, encouraging those with negative experiences to take part in the study, thus, skewing the numbers of negative versus positive or neutral interactions. On the other hand, those who shared their narratives could have emphasized their negative experiences with medical personnel to tailor their stories to what they thought to be the research's main objective. It is not possible to determine whether the flyer influenced the participants or not. Nevertheless, when comparing the types of medical interactions reported in YouTube vlogs versus the interviews, there is a substantial difference, as illustrated in table 5.1.

	Interviews	YouTube
Reported medical interaction	Positive	4%
	Negative	56%
	Both	12%
	Neutral	28%
No reported med. interact.	0%	7%

Table 5.1 Distribution of medical interaction in the interviews and the YouTube vlogs

All of the women interviewed mentioned interacting with medical personnel at some point in their narratives, through reported speech or by voicing their opinions of the treatment received or the medical personnel involved. Most of the participants (56%) reported negative interactions, followed by neutral reports (28%) where the interviewee did not display any emotions towards the care received. A mere 4% of the women interviewed expressed positive attitudes (e.g., praise or gratitude) towards the medical staff and the care received. Conversely, not all of the YouTube vlogs mentioned interaction with medical personnel. The distribution of types of interactions among those who included them in their stories contrasts greatly with the distribution in interviews. The majority of reports in YouTube regarding medical personnel were neutral (53%), followed by 20% of vloggers reporting positive interactions. Although both datasets were created under very different circumstances and are not comparable in terms of motivation, goals, and structure, the significant difference in positive versus negative reports in both datasets could be an indication of a bias caused by the recruitment procedure. Nonetheless, the entire dataset is a valid reflection of the poor experiences some women are subjected to when suffering a pregnancy loss. Through the negative reports collected it is possible to understand how the discrepancy between expected versus received care plays a crucial role in how these women frame their losses and attempt to overcome the traumatic experience.

Reported Speech

Whether the reporter-speaker assumes the role of the reported-speaker or not is one of the main differences between direct and indirect reported speech. It has been previously argued that because in direct discourse the reporter-speaker takes on the role of another speaker, this form carries a ““theatrical”, playful, imaginary character” (Wierzbicka, 1974, p. 272) not present in indirect discourse. In direct quotation the *verbum dicendi* (e.g., he said) marks the separation of the reporter and reported speakers (Vološinov, 1971), giving the recipient the illusion that the speech was produced as it is being transmitted (De Fina, 2003). Nevertheless, through

laminated structures, “speakers can display complicated stances toward the talk they are producing” (C. Goodwin & Goodwin, 2004, p. 224). Thus, speakers construct and transmit meaning through the interconnection of reported speech and reporting context (the speech doing the reporting), and failure to acknowledge this interrelation inhibits the ability to understand any form of reported speech (Vološinov, 1971). On the other hand, when producing indirect quotation, “the form and the non-verbal messages of the reported speech belong to the reporter-speaker” (Li, 1986, p. 38), thus facilitating the lamination of affective stances as a comment on the reported discourse. The similar accessibility to embed commentary onto either form of reported speech is apparent in the data collected and is illustrated in table 5.2, where the percentages of positive and negative reports in the data are relatively similar.

	Reported Speech	
	Indirect (32%)	Direct (68%)
Positive	2%	1%
Negative	29%	38%
Neutral	69%	61%

Table 5.2 Distribution of Indirect and Direct Reported Speech¹

De Fina (2003) reports that border-crossing immigrant narratives favor direct reported speech (92.2%) and none of the chronicles she analyzed include only indirect reported speech. This difference in usage would suggest that indirect quotation is much more limited than direct quotation, “both quantitatively and qualitatively, as the former is often used in alternation, or as a complement, to direct reported speech” (p. 104). Although, the narratives of pregnancy loss in this study also reveal a preference for direct discourse (68%), the difference in frequency between both forms is not as significant as in De Fina’s (2003) work. Furthermore, there are a few narratives where only indirect reported speech occurred, indicating this form is not subordinate to direct quotation.

A first glance at the reported utterances indicates the affect in the commentary embedded on the reported speech is relatively equally distributed in direct and indirect reports. Most reports are factual with no affective stances (69% of indirect discourse and 61% of direct discourse), followed by negative stances embedded onto indirect (29%) and direct quotation (38%). Considering the prevalent dissatisfaction with medical personnel present in the interviews, a larger number of negative reported speech that reflected this dissatisfaction was expected. However, several women reported their interactions with medical personnel in a neutral manner, immediately followed by an explicit commentary of dissatisfaction, as illustrated in excerpts 5.1 and 5.2 from Candra's and Linda's interviews respectively.

Excerpt 5.1: It felt businesslike (Candra's interview)

1 Candra: So: uhm (0.4) we went into his office. (0.4) and he just kinda (.)
 2 let us stay there for an hour so we kinda processed what happened,
 3 and then we came out, and he had my file,
 4 an:d he was just saying "okay her- here are the tests
 5 that we're gonna do now."
 6 (1.2) And so it just- it felt- (1.4) it felt businesslike.
 7 Like he gave us that time to grieve,
 8 as a couple but then he's down to business.
 9 like (0.2) here's where we're going from here.

Reported Speech
(neutral stance)

Explicit commentary
on the interaction
(negative stance)

Excerpt 5.2: You can't use the two together (Linda's interview)

1 Inter.: And then eventually did you s- (.) try (0.6) to get pregnant again
 2 or: it (.) happened.
 3 Linda: Uhh No we were not trying. (1.2) We were not trying. Uhm (2.0) .hh
 4 The doctor? (1.0) that I didn't go back to? (0.2) had put me on:
 5 I was using a diaphragm? (0.4) an::d (0.2)
 6 she had told me to add the Nuvaring? (1.2) to the diaphragm?
 7 You can't use the two together.
 8 Inter.: Ye:ah.
 9 Linda: But she had- that's what she had me on.
 10 Was the Nuvaring with my diaphragm. (1.2)
 11 And that's how I got pregnant with my next miscarriage.

Reported Speech
(neutral stance)

Commentary on
the interaction
(negative stance)

In excerpt 5.1, Candra narrates her interaction with her OBGyn during the visit she found out she miscarried. After being given time to process the loss, the doctor returned to the consultation room and explained to her what the next steps would be to determine the etiology of the loss. As Candra reports his speech, she does not embed any layers of affective stance onto her discourse. Her intonation remains similar to the previous utterances, and the prefacing language conveys neutrality (“he was just saying”, line 4). Nevertheless, following the auctorial portion of her discourse she introduces her commentary on the situation (“it just- it felt- (1.4) it felt businesslike”, line 6). Her qualification of the interaction as businesslike suggests she was expecting a more empathetic or at least sympathetic response from her doctor, thus denoting dissatisfaction with the interaction reported. Given the use of direct quotation, it could be argued that the format chosen does not allow for embedded commentary that would pinpoint the exact reason for dissatisfaction, since a distinct intonation would connote dissatisfaction but not the reason behind it. This structure consisting of reported speech followed by the reporter-speaker’s commentary is not unique to direct discourse, since Linda also employs this formula in excerpt 5.2. In this case, she explains how she became pregnant while on birth control; she was using a diaphragm and reports the doctor instructed her to add the Nuvaring². Linda’s intonation in lines 5 and 6 indicates a problem with the content transmitted as she reports the doctor’s instructions with emphatic rising intonation. However, the neutral verbal dicendi (“she had told me”, line 5) seems to preface a factual, non-affective reported speech. This discourse contrast with the commentary inserted after the reported speech concludes, where Linda’s demeanor changes; her tone denotes resentment towards her doctor for conceiving when she was avoiding a pregnancy, as she introduces the reason for becoming pregnant and also questions the doctor’s epistemic stance. This formula (neutral/factual reported speech + commentary) appears often in the data set, thus lowering the number of occurrences of negative direct and indirect quotations. The next sections elaborate on how negative affective stances are introduced through indirect and direct reported speech, how the two forms interact with each

other when used together in the same turn, and what might trigger speakers to switch from one form to the other within the same turn.

Direct Reported Interaction

The most common form of reported speech in the data collected consists of direct quotation, where women take on the character of the reported-speaker through language and embodiment. Despite the seemingly low number of negative instances of direct reported speech (26% of all reported interactions), dissatisfaction with medical personnel is a recurring theme in most of the narratives, particularly in the interviews collected. Through prosody, facial expressions, embodiment, and lexical choice women are able to portray the speakers being reported while embedding their own affective stances towards the medical interaction in question. The significance of these affective stances lies in the impact that perceived poor bedside manners has on the women as they undergo the physical and psychological recovery process from a pregnancy loss, illustrated in excerpt 5.3.

Excerpt 5.3: Let's go look at the specimen (Carla's interview)

- 1 Carla: So hhh. (0.2) They take her awa:y and they come in
2 to make sure the placenta's come out,
3 and my doctor says: (0.2) y'know, (.) like (.)
4 I can see like the bowl full of placenta down there.
5 **And he's like "well let's go look at the specimen."**
6 (.) And he wasn't talking about the placenta
7 because that was right in front of him. **Reported speech**
8 He was talking about my baby. **(neutral stance)**
- ((1min. 15sec. omitted))
- 40 Carla: I just couldn't believe they could treat somebody like that y'know
41 and (2.2) y'know I mean I would- (0.2) like
42 I couldn't even sleep for like weeks afterwards
43 because I- every time I closed my eyes and tried to go to sleep
44 I could just hear that doctor saying ***Let's go get the specimen.* ((singsong intonation))** **Reported speech**
45 .hh y'know and that's all she was to them, **(repetition)**
46 and that's all she: really is to a lot of people. **negative stance**

Carla's first pregnancy seemed normal and with no complications; her 18-week anatomy scan showed no signs for concern, but a month later doctors were no longer able to find the fetus' heartbeat. The previous interaction took place after Carla delivered her stillborn daughter at 22 weeks and 6 days. The etiology of the fetal demise was unknown; for this reason, the doctor present during the delivery ordered the body to be taken to determine cause of death. Carla reports how he referred to the baby as a *specimen*, which in the midst of her loss, she found upsetting and disconnected from her reality of having just lost a child. Although *specimen* is an appropriate medical term in this case, it does not reflect the relationship between the baby and the grieving mother or show any sympathy towards the loss. Brier (1999) reports this detachment between physicians and patients after a pregnancy loss often serves as means for physicians to mask their emotions of anger and the "discomfort relating to loss, being in a specialty uniquely focused on the beginnings of life" (1999, p. 153). The danger of disengaging in these situations lies on the effects this behavior has on the patients, who as a consequence feel neglected and dismissed; furthermore, this negative emotional environment affects their recovery process both psychologically and physically (Brier, 1999; Paton et al., 1999; Swanson & Wojnar, 2004). Although Carla first reports the doctor's discourse in a seemingly neutral manner and does not incorporate any negative emotional stances, aside from the emphasis on the first syllable of "specimen" (line 5), the commentary that follows this quote expands on the degree of her dissatisfaction. The lack of sympathy Carla experienced affected her for several weeks, as she lost sleep because the doctor's words would play in her head every time she closed her eyes. To highlight how his utterance impacted her and to stress her anger, she repeats it in line 44 with a singsong intonation, illustrated in figure 5.2.

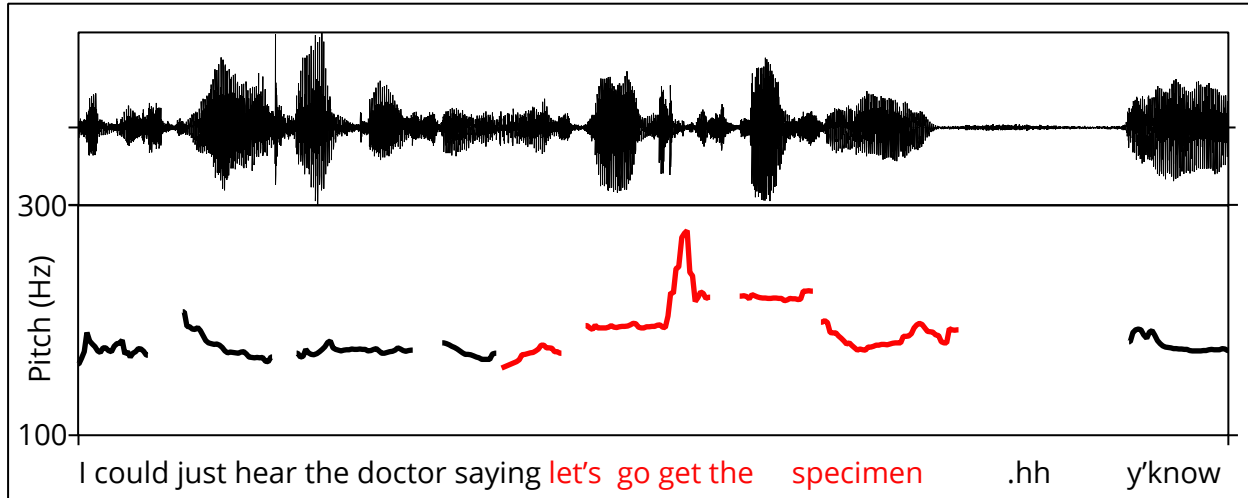


Figure 5.2: Sing-song intonation in direct quotation

The reported utterance’s pitch contour, highlighted in red in figure 5.2, does not convey any meaning in isolation. Pitch labels that refer to the speaker’s behavior (e.g., arrogant, sympathetic, etc.) are inferred by the hearer as part of a complex interaction between text, prosody, and context (Wichmann, 2002). When Carla enacts the doctor’s discourse, the reported pitch can be interpreted as condescending given the wide pitch range, the repetition of the doctor’s utterance as a salient part of speech that disturbed her, and the context of the loss. In other words, by embedding an emotional layer onto the utterance through the wider pitch range, she denotes the condescension she perceived in the doctor’s utterance, and how this affected her in the grieving process. Furthermore, she projects this condescension and lack of sympathy from the medical personnel—i.e., the pronoun *them* in line 45 indexing the doctor and his staff—to some of her family and friends who also dismissed the significance of the loss, as she concludes her daughter was just a specimen to “a lot of people” (line 46).

Carla’s excerpt 5.3 illustrates one of the many reasons for the conflict between doctors’ and patients’ explanatory models of sickness. Carla believed her daughter was more than just a specimen, which is why the term used and its connotations caused her severe emotional distress that was still present during the interview, years after the loss. Lines 45 and 46 carry an implicit

contrast of what the fetus meant to others versus what she was for her. To others she was only a specimen, whereas for her the fetus was her baby and her daughter, according to the referents she uses in several parts of her narrative. The critical distinction between these two interpretations of the fetus is the personhood attributed or not to it. Aside from the social and legal ongoing debate of whether an embryo or a fetus should be considered a person or not, particularly in matters of abortion (see (Freedman, Landy, & Steinauer, 2008), Ginsburg (1989), Layne (2000)), the woman's relationship with the fetus greatly impacts her outlook on her interactions with medical personnel and others who might constitute the personhood of the fetus differently than her. Borrowing from Schutz' (1967) words, Carla assumed a "Thou-orientation" attitude towards her fetus, understanding a Thou-orientation as "the intentionality of those Acts whereby the Ego grasps the existence of the other person in the mode of the original self" (Schutz, 1967, p. 164). It could be argued the interaction with her baby was unidirectional or one-sided, resulting in a direct social observation (Schutz, 1967), as Carla was aware of the presence of her baby inside her womb, but the baby did not consciously experience the existence of Carla. Nevertheless, often women report babies in their womb do react to light, loud sounds, and even their emotional states by means of kicking or moving. This Thou-orientation, therefore, gave rise to a we-relationship between Carla and her baby, in which they are "aware of each other and sympathetically participate in each other's lives for however short a time" (p. 164). Conversely, the Others that Carla indexes with "them" (line 45) and "a lot of people" (line 46) do not have a relationship or the possibility of building any type of relationship with the fetus. Medical personnel's closest relationship with the fetus is through the monitor of an ultrasound device, where they can see a grainy image on a screen and hear the heartbeat. Even if they were to see the fetus moving and acting like a baby—for instance sucking her thumb or "waving"—the possibility of an interactive relationship does not exist, nor they can engage in direct social observation as they cannot access her "body as signs of [her] conscious experiences" (Schutz, 1967, p. 173). This difference in attainability of an intersubjective relationship results in

different constitutions of the Other—i.e., a specimen versus a person—which leads to different understandings of what the fetal demise means and conflicting explanatory models of sickness.

The disjunction between physicians and pregnancy loss patients is present not only on the linguistic level through the lexicon chosen, but also in a more deep-rooted level of what deserves immediate medical attention. The latter is particularly salient when analyzing cases of early pregnancy loss. Miscarriages are relatively frequent (Tulandi & Al-Fozan, 2012) and in most cases they are not preventable (Babarinsa, 2012); unfortunately, women experiencing a miscarriage for the first time are often unaware of these facts. This disparity in epistemic stances between patients and medical personnel in many cases leads to opposing standpoints regarding the need of immediate medical care. The next excerpt illustrates how through prosody Jordan expresses her dissatisfaction towards the nurse who determined her threatened miscarriage was not an emergency, despite Jordan's vaginal bleeding.

Excerpt 5.4: It's not an emergency (Jordan's vlog)

1 Joan: uhh We- and once we left we asked the nurse we're like, .hhhhh
2 Is there any way we can get into radiology tonight
3 so that we can uhm so we can get internal ultrasound?
4 to see what's going on?
5 Because like at that point we still didn't have any answers like
6 we did- he was so nonchalant about everything like, .hhhh
7 And she's like "<Well:: since it's not an emergency probably not.>"
8 (.) And I'm sitting here thinking okay if you cannot find,
9 (1.0) I'm trying not to cry. (0.2)
10 If you cannot find? (1.0) .hh *a heartbeat? with the Doppler?
11 or the (.) abdominal? (3.6) ultrasound?* ((voice breaks))
12 .hhh (0.4) If you're not able to detect a heartbeat or-
13 I don't care if it's because it's not clear,
14 because your stuff- (.) your technology isn't (0.4)
15 y'know the most up-to-date or whatever
16 (1.0) ↑Don't you think that that could be an emergency?

Reported speech
(negative stance)

Explicit commentary
Questioning of the
nurse's explanatory
model of sickness

After bleeding lightly all day while being six weeks pregnant, Jordan went to the emergency room as she feared a miscarriage. The on-call doctor performed an abdominal ultrasound and was able to see the embryo but no cardiac activity. The fetal heart can usually be

detected at eight weeks with an abdominal ultrasound and at twelve weeks with a Doppler (Lockwood & Magriples, 2015), which is why not finding any cardiac activity at six weeks with an abdominal ultrasound or a Doppler was not a source of concern for the doctor. For an accurate diagnosis of the bleeding, a vaginal ultrasound was needed, but they were not able to perform it at the emergency room that night, so the doctor referred Jordan to an OBGyn for a follow up the next day. After the doctor left the room, Jordan asked the nurse if the on-call radiologist could perform a vaginal ultrasound that night (lines 1-4, excerpt 5.4). Jordan's dissatisfaction with the nurse's response is clearly portrayed in her report in line 7. The elongated "well::" prefacing a dispreferred answer to a yes/no question (Pomerantz, 1984) shows Jordan's interpretation of the nurse trying to evade the question. She states the reason for denying the request ("it's not an emergency") before politely rejecting the request ("probably not"). To highlight how infuriating this response was, Jordan slows down her speech throughout the entire utterance. Furthermore, she follows the reported discourse by questioning the nurse's stance regarding her case not qualifying as a medical emergency. After Jordan visited the emergency room, the reason for the bleeding remained unknown, and since the abdominal ultrasound did not display any cardiac activity, the possibility of a miscarriage had not been eliminated. This uncertainty caused Jordan to interpret her situation as a medical emergency, which she voices when questioning the nurse's stance (lines 8-16). Jordan's viewpoint of a medical emergency contrasts with the medical staff's stance. A threatened miscarriage is understood as bleeding during the early stages of pregnancy concurrent with detectable fetal cardiac activity, if the pregnancy is sufficiently advanced. Approximately 90 to 96 percent of threatened miscarriages between 7 and 11 weeks of gestation result in a successful pregnancy (Tulandi & Al-Fozan, 2012); nevertheless, "there is no known evidence-based specific treatment for a threatened miscarriage" (Babarinsa, 2012) to prevent it from developing into an inevitable miscarriage. If Jordan was bleeding due to an imminent miscarriage, no medical treatment could have changed the course of events. On the other hand, the confirmation that the embryo

was implanted in the uterus and that the pregnancy was not ectopic³ dissipated any reason for urgent concern. Nevertheless, what the emergency room staff did not take into consideration in this encounter was the psychological aspect of a miscarriage and the emotional burden that waiting for further medical intervention puts on a woman in this situation (Murphy & Merrell, 2009). This is a clear example of how different explanatory models of sickness between doctors and patients create misunderstanding, in which patients feel dismissed due to a lack of information. In turn, this powerlessness sense becomes dissatisfaction towards the medical care received. Jordan's commentary following the reported discourse confirms this epistemic discrepancy as the reason for the negative emotional stance she embeds onto the quote by means of a distinct prosody.

Prosodic marking is one of the most common resources women in the data used for embedding affective stances onto reported speech. In excerpt 5.5, Karen produces an even more complex lamination by adding distinct facial expressions to the direct reported speech. Also at around 6 weeks pregnant, Karen noticed some spotting that turned into bleeding. Since the amount of bleeding was heavier than what could be considered normal during pregnancy, she called her midwife for a consultation over the phone, reported in excerpt 5.5.

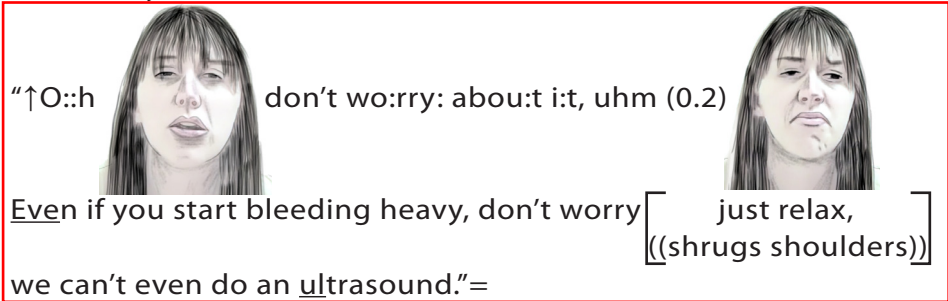
Excerpt 5.5: She told me don't worry, just relax (Karen's vlog - First loss)


1 Karen: .hh Monday January third_
 2 I felt like it go:t a little bi::t (.) heavier than my comfort. (.)
 3 .hhh It was never red though so I just y'know
 4 (1.2) tried not to panic, (.) .hh but (0.4)
 5 I called my midwife a:nd she told me_

Reported speech
negative stance

6 "↑O::h don't wo:rry: abou:t i:t, uhm (0.2)

7 Even if you start bleeding heavy, don't worry [just relax,
 8 we can't even do an ultrasound."=]
 ((shrugs shoulders))



9  =And I was six weeks e- exactly.

10 (.) .hhh o:n- that was a Monday, .hh a::nd uhmm (1.0) which

11 which I thought was a little odd and I just didn't feel comfortable with,

After setting up the background for her story, in line 5 Karen introduces the midwife's speech in a neutral manner by means of the verbum dicendi *told*, which merely relies information to the audience. However, this neutrality changes as she begins the midwife's speech enactment in line 6 by squinting her eyes and changing the prosody, depicted in the pitch contour in figure 5.3.

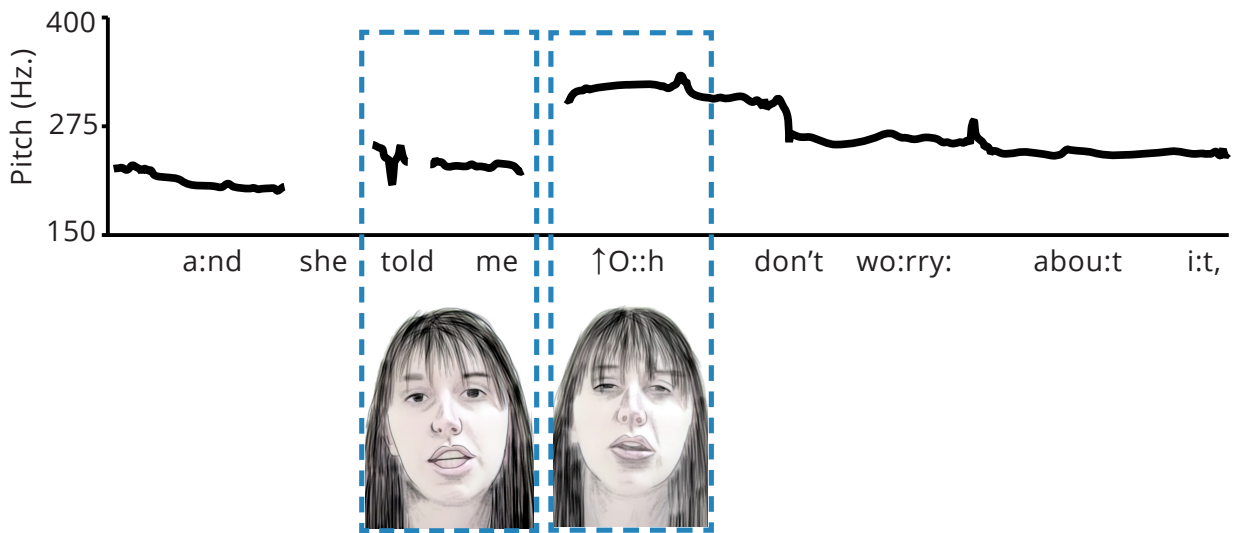


Figure 5.3: Pitch Raise in Direct Quotation

The pitch raise at the beginning of the reported utterance gives a demonstrable signal to the addressee on how to parse the string of talk into two sequences, marking the beginning of the quotation. This marked shift in prosody is a common resource used in reported speech to mark the start of an enacted turn (Holt, 2007). On the other hand, prosodic marking is often used to convey information about the personality or conduct of the reported speaker (Günthner,

1997). In this case, the pitch raise allows for a wide pitch range in the reported utterance, which paired with Karen's facial expressions and the context of the utterance produced, denotes the condescending attitude she perceived from the midwife's response. According to Goffman's (1981) speaker paradigm, revisited by C. Goodwin (2007) and C. Goodwin and Goodwin (2004), a speaker changes its footing and takes onto different roles throughout her discourse. As C. Goodwin and Goodwin (2004) summarize it, these roles are:

- (1) the person actually producing the talk, what he calls **Animator** (or Sounding Box);
- (2) the **Author**, or entity responsible for constructing the words and sentences at issue (who can be someone different from the current speaker);
- (3) the **Principal**, the party who is socially responsible for what is said; and
- (4), the **Figure**, a character depicted in the Animator's talk. (pp. 224, emphasis in original)

Following Goffman's (1981) deconstruction of the speaker and speech, Karen's re-enactment of the midwife's discourse is disentangled in figure 5.4 to illustrate how the language, prosody, and facial expressions come into play to represent the midwife's discourse and Karen's stance towards it.

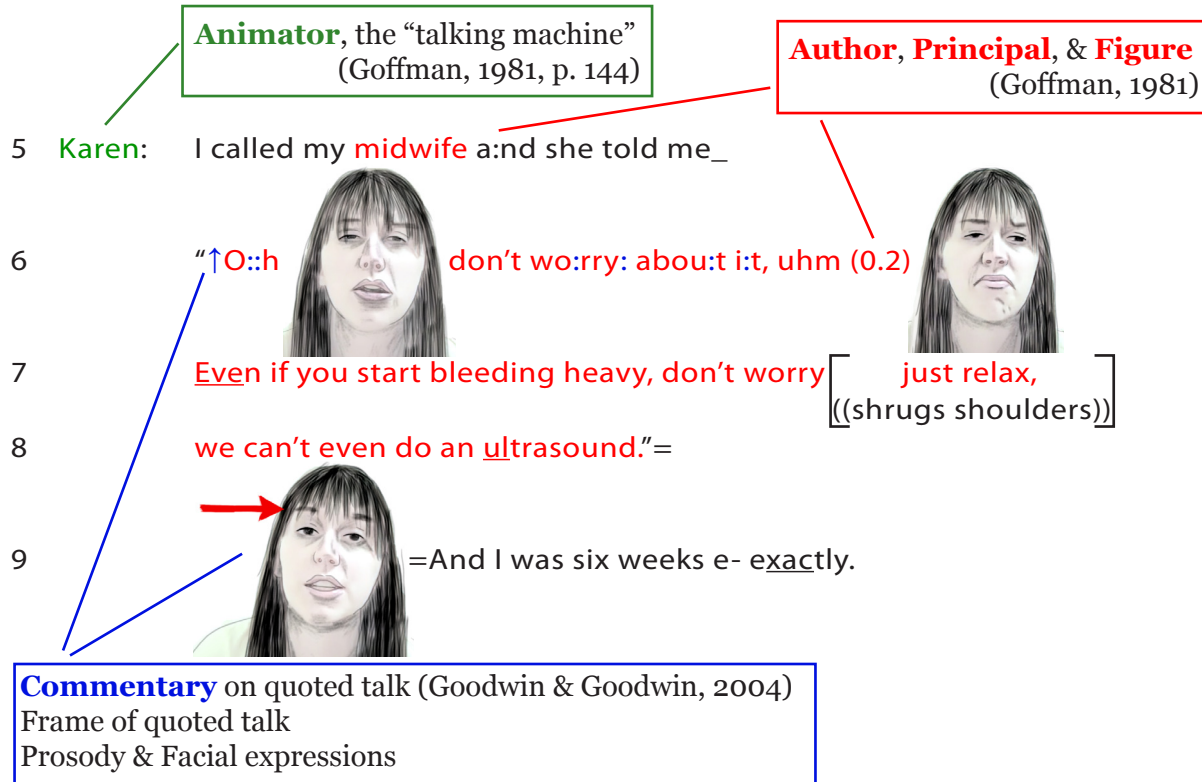


Figure 5.4: Deconstruction of Karen's reported speech

When focusing on the quoted talk in figure 5.4, Karen is the animator enacting the discourse. Following Goffman's (1981) idea of frame analysis, although Karen is the narrator throughout her story, in this particular instance she is performing the midwife's talk, which makes the midwife the author of the talk, the figure being portrayed, and the principal responsible for the original talk. Additionally, the auctorial context (Vološinov, 1971) is present through Karen's embedded commentary on the quoted talk, by means of the prosody, the facial expressions, and also the language used. Even though there is no recount of what Karen had asked the midwife before she responded, it can be in part reconstructed by the answer "don't wo:rry: abou:t i:t," in line 6. At the end of this phrase, "i:t" indexes the topic of Karen's concern posed in her question (a possible miscarriage), which viewers are expected to be able to recover given the previous setting of the story. This emotional stance of concern about her pregnancy is evident from the midwife's response "don't wo:rry:", which intends to alleviate her distress.

Karen's negative interpretation of the midwife's stance is further reinforced in the next phrase with "Even", suggesting that her current bleeding does not pose a threat, and in fact heavier bleeding would not pose a threat either. Given this negative perception of the interaction with the midwife, it is possible to return to the beginning of her reported speech in line 6 and see how "O::h" emphasizes her perception of the midwife as being dismissive. In this case, the particle *Oh* in turn-initial position after a question indicates the inquiry was inappropriate given the context (Heritage, 1998), as the midwife confirms when she states in lines 6 through 8 the bleeding is not a matter for concern. Furthermore, Karen constructs the character of the midwife as one who has just received a phone call from one of her patients, alarmed because she was bleeding and was afraid her pregnancy was in danger. Regardless of Karen's state, the midwife tries to convince the patient there is nothing to be concerned about, treating the call as not meriting further concern. It is important to emphasize that since this is reported action, it is not possible to determine if Karen's report was an accurate representation of the midwife's talk or if her report was heavily influenced by her interpretation of the midwife's epistemic stance vis-à-vis the phone call. The high pitch and the *oh* particle in turn initial position point out how Karen interpreted the midwife's stance as an unwarranted dismissal of her concern. Here Karen blurs the boundaries of the direct reported speech of the midwife so as to present two points of view intersecting within one string of talk. Although when examining the language exclusively it is easy to infer what portions of her discourse are quoted speech, particularly because of the switch from the first to the second person singular when referring to herself in lines 6 through 8, the midwife's discourse, if present at all, cannot be easily determined in the prosody or facial expressions.


Aside from the midwife's stance and perceived condescension, there is a third lamination on the discourse, which is the facial expressions that represent how Karen perceived and enacted the midwife. She begins the reported speech by squinting and tightening her eyebrows (this transition can be seen in figure 2), which she maintains throughout the entire enactment,

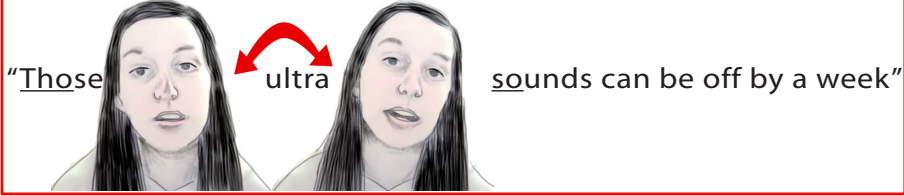
adding to the feeling of condescension. In the 0.2 second pause at the end of line 6, her pressed lips and the deeply lowered corner of her lips, combined with her wrinkled nose, denote a blend of anger and contempt (Ekman & Friesen, 2003), illustrating Karen’s discontent as she felt the midwife did not care for her problem. This idea of indifference and lack of sensitivity is further developed as she shrugs her shoulders when saying “just relax” in line 7. In the reported speech in lines 6 through 8, Karen is taking up a stance toward what the midwife said, showing disapproval of her discourse. In line 9, with “And I was six weeks e- exactly.” she shifts from the midwife’s character back to herself, also denoting a sequentially next action to what was just described. This change in actors can also be observed physically: she moves forward toward the camera and raises her eyebrows (image on line 9) depicting her epistemic stance on the whole discussion. With *exactly* at the end of the phrase in line 9 she reinforces the discontent with the midwife. Karen was at a point in her pregnancy where an ultrasound would have shown the embryo and there was a possibility that it would have also shown a heartbeat, so for the midwife to say “we can’t even do ‘n ultrasoun’.” in line 8 was medically inappropriate and dismissive of her worries. It is also important to take into consideration that when Karen retells this conversation, she already knows the outcome of the bleeding, which is also why all the semiotic resources come into play and the reported speech and reported context converge within the same speech act, creating a complex lamination of embedded characters and stance displays.

The next excerpt also illustrates how different semiotic resources interact in direct reported speech. In this case, Karen reports a conversation with her OB/Gyn doctor about an ultrasound performed days before her second loss. The main difference with the previous example is the way in which she introduces the doctor’s speech.

Excerpt 5.6: My doctor reassured me⁴ (Karen’s vlog - Second loss)

- 1 Karen: I was five weeks and six day:s, (0.6) we did an ultrasound and
- 2 on the ultrasound we saw a gestational sack and the yolk sack. (0.2)
- 3 .hhh But it was only measuring five weeks and two days.

4  My doctor reassured me, he's like,
Reported speech
(negative stance)

5  "Those ultra sounds can be off by a week"

6 and:, .hh ((rolls her eyes)) I'm just like No. (.)

7 I'm one hundred percent sure on my dates so that's not right. y'know,

As can be determined by examining both excerpts, the auctorial context can be present in different degrees of intensity within reported speech. Vološinov (1971) points out that reported discourse in which the auctorial context portrays heavy value judgments and attitudes onto the character carries over to the reported speech and in turn weakens the objectivity of the reported context. An example of this “weakening of objectivity in the auctorial context” (p. 168) is illustrated in excerpt 5.6. Contrary to excerpt 5.5 from Karen’s first loss where she displays her stance towards what the midwife said as she was enacting it and not before, in this case the lamination begins with the introduction of the reported speaker, before the reported discourse. Line 4 begins with “My doctor reassured me,” displaying not only the doctor’s epistemic stance but also with the use of “reassured” she invokes how this trying-to-convince action was forcefully directed at her at the time of the telling. Moreover, her quick eyebrow-raising and opening of the eyes—shown at the beginning of line 4—as she says “reassured” forewarns the viewers that from her point of view there is something problematic with the doctor’s discourse she will report next. Immediately after this introduction, “he’s like” signals she is about to perform an actual enactment of the doctor, giving her the opportunity to further embed her stance against what he told her.

Similar to excerpt 5.5, as Karen portrays the doctor’s character she raises her pitch; however, this time the difference in pitch is not as dramatic as in the previous case. Given that

from the prefacing of the reported speech viewers already know what her stance towards the doctor is, she does not need to be as prosodically emphatic to demonstrate her disbelief in what the doctor said. However, she does add a side-to-side head tilt (depicted in line 5) on the stressed syllable of each word in “Those ultrasounds” paired with subtle cues of contempt—e.g., slightly pressed upper lip and lower eyelids—which together can be understood as disbelief (Ekman & Friesen, 2003). This back and forth lateral movement of the head paired with facial expression and the language used once again exemplify the enactment of opposite stances onto the character. On the one hand, she displays her own disbelief, and on the other hand, she conveys the doctor’s epistemic stance vis-à-vis Karen’s worry. The end of the quotation trails off at the beginning of line 6; after which she rolls her eyes, signaling the enactment has ended and also incorporating her emotional stance towards what was said. This makes the utterance performed by the doctor closed in between two large stance displays acting as quotation marks.

In a similar manner to excerpt 5.5 from Karen’s first loss, in this example after Karen finishes the reported speech she presents to the viewer the reason for her disbelief. In this case, the doctor told her the difference between the measurement of the embryo in the ultrasound—5 weeks and 2 days—and the time she believed the embryo was—5 weeks and 6 days from her estimation on when she had ovulated and conceived—was not a matter of concern. Her unease arose because of her lack of accurate information, as she believed the different gestational age determined by the ultrasound implied a slow-growing embryo and would result in a miscarriage. Gestational age as estimated by mean sac diameter through ultrasound imaging is accurate to plus or minus 5 to 7 days (MacKenzie, Stephenson, & Funai, 2014); this means the difference in 4 days between Karen’s estimations and the ultrasound was within the normal range of error and confirmed the doctor’s statement that there was no reason for concern at the moment. This example has to be analyzed taking into consideration Karen’s context: she had experienced a miscarriage before this pregnancy, and she is telling this story after the second miscarriage has already taken place. From her point of view, the inkling she had during the medical encounter,

that the discrepancy in gestational age was a source of concern, was confirmed given that she did lose that pregnancy, regardless of whether the doctor's position was correct or not. To emphasize the validity of the suspicion she had when she encountered the doctor, as she says "I'm one hundred percen' sure on my dates." (line 7) she raises her eyebrows and nods on the stressed syllables of "hundred", "sure", and "dates", confirming to her audience the disbelief previously displayed was rational and based on evidence she had gathered.

Indirect Reported Interaction

Indirect reported speech occurred less frequently in the data than direct reported speech (32% versus 68% respectively). In addition, the overall percentage of reported discourse with embedded negative emotional stances was also smaller in instances of indirect discourse (29%) compared to instances of direct discourse (38%). In a similar way to the cases of direct reported speech previously analyzed, women often reported indirect discourse in a neutral manner and added negative comments immediately after the report was completed. Nevertheless, a significant number of cases presented embedded semiotic resources that layered different emotional and epistemic stances onto the discourse being reported. The most productive resource for embedding emotional stances encountered in the data is prosody. Excerpt 5.7 illustrates how the prosodic lamination on the report is the main resource that conveys the animator's stance towards the talk, which would be considered neutral if only examining the language used.

At about 12 weeks of gestation, on a Saturday, Hillary started spotting and experiencing abdominal cramps. The symptoms persisted for over 24 hours, and the intensity of the cramps started escalating to the point where Monday morning she could no longer sleep as the pain was coming and going in waves, similar to labor contractions. Since she was bleeding heavily, she decided to go to the emergency room at 7am. After being admitted, she passed several blood clots and large pieces of tissue while still waiting to be seen by a doctor. Finally around 1pm they

performed an ultrasound, and a couple of hours later a doctor came into her room to tell her she had miscarried. In excerpt 5.7 Hillary reports a fragment of the interaction with this doctor at the emergency room.

Excerpt 5.7: Try again (Hillary's interview)

- 1 Hillary: There was this one doctor who: sat there next to me Reported speech
 2 for like ten minutes or so. (.) (negative stance)
 3 Telling me *that it was all gonna be okay (.)
 4 and that I'll be able to have another baby again.
 5 And that as soon as I was healed I could start trying again.*
 ((singsong intonation))
 6 And it was just- (0.4) it was- it was awful. Explicit
 7 Inter.: You don't wanna hear that. commentary
 8 Hillary: (0.2) That is not what I need to hear at all right now. hhh. (negative stance)

In the previous excerpt, Hillary narrates how the doctor sat next to her and told her that soon she would heal and be able to try to conceive again. Although those words might seem compassionate and encouraging, several women interviewed for this study, including Hillary, disagree with this point of view. They argue that at the time of a loss, parents need their pain to be recognized through understanding and sympathy with the demise; contrary to this, focusing on the future and the prospect of a new pregnancy feels dismissive of the present heartbreaking experience. In Hillary's report, lines 3 through 5, the singsong intonation embedded onto the discourse, represented in the pitch contour in figure 5.5, signals the intention of the speaker doing the reporting is not neutral.

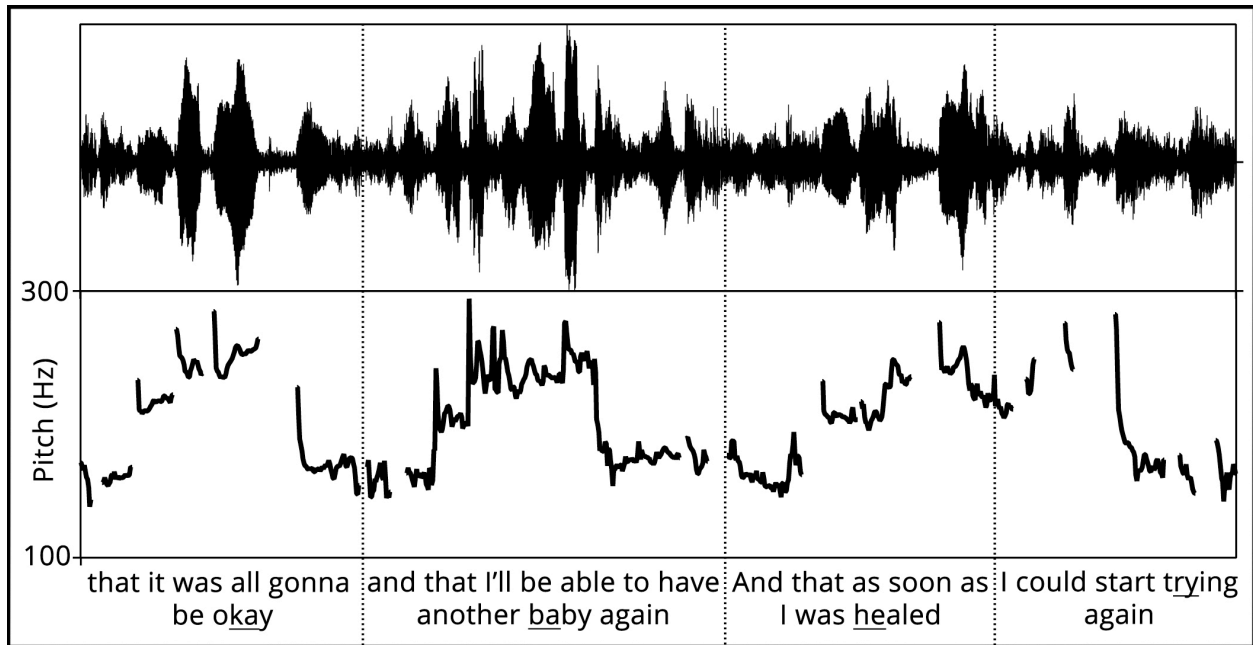


Figure 5.5: Sing-song intonation in indirect reported speech

Hillary laminates the entire report of the doctor’s speech with a singsong intonation. This utterance can be parsed into four melodic phrases or waves, where the stressed syllable of each phrase (marked in the transcript with underlining) coincides with the first drop in pitch after the highest peak for that particular phrase. As it was illustrated in the previous section with Carla’s excerpt 5.3, singsong intonation can be laminated onto the talk to “index (...) insincerity” (Haiman, 1997, p. 37) and portray a negative emotional stance towards the reported talk. While a genuine or heartfelt intonation reinforces the lexico-syntactic meaning of talk, an inappropriate one—in this case singsong intonation—undermines it, revealing the importance of suprasegmental phenomena in the analysis of discourse (Haiman, 1997). In excerpt 5.7, Hillary confirms the significance of the embedded intonation as a layer of embedded meaning. She explains in lines 6 through 8 how she is upset the doctor was dismissing the loss and her current state of distraught by shifting his attention to a possible future pregnancy. At the time of the narration, Hillary’s emotional stance on the doctor’s talk is aggravated because she had not been able to conceive in the 10 months since the miscarriage occurred. This highlights how the

psychological aspect of the trauma can take much longer to heal than the physical one, and how failure to acknowledge this crucial component on the part of medical personnel can result in patient dissatisfaction with the care received.

In this case, Hillary's dissatisfaction arises from the medical aspect of the care received. During the interview, she gives a detailed account of how long she waited during her visit at the emergency room, how poorly she was treated when she was bleeding and passing clots, and how little information she received throughout the entire process. Although perception of waiting time in ER visits is not considered a predictor of dissatisfaction, perception of information delivery and staff attention and responsiveness are predictors of overall patient's satisfaction (Thompson, Yarnold, Williams, & Adams, 1996). To exacerbate the situation, as she reports in excerpt 5.7, the lack of the doctor's sympathy towards her present emotional state during their encounter made the entire episode even more traumatic. Her distress is reflected with the prefacing phrase "sat there next to me for like ten minutes or so. Telling me ..." (lines 1-3). The emphasized words *sat* and *ten* mark a pause in time within the larger narrative. Contrasting with other personnel who were not paying much attention to her during her stay at the ER, the doctor sat next to her, indicating more focused attention on her as a patient. She highlights he was there for ten minutes, which is actually considered below the average time for doctor-patient interaction in a hospital setting (Keeler, Solomon, Beck, Mendelhall, & Kane, 1982). However, the modifier *like* preceding *ten minutes* coupled with the laminating verb *Telling me* indicates she perceived the interaction as a long one. By introducing the doctor's talk with a verb in the progressive aspect (i.e., "-ing") as opposed to the simple past (i.e., "He told me") she marks this idea of continuity in time during her interaction with the doctor, which is reinforced by the singsong intonation embedded onto the reported talk. This layering of positionality vis-à-vis the interaction with the doctor produced through the combination of the grammatical formulations and the lamination of pitch depict the encounter with the doctor as unnecessarily long and also dismissive of her emotional state at the time of the loss. Furthermore, she

confirms her affective stance towards this medical encounter by her explicit commentary in lines 6 through 8. Part of her dissatisfaction with this interaction arises from the lack of the doctor’s understanding. As she points out in line 8, that was not what she needed to hear in that situation; thus, her desire for being understood was not reciprocated, resulting in the lack of empathy she perceived from the doctor. This case contrasts with Karen’s example in excerpt 5.8, where the ER doctor that met with Karen was sympathetic, but seemed to not be knowledgeable on the subject of pregnancy loss. Karen’s dissatisfaction is apparent in excerpt 5.8 when analyzing her facial expressions coupled with the complex phrase used to introduce the reported discourse.

Excerpt 5.8: The ER Doctor was sweet BUT (Karen’s vlog - First loss)

1 Karen: An:d (.) the emergency room (.) doctor she was so sweet.

2 But she:  I feel like (0.2)

Reported speech
(negative stance)

3 .hh didn’t really know what she was tal:king about, (.)
 4 .hh she tried telling me that she thinks it’s a: blighted ovum,
 5 which means it’s just a sac and a baby never developed.
 6 (0.2) .hhh I’m like o:ka:y. (0.2) y’know
 7 and I went home and did some research.
 8 and if it’s a true blighted ovum, there won’t be a yolk sac.

After finding out she was bleeding, Karen called her midwife and was dissatisfied with the conversation they had over the phone (excerpt 5.5). She later went to the emergency room for further evaluation of her condition, which is described in excerpt 5.8. Karen begins narrating her interaction with the emergency room doctor by describing her as “she was so sweet.”, portraying her as someone gentle, with good intentions, and conveying a positive emotional stance towards the doctor. Nevertheless, at the beginning of line 2, she marks an oppositional stance to this positive description by placing *But* before her next utterance. She puts the doctor’s character on stage precisely so she can take the oppositional stance towards her and what she

said. This opposition-stance-to-be is interrupted and mitigated with “I feel like” to what otherwise would have been “But she: didn’t really know what she was tal:king about”. Her facial expression as she utters this phrase, depicted at the beginning of line 2, portrays disgust and emphasizes this oppositional stance. Disgust is mainly signaled by nose wrinkling and raised upper lip (Ekman, 2007), which in this case are simultaneously produced. Although Karen’s intention is to denote disbelief of the doctor’s speech, she is aware she is in no position to give an absolute statement regarding the doctor’s knowledge, or lack thereof, of ultrasound images. By adding the laminating verb phrase *I feel like*, she introduces the judgment as her perception of the doctor and not an irrefutable fact. So before introducing the talk, the audience already knows what her stance is vis-à-vis the doctor.

The doctor’s speech is introduced in line 4 with a quite complex lamination, “she tried telling me that she thinks”. There are three levels to this lamination phrase: her stance on the doctor’s speech, the introduction of speech per se, and the doctor’s stance on the ultrasound image. First, *she tried* is an epistemic marker that has a duplicitous sense embedded in it: on the one hand, the forceful action directed towards Karen that she rejected, and on the other hand her perception that the doctor was telling her something untruthful. Second, *telling me* actually introduces the reported speech that is to come. Unlike in cases where someone *tries to tell something to someone else* but fails to do so, here the doctor actually told her something, which is why *she tried* should be considered a lamination of stance addressing disbelief and not the mere introduction of indirect quotation. The third and last level, *she thinks*, is a representation of the doctor taking an epistemic stance of uncertainty as she did not reassure Karen – like her OB/Gyn did in line 4 in excerpt 5.6. This last laminating verb is also distancing the quotation from being a true statement, adding to the feeling of doubt. Looking at the lamination as a whole, it could be translated into a simplified “she told me something that wasn’t correct”. This interaction with the doctor took place in the emergency room after she was admitted for heavy bleeding, which resulted in a pregnancy loss. At that moment, the doctor told her she thought

the cause of the bleeding was a blighted ovum⁵, but Karen did not believe it and “did some research” (line 7) on the topic. She was convinced that, since she had already seen a yolk sac in a previous ultrasound, she could have not had a blighted ovum, hence imparting distrust to the doctor’s speech. Contrary to the previously analyzed examples where patient’s dissatisfaction arises during the consultation, in this case Karen’s epistemic stance towards the doctor’s discourse shifted after the visit. Her knowledge of the medical terminology changed after the interaction took place, which could be the reason why she first framed the conversation in a positive light—i.e., “the emergency room (.) doctor she was so sweet.”, in line 1—only to deconstruct the doctor’s character and discredit her knowledge state later in the reported speech.

Combining Methods for Reporting Interaction

The previous sections in this chapter examined how speakers reported doctors’ and medical personnel’s discourse through direct and indirect reported speech. All of the instances analyzed incorporated only one form of reported discourse within the same passage. Whether the reported speech was delivered in contiguous utterances within the same passage or not, speakers used either direct or indirect reported speech in the segment but not both of them. In contrast, this section focuses on passages where the women interviewed switch from indirect to direct reported speech, or vice versa, in order to understand what drives the preference for one form over the other.

In her analysis of immigrants’ border crossing narratives, De Fina (2003) explains direct reported speech is the predominant form found in her data . This prevalence could be attributed to “a style of telling where a great deal of the evaluation of events is conveyed, not directly commented upon, and the speaking characters have the task to transmit the fear, anxiety, or dangers of the border crossing or to convey the saliency of certain actions, without open evaluative comments” (2003, p. 105). Although in the women’s narratives collected for this

study direct reported speech is also the most common form with 68% of all occurrences, the true functional difference between both forms can only be understood when comparing both forms side by side within the same report. The next three excerpts present this opportunity since the women interviewed shift from indirect to direct form (and vice versa) as they report a single interaction.

In excerpt 5.9, Tara shifts from indirect to direct reported speech as she narrates the moments immediately following the delivery of her second stillborn baby at 22 weeks of gestation, which occurred three months before the interview took place.

Excerpt 5.9: I wasn't even able to grieve over her (Tara's interview)

1 Inter.: So di- did you at least get to hold her? or like wha-
 2 what did they do with her.
 3 Tara: They: they let her at the- (0.2) cause I was still giving birth, Indirect
 4 after they uhm took everything and they were done with me. reported
 5 They asked me if I wanted to hold the baby speech
 6 and of course was yeah: I did. And so I hold the baby but y'know
 7 tha- that is all we did we hold the baby and we got pictures,
 8 and then (0.2) they uhm (0.2) took the baby,
 9 and then right after they came in. (.) Direct
 10 They were like "okay well now we need to start talking reported
 11 about what you're gonna do with your daughter like (.) speech
 12 you know you now have to bury her and everything right,"
 13 .h so I wasn't even able to like grieve over her.

After Tara narrates the delivery of her stillborn baby, I ask her if she was able to hold her daughter (lines 1-2). In her response, Tara reports in line 5 through indirect discourse how she was asked if she wanted to hold the baby. This discourse contrasts with the next reported speech in lines 10 through 12, where she describes how she was told to start thinking about what to do with her daughter's remains. Aside from the obvious difference in the form used (i.e., indirect vs. direct reported speech), there is a substantial difference in the tone and polarity of emotional stances in each discourse. The reported speech in line 5 conveys a relatively neutral interaction, where she is given the opportunity to hold her daughter, take pictures with her, and make

memories. Contrary to previously studied excerpts in this chapter, where a neutral reported discourse is followed by a negative commentary regarding the interaction, the negativity of the commentary that follows this report is related more to the actual circumstances of the loss rather than the interaction with medical personnel. The phrases “that is all we did” (line 7) and “they uhm (0.2) took the baby,” (line 8) reflect Tara’s disappointment as she was only able to be with her daughter for a short time⁶, but it does not refer to the staff’s talk. The transition from this neutral stance to a clearly negative one occurs in line 9, as she prefaces the next reported speech. She states “right after they came in” and they inquired what she would do with her daughter’s remains, highlighting the temporality and immediacy of the event. As opposed to the sadness and disappointment associated with the short amount of time she spent with her daughter, in this instance she expresses frustration and anger related to how she had to rush through making a decision regarding the burial of the body. Although this was her second stillbirth, it was the first time she was confronted with burying her baby. When she delivered the previous stillborn, the hospital handled all the paperwork related to the demise since the baby had been born already dead. However, since this time her daughter had a heartbeat at birth, it was Tara’s responsibility to make the necessary arrangements with the mortuary. As Tara reports how she received the news, she places emphasis on the idea of having to “bury her” (line 12), which emphasizes the notion of death, the loss of another pregnancy, and her frustration towards the entire situation. Furthermore, she adds how this request posed an interruption to her grieving process, as she had to switch the focus of her attention from trying to understand the loss and what just happened, to processing paperwork and complying with the bureaucracy of the situation. By relaying the discourse in direct form, Tara brings into the present narrative the medical staff involved. The reconstruction of their past voices and actions help shape Tara’s own experience as a subject of poor bedside manners, and it also facilitates the understanding of her experience from an outside perspective. In this way, I can have a sense of Tara’s defeat for the loss and the overwhelmingness for having to immediately make arrangements with the

mortuary. It is clear then when comparing the emotional stances attached to each one of the reported discourses, indirect reported speech was used to represent a less impactful interaction, and direct reported speech characterized more vividly the interactions that greatly affected her emotionally.

Tara's dissatisfaction with the medical personnel involved during and after the delivery of her second stillbirth is clear in excerpt 5.9, particularly through the direct reported speech. She was not given much time to hold her daughter and bond with her, even though she had been born with a heartbeat and decomposition would have not started immediately. To aggravate the situation, soon after they took the baby away Tara had to make a decision regarding the resting place for her daughter. As mentioned previously, the inability of being able to bond or even hold the deceased baby is a recurrent theme in cases of late miscarriage or stillbirth. The next excerpt involves Vesna, who found herself in a similar situation. At 44 years old, she had her third pregnancy after two chemical pregnancies. Although she was suffering from severe depression, the pregnancy seemed normal. However, at around 21 weeks of gestation when she went into her doctor's office for a routine ultrasound, they were not able to find the baby's heartbeat. Because she was not having labor contractions, she chose to have a D&E to evacuate the fetus. After the procedure she was not allowed to see the remains, so the following day she called her doctor and asked her to see her son, which is illustrated in the following excerpt.

Excerpt 5.10: She's not whole (Vesna's interview)

1 Vesna: *And then uhm I- when I got home Tuesday night,
2 I called- (.) Tuesday afternoon I called Dr. Celeste again
3 and she- >and I said< I really need to see him. Direct reported speech
4 And she's like "no: I won't- you know
5 We don't advise that because (.) it's not whole. (0.2)
6 It's not what you think it is."*

7 ((searching for picture on her phone))
8 (2.0)
9 So:: uhm (2.0) ((sniffs)) and then what a-
10 She told me that (0.2) you know (.) that it was not 21 weeks.
11 It was- I probably lost the baby ((sniffs)) when I was uhm
12 (1.6) it w- it was probably (0.2) gone already 2 weeks.

Indirect
reported
speech

Dilation and evacuation (D&E) procedures for second trimester pregnancy losses are associated with fetal dismemberment (Hammond, 2015) since the surgeon extracts the fetus by parts and using forceps. After analyzing the interview, it seems as if Vesna was not aware of this possible outcome before the procedure took place. When she reports the doctor’s advice against seeing the baby, she claims the doctor told her, “It’s not what you think it is” (line 6), indicating this lack of knowledge. However, it is apparent that being able to see and hold her baby was very important to her (“I really need to see him”, line 3). For this reason, receiving the news the baby was not whole resulted in a traumatic moment within the larger painful experience. After the D&E, her doctor had given her the baby’s handprints and footprints, but this image was not sufficient for her to attain closure and come to terms with the loss. Up until moments before the D&E, she had still not accepted the idea of the baby actually being dead. She received the news of the demise through language and imagery; doctors explained to her what had occurred and also shared with her the ultrasound scans showing no cardiac activity. Nevertheless, without actual physical proof or contact with the baby, Vesna could not understand the reality of the pregnancy being lost. During the interview, she highlights how learning about the impossibility of seeing and holding her son caused her severe distress. The opposition provided in lines 3 and 5 between Vesna requesting “I really need to see him” and the doctor replying “no: (...) we don’t advice that” denotes Vesna’s frustration and dissatisfaction towards her doctor and also the situation as she had no control over it. By using different forms of reported speech in her narrative, she manifests the higher importance of this piece of news compared with the rest of the news the doctor delivered over the phone—reported in lines 10 through 12. Through direct

quotation she embodies her doctor as she informed her she would not be able to see her son because he was dismembered, placing particular emphasis on the phrase “it’s not whole” (line 5). Vesna portrays the character of the doctor as the author of the discourse, and brings into the present the figure that shaped her experience as a mother who could never see or hold her child.

In contrast, she reports through indirect quotation the rest of the conversation with the doctor, in lines 10 through 12, denoting this discourse as less important for her within the context of the emotional experience. Contrary to previous cases analyzed in this chapter, where repeated pauses and hesitations marked the interviewee’s emotional stance and sense-making process at the time of the telling, in this excerpt the pauses and restarts are a manifestation of how the present physical environment is affecting Vesna. As she narrates lines 1 through 6, she is searching through her phone for the pictures of the footprints she received from the doctor. Aside from the baby’s ashes the mortuary shipped in a plain brown box, which she had not opened yet, the pictures of her son’s handprints and footprints were the only physical evidence of his existence. In the interview, she acknowledges looking at those pictures on a regular basis as they bring her comfort. So this conflict in attention—between Vesna narrating the past when she was denied to see her son and her present of actively searching for the only memory of her son as a baby—further corroborate the psychological impact of the news she received regarding the status of her son’s body. After she finds the picture in the two-second pause in line 8, she narrates how the body had already begun decomposing in-uterus since it had probably been gone for two weeks before the procedure. The juxtaposition of talking about the decayed body and seeing the vivid pictures of the imprints brings about the emotions that surface through the repetitive pauses in her indirect reported speech in lines 10 through 12.

Although both excerpts presented in this section denote dissatisfaction with medical interactions, combination of direct and indirect reported speech not always serve this function in the narratives collected. The next excerpt also illustrates this transition in emotional polarity, from a more neutral report that did not have much of an emotional impact to reporting an

interaction that clearly changed the woman’s life. Rosy was a college student who at 38 weeks and 4 days pregnant (i.e., full-term pregnancy) started experiencing labor contractions but stop feeling the baby move. At that moment, she called the hospital for advice on whether to go to the Labor and Delivery Department or not. Excerpt 5.11 illustrates the conversation she had over the phone with the hospital staff.

Excerpt 5.11: That was the moment where everything changed in my life (Rosy’s interview)

1 Rosy: They told me that if the (0.2) baby hadn’t- (0.2)
 2 They asked me a number of questions,
 3 and then at some point they realized the baby hadn’t kicked_=
 4 They asked me what I’d eaten.= Indirect
 5 I told them.= reported speech
 6 They started to repeat the questions.=
 7 I started to get scared. .h They said if you:- Direct
 8 Inter.: This is over the phone? reported speech
 9 Rosy: Over the phone, “if you: (.) haven’t felt your baby mo:ve,
 10 you need to get in here right away.”
 11 (.) Like verbatim that’s what they said.
 12 And then that was the moment where everything changed in my life.

Rosy begins the indirect reported speech in line 1 by referencing a statement about the baby—possibly the person on the phone telling her how to proceed if they baby had not kicked for a certain amount of time—but she self interrupts before completing the utterance. Instead, after the restart at the end of line 1, she mentions how she was asked several questions before they realized the baby had not kicked. At this point, she attempts to give a more detailed account of the interaction but only elaborates on one question and the fact that the questions where repetitive. Up to this point, her report is rushed, with latched phrases and no natural pauses in between utterances, prefacing the climax of her story. Although the interaction appears to be worrisome, the way she speeds through it forecasts there is an even more dramatic interaction to come. In fact, her talk in line 7 (“I started to get scared”), implies this sense of escalating distress and marks the boundary between the worry for her baby and the beginning of the worst day of

her life. Moreover, this transition is linguistically marked as she switches from indirect to direct reported speech.

After Rosy relays—through direct quotation in lines 9 and 10—the instructions she received over the phone, she confirms “that was the moment where everything changed in [her] life” (line 12). The stress placed on the pronoun *that* reinforces the great impact of hearing she needed to head to the hospital immediately if the baby had not moved. Contrary to Tara’s and Vesna’s experiences in excerpts 5.9 and 5.10 respectively, Rosy’s shift in emotional stance between indirect and direct reported speech was not associated with her rapport with medical personnel. There is no indication in her talk that she was either satisfied or dissatisfied with the interaction. When comparing what non-linguistic features distinguish her use of indirect versus direct reported speech, it is clear that the psychological impact of the interactions had very different weight on her. As she first consulted with medical staff over the phone about the status of her labor, given her contractions and the lack of baby kicks, she probably did not imagine there was something wrong with the baby. It was when they started to repeat the questions that she began to feel scared. However, the cause-effect relationship between the lack of baby movement and her having to immediately go to the hospital is what triggered a higher degree of fear. By employing the direct form of reported speech in this instance, she relives the moment of the conversation at the time of the telling, embodying the different actors involved. This vivid characterization contrasts with the summary of the conversation at the beginning of excerpt 5.11, highlighting the experiential significance of one over the other. She confirms the reenactment quality of the direct quotation in lines 9 and 10, marking it as a relived experience within her narrative, as she explains she repeated the phrase almost verbatim (line 11). Rosy suffered from severe depression for several months after her loss, and she probably would have been diagnosed with PTSD as many other cases of pregnancy losses. It is common for PTSD patients to present a memory bias associated with the traumatic event, which entails recalling the trauma more vividly than other non-traumatic experiences (Paunovic, Lundh, & Öst, 2002;

Zeitlin & McNally, 1991). This bias occurs as a consequence of the recurrent and involuntary distressing memories, nightmares, or flashbacks of the traumatic event that characterize PTSD (APA, 2013; Zeitlin & McNally, 1991). As Rosy recalls her story, over twenty years after, some of the distressing memories that tormented her immediately after the loss come back to life in the form of direct reported speech, invoking the same intense emotions in the present as they did in the past.

Conclusion

This chapter examined instances of direct and indirect reported speech of medical interaction in order to understand how these two forms are used in combination with other semiotic resources to display dissatisfaction with medical personnel. The vast majority of instances of reported speech did not have any emotional stances embedded onto the discourse. Instead, most women presented quoted discourse with no layers of emotional stance (i.e., 69% of indirect and 61% of direct reported speech instances were considered neutral) and added a subsequent commentary about the reported talk, thus marking the stance as their own. This clear distinction between the author of the reported talk and the author of the commentary afforded the women the possibility to openly assess how the reported discourse had affected them from a physical and mostly psychological perspective. Nevertheless, the remaining 31% of indirect reported speech and 39% of direct reported speech did include the speakers' affective stance on the discourse or the character being reported. The animators—i.e., the women who produced the narratives—had several resources available to them in order to add layers of commentary onto their speech. As it was illustrated throughout this chapter, facial expressions and prosody were the two most salient semiotic resources incorporated onto the reported speech, aside from the verb *dicendi* that prefaced the reported discourse. The speakers' ability to embed layers of prosody or facial expressions to either direct or indirect discourse revealed the syntactic structure of the discourse does not restrain the speaker's capacity to represent their

interpretation of the original discourse. Nevertheless, the boundaries between animator and author of the speech become unclear when more layers are embedded onto the discourse. This is particularly apparent when no cues of the animators' emotional stance are given in verbal form. Such was the case of Karen in excerpt 5.5, where she reported her interaction with her midwife. The language Karen used, if isolated from all other non-verbal forms, conveyed a neutral stance that could only be interpreted as negative when examining also her prosody, her facial expressions, and the entire context of the interaction. However, because of this juxtaposition between the verbal and non-verbal discourse, the recipient still has to determine whether the embedded stances belong to the author or the animator. To overcome this ambiguity, most speakers include a commentary that follows the reported discourse, where they can clearly express their affective stance towards the interaction reported.

Through the evaluation of the reported interaction integrated in the commentary that followed the reported speech, women were able to make evident their dissatisfaction with the medical personnel involved. In most cases, this dissatisfaction is attributed to lack of sympathy or understanding from the part of doctors, midwives, or nurses. Women often feel dismissed or misunderstood regarding the significant impact the pregnancy loss had in their lives, and through a rich layering of stance and positionality they are able to bring into the telling the intersubjective relationship with those involved in the experience. The lack of empathy and lack of sympathy many women perceived and manifested during the interviews is attributed mainly to a disconnection between patients' need and medical personnel's understanding and response to those needs. The loss of a pregnancy involves the loss of hopes and the disruption of a planned future, creating a void they can only overcome through acceptance and understanding. When women seek answers for the demise and the extreme emotional pain they experience, they yearn others' understanding to validate their affective stance. Providing that understanding in this context not only can result in an empathetic relationship, but it can also positively trigger the grieving and emotional healing process. "It is only through the connecting of consciousness

and body into a natural unity that can be empirically intuited that such a thing as mutual understanding between the animal natures that belong to one world is possible” (Husserl, 2012, p. 105). Consequently, medical personnel’s lack of attunement with the women’s experience results in a lack of an empathetic relationship that could carry devastating psychological consequences as the women feel misunderstood, leading even to severe depression.

The lack of understanding and disconnection with medical personnel is particularly evident in cases of early pregnancy loss, given the high rate of incidence among women of all ages (Tulandi & Al-Fozan, 2012). A factor that could be correlated with dissatisfaction, given the analyzed dataset, is the setting of the medical encounter. Every woman in the data that visited the emergency room had at least one problematic interaction, and in most cases they attributed this negative experience to lack of time or sympathy on the part of the staff. Even in interactions where there was perceived sympathy (as in Karen’s visit to the ER illustrated in excerpt 5.8), the lack of time spent properly informing the patient of the situation resulted in misunderstanding the diagnosis and dissatisfaction with the overall encounter. Although medical staff often report not being appropriately prepared to tend to the psychological aspect of a pregnancy loss (Prettyman & Cordle, 1992), several cases in the data revealed more time spent educating the patient on her situation, possible outcomes, and viable methods for management could narrow the gap between patients’ need and provided care. This difference in epistemic stance between providers and patients was illustrated in Jordan’s excerpt 5.4, where the nurse did not fully explain why her imminent miscarriage was not considered a medical emergency. Through a combination of prosody, facial expression, and speech, patients were able to report the significant interactions that shaped their experiences and their dissatisfaction towards the personnel involved.

Finally, the last section of this chapter revealed how different degrees of dissatisfaction and psychological impact of the reported utterances can be denoted through a shift in reported speech form. When both methods of reporting speech are combined within the same passage,

direct quotation is used to report more salient and critical interactions. On the other hand, women report indirectly those interactions that are secondary or subordinate to the main traumatic event. In this way, as they narrate their stories and make sense of their experiences, women bring into the present the characters and discourses that impacted them the most. These interactions do not necessarily represent instances of dissatisfaction, but they do portray the most traumatic exchanges they had with medical personnel—as in excerpt 5.11 when Rosy admits the moment reported changed her life. In most of the examples analyzed, the outcome of the pregnancies could not have been reversed. Nevertheless, most of these instances of negative reported discourse could have been avoided or significantly improved with time and compassion, educating patients and sympathizing with their losses and their grief.

Notes to Chapter Five

1. As it was previously discussed in the data section of this chapter, the interviews included more negative reports of medical interactions than the YouTube vlogs; however, since both datasets had similar uses of direct and indirect reported speech, the datasets were combined for this chapter's analysis.
2. The diaphragm is a reusable female contraceptive device; it is shaped as a dome and before coitus it has to be filled with a spermicide gel and inserted vaginally to cover the cervix (Barbieri, 2015). Conversely the Nuvaring is a hormonal birth control plastic ring that is inserted vaginally once every menstrual cycle, and it should not be used in conjunction with a diaphragm (Mayo Clinic Staff, 2015).
3. An ectopic pregnancy occurs when the embryo is implanted at a place other than the uterine cavity, the most common site being the fallopian tubes (Tulandi, 2015c). It's most common clinical manifestation is vaginal bleeding with or without abdominal pain (Tulandi, 2015a). Due to the risk of tubal rupture (or the rupture of other structures where the blastocyst implants) that can result in life-threatening hemorrhage, an ectopic pregnancy is considered a gynecologic emergency (Tulandi, 2015a, 2015b).
4. The yolk sac becomes visible inside the gestational sac at approximately 5 weeks of gestation via transvaginal ultrasound. Because its "diameter correlates poorly with gestational age (...) it is not used for gestational dating" (MacKenzie et al., 2014). Instead, the crown-rump length of the embryo is used to estimate gestational age in days, which is accurate within three days during the first trimester (Goldstein & Wolfson, 1994).
5. A blighted ovum or anembryonic pregnancy is "a pregnancy in which no embryo is seen" (Tulandi & Al-Fozan, 2012). Although a gestational sac and even a yolk sac could be detected with a transvaginal ultrasound, this type of pregnancy is not viable (Doubilet et al., 2013).
6. Other women in the data who delivered stillborn babies also expressed this discontent in their narratives. They explained that according to medical personnel, a lifeless baby begins

decomposing quite fast if not properly maintained; in fact, one of the women mentioned how she received her daughter in a plastic bag to delay the rate of decomposition. Nevertheless, from the narratives collected it can be extracted that when the baby dies outside of the uterus—which was Tara’s case— a baby can remain with her parents for several hours without any visual or olfactory signs of decomposition.

Chapter Six

YOUTUBE'S PREGNANCY (LOSS) COMMUNITY OF EXPERIENCE

I really got into the pregnancy world on YouTube over the past year. I really just enjoy watching all the people that I'm subscribed to, and I really just decided I wanted to start my own vlog. I fell like I have a story, and I wanna tell it. I wanna be able to help other women who go through the same struggles as me. (...) I want them to be able to know that they're not alone; I'm not alone. (Missy)

Introduction

The production of narratives is central to humankind, and “when people are together they are inclined to talk about events, [which] often takes the form of personal narrative” (Ochs & Capps, 2001, p. 1). However, physical proximity is not a condition for the exchange of those stories as other settings can also bring people together, even from great distances. In the past two decades, the use of the Internet has increased exponentially, which resulted in the growth of social networks and digital communities where members upload written or video blogs (e.g., YouTube, Blogger, Tumblr, etc.). This new media has facilitated a new way for individuals to communicate, find others with similar interests, and share their experiences online. Once connections in an online community are established, in settings such as forums, blogs, chat, messaging, etc., tighter relationships frequently result from discussions with other participants in the same space (Nardi, Schiano, & Gumbrecht, 2004; Nardi, Schiano, Gumbrecht, & Swartz, 2004). This notion of a community whose members have no physical contact with each other has been previously discussed for other settings (Barak, Boniel-Nissim, & Suler, 2008; Blank & Adams-Blodnieks, 2007; Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004; Mo & Coulson, 2008). In fact, Wright, Ursano, Bartone, and Ingraham (1990) define a *disaster community* as one that includes everyone affected by a given tragedy, regardless of their geographical location

or degree of involvement. In the aftermath of a disaster, through the lived experience, “a shared sense of meaning [forms] the basis of community support” (Wright et al., 1990, p. 41). But communities based on shared experiences are not exclusively formed after catastrophes or disasters. These communities, particularly those found online, can revolve around different interests or topics; “there are users who publish videos relating to their everyday life, including being blind, deaf or coping with chronic debilitating diseases” (Fernandez-Luque, Elahi, & Grajales III, 2009, p. 292). Others share their pregnancy (loss) stories, creating an online community of experience that enables a dialogue between bloggers and viewers.

In their study of narratives of trauma and suffering, Coetzee and Rau (2009) indicate that “participants’ memories of suffering are composed and recounted in a way that makes their suffering more meaningful, worthwhile, and perhaps bearable, to themselves” (p. 3). These stories are not mere factual descriptions of previous events; they also incorporate a recollection of feelings and emotions from the past and the present. And since “[traumatic events] move to the center of one’s being, and in doing so, give victims the feeling that they have been set apart and made special” (Erikson, 1994, p. 231), they can create a community of experience. The term *community* here is not used in the traditional sense of people who generally know each other and who inhabit a limited geographical space where they interact with one another. Instead, the community being formed here is one with reference to these traumatic events, pain, and suffering. It is constituted by experiencing the world with common resources and created even among people who have no contact with each other outside this framework. Erikson (1994) examined this notion of a community being formed with reference to traumatic events and suffering. He referred to the 1972 Buffalo Creek Flood disaster, maintaining that “for some survivors, at least, this sense of difference can become a kind of calling, a status, where people are drawn to others similarly marked” (p. 231). It is easier to talk to those who have experienced the same problems; but most importantly, it is easier to relate to and receive comfort from them. Nowadays these communities of experience can be widely observed in social media where

members post written or video blogs telling their stories of surviving cancer or fighting multiple sclerosis among other issues (Chou, Hunt, Folkers, & Augustson, 2011; Fernandez-Luque et al., 2009). Nevertheless, communities in social media do not always revolve around misfortunes. Although the data for this project focuses on pregnancy loss narratives, most of these women belong to a YouTube community centered on pregnancy and starting or expanding a family.

In face-to-face storytelling, interlocutors can show affiliation immediately after a story is told through request for clarification or expansion on the topic, display of understanding of the content and/or the emotions involved, or even by sharing a second story (Sacks, 1995a). Conversely, YouTube vloggers can receive a response to their videos any time from a few minutes to even years later. Nonetheless, it is possible to have a delayed dialogic interaction with the viewers. Participants on the Internet frequently use some of the features that organize face-to-face interaction, in the sense that viewers can post their feedback about a particular video showing affiliation, displaying solidarity, initiating second stories, etc. This dialogic interaction starts with the vlogger as she creates her video, thus taking the first turn in the interaction, and continues in the form of comments posted for each video. As Nardi, Schiano, and Gumbrecht (2004) point out, “blogs create the audience, but the audience also creates the blog [space]” (p. 224). Through recipient-oriented narratives (Sacks, 1995a), specific audiences can be targeted and brought into the discourse. “Bloggers consider audience attention, feedback, and feelings as they write” (Nardi, Schiano, & Gumbrecht, 2004, p. 224), thus rendering the viewer of vlogs a crucial player in this interaction. Parallel to face-to-face interaction, in YouTube meaning is built by both the speaker—i.e., the vlogger— and the recipient—i.e., the viewers. To achieve an effective communication and maintain a live community that stays connected over time, vloggers have to consider their viewers. As C. Goodwin (2013) indicates, “actions are built by performing systematic operations on a public substrate [which] is central to the distinctive organization of human culture and society” (p. 8). Therefore, it is crucial for the creation of an online community that, similar to face-to-face interaction, when vloggers make a video they take

into account prior information and knowledge available to their audience. In the context of pregnancy vlogs, this exchange between vloggers and viewers creates a network and a community of experience where members share their own stories and support each other. However, the vlogs are public and available to anyone with access to YouTube. Nevertheless, those viewers who do not follow the vloggers' channels and frequently watch their videos do not have access to these public substrates and the information embedded in the discourse; thus, the public vlogs become part of a *private community* within the public sphere of YouTube.

In an aim to understand how this community of experience is built and maintained on YouTube, and how vloggers' videos trigger an interaction with the viewers, this chapter analyzes the multimodal discourse of 40 YouTube vlogs. The focus lies on two distinct aspects of the setting. The first section examines the recipient-designed discourse of these videos, paying particular attention to how vloggers bring the audience into the narratives. This can be accomplished by greeting the viewers and talking to them as if in a face-to-face interaction, and by making the vlogs relevant to them through the advice given. The second section examines YouTube as a semiotic ecology and its role in the interaction, concentrating on the manipulation of the physical space, how viewers invite audience participation in the form of written comments or questions, and how vloggers appreciate relationships they built with other vloggers as a result of this online community centered on family and pregnancy.

Data

The 40 vlogs collected from YouTube were the only data considered for this chapter. Since the purpose of this chapter is to understand how vloggers stimulate the creation of an online community through their videos, it is necessary first to understand the context of these vlogs. Among the collected videos, six of them reported a stillbirth, and the remaining 34 referred to a miscarriage or an early pregnancy loss (e.g., recurrent miscarriage, missed miscarriage, blighted ovum, etc.). The average duration of the videos originally collected (i.e.,

not considering additional vlogs that formed part of the same narrative) ranged between 4.8 and 34.9 minutes ($M = 15.1$ min., $SD = 7.8$ min.). Those narratives that included several parts were on average much longer ($M = 36.2$ min., $SD = 11.3$ min.), but their individual segments were close to the average duration of the originally collected vlogs ($M = 10.5$ min., $SD = 5.5$ min.). In general, no explanations were found for segmenting the narratives into separate vlogs, although one vlogger did mention that the length of each vlog was limited by the memory capacity of her camera.

Based on the channels' titles and their descriptions—or based on the list of videos for those channels with no descriptions—, most of the videos examined belonged to channels that focused on pregnancy and family, as illustrated in table 6.1.

Topic	Frequency	
Family	16	28%
Pregnancy	15	26%
Beauty	7	12%
TTC	2	4%
Infertility	1	2%
Other	16	28%
Total	57	100%

Table 6.1. YouTube vlogs' topic frequency

Some channels stated their main objective was to share videos about more than one topic (e.g., beauty & family or family & cooking), but for the most part they centered on one particular topic. The “other” category encompasses topics with low frequencies that were not related to pregnancy or family (e.g., cooking, cats, etc.) and topics that seemed random or were not clear from the description or from the list of uploaded videos.

The titles of the vlogs were very similar, regardless of the type of channel they belonged to. Given the keywords originally used to search for these vlogs, it was expected that all of the titles would include at least one of them (i.e., *miscarriage*, *stillbirth*, or *pregnancy loss*). Out of the forty videos analyzed, all but one included either *miscarriage* or *stillbirth/born* depending

on the type of loss the video referred to. The one video that did not mention either term in its title did include *miscarriage* in the description of the video. Although there were also other salient key terms incorporated in the titles, these were sporadic and none of them appeared more than one time in the dataset¹. However, *baby* was used in three different key phrases (i.e., *baby*, *lost our baby*, and *passing the baby*).

Finally, further examination of each vlogger's channel indicated that a few women prefaced their pregnancy loss vlogs with a video that updated their viewers on the negative status of their pregnancies. These prefacing-videos consisted of a short written narrative animated on a plain color background accompanied by soft music, uploaded anywhere from the same day to a week after the loss. In total, four of these text-based narratives were found. The title of these videos roughly anticipated the contents (e.g., "SAD UPDATE!!" or "Really, AGAIN?!?"), and the videos briefly announced and summarized the loss in approximately one minute. All of these short prefacing-videos were posted approximately seven to ten days before the full vlogs that were collected for this project. Although during the data collection process non-oral narratives were excluded from dataset, these four vlogs are taken into consideration in this chapter's analysis because they prefaced some of the narratives that had already been collected for this project and are relevant in the creation of a pregnancy (loss) community on YouTube.

Recipient-Designed Discourse

In YouTube, vloggers have to create a connection with their viewers in order to keep their interest in watching the vlogs on a regular basis. To accomplish this, most vloggers create materials relatable to viewers by incorporating features found in face-to-face interaction. On the one hand, they bring the viewers into their videos as participants of a dialogic interaction. Vloggers often greet the viewers and address them in the second person, as if they were communicating with each other face-to-face. They sometimes even select a specific subset of the

audience and deliver a message clearly tailor to that subgroup, such as asking those viewers to remember similar experiences in order to understand the vloggers' own experience. On the other hand, vloggers attempt to make their stories and videos relevant to the current and future audience by sharing advice with them. This first section illustrates how through recipient-oriented discourse, vloggers are able to relate with their audience and set-up the foundations for a community of experience on YouTube.

Addressing and Selecting the Viewers

A sense of dialogue and interaction between the vloggers and the viewers is always present in the YouTube dataset, as most of the vlogs analyzed begin with the vlogger greeting the viewers. Structurally, in face-to-face interaction a greeting normally entails the first part of an adjacency pair (Sacks, 1995a). Additionally, previous research on greetings supports the idea that this structure is essential in the construction of interpersonal relations (Firth, 1972; Goffman, 1971), acknowledging the presence of another person (Searle, 1969), and displaying “pleasure in the company of the other” (Goffman, 1971, p. 74). Contrary to the organization of face-to-face greetings, YouTube vloggers' greetings do not constitute the first pair part of an adjacency pair, since viewers do not have the opportunity to greet the vloggers as a response. Nevertheless, the action accomplished by greetings can be similar to face-to-face interaction as they “can distinguish between Us and Them, insiders and outsiders” (Duranti, 1997, p. 71) and can establish a degree of familiarity and closeness, as illustrated in excerpts 6.1 and 6.2.

Excerpt 6.1: Just wanna update you guys (Alysha's vlog)

- 1 Alysha: Hi YouTube? It's me Alysha, Greeting
- 2 (0.6) .hh uhm (0.8)
- 3 Sorry I always tend to do: videos from my car. h. (0.2)
- 4 .h it's just the best time for me,

5 It's when I: can uhh (1.8) get some- not alone time but
 6 you know what I mean,
 7 Wyatt's s(h)trapped in his seat so he can't (0.2) sit there
 8 and bug me through the whole video.
 9 (0.2) .hh uhm (0.6) Just wanna update you guys on how I'm doing,

Miscarriage
story preface

Excerpt 6.2: Welcome back to my channel (Allisen's vlog)

1 Allisen: Hey guys so welcome back to my channel? I hope you're all doing well
 2 and thank you so much for your support, .hh uhm
 3 and doing Vlogtober, on Twitter, .hh and on YouTube
 4 with your comments and all of that.
 5 So I am doing mainly vlogs,
 6 but some of the days I won't have vlogs and I'll have beauty videos,
 7 or .h videos that are more uhm tsk intimate? like this one?

Greeting

Viewers' interaction
appreciation

Producing a video for an online audience on YouTube implies visualizing these viewers and anticipating a possible interaction with these imagined Others. Although most vloggers record these videos alone, even if they are in the presence of other people—as is the case of Alysha in excerpt 6.1, who recorded her video in front of her son—the imagined Others are the target audience vloggers attempt to connect with through a recipient-oriented discourse. In the two excerpts above, the vloggers greet this envisioned audience at the beginning of their videos, acknowledging their presence and establishing a relationship with them; however, these two women perform these actions through different means. Alysha in excerpt 6.1 begins with a very concise greeting “Hi YouTube?” (line 1) before briefly introducing herself. This short introduction does not reflect the way people interact face-to-face, as acquaintances do not normally introduce themselves after greeting each other. Only if the interlocutors are not familiar with one another they might introduce themselves after a greeting, but in this case a greater introduction would be needed before launching a conversation on such an intimate topic. Instead, this structure (i.e., greeting + It's me + name) parallels an interaction that could take place over the phone or text message between two people who do not frequently call each other. By saying “It's me” in line 1 before stating her name, Alysha assumes the recipient knows


who *me* is, which is anyhow clarified as Alysha says her name. This assumed familiarity is confirmed in lines 2 through 8 as she apologizes for the setting in which she recorded the video—i.e., while driving her car with her son seated on the back seat, talking at times. She states, “I always tend to do: videos from my car.” in line 2, implying the viewers are familiar with the format of past videos. She explains how this setting, although not ideal, is practical since her son cannot interrupt her during the recording. As she constructs this explanation, she mentions “not alone time but you know what I mean,” in lines 4 and 5. Here she involves the viewers in the description of the setting, one more time presupposing the viewers are familiar with her vlogs and can therefore understand the benefits and drawbacks of filming in the car. Finally, to preface the story of her pregnancy loss, she says she wants to “update you guys” (line 9) on how she is doing, meaning her audience knows of the loss and is expecting news on her current status. Through her brief greeting coupled with her acknowledgement of a poor setting for the video and the preface of her story, Alysha selects her audience and indicates the video is addressed to those who follow her and understand all the embedded content in her discourse. In excerpt 6.2, Allisen also establishes a degree of familiarity and closeness but by producing a more complex greeting in her discourse. Her greeting incorporates the explicit notion of familiarity when she states “welcome back” (line 1), overtly presupposing viewers have seen her vlogs before and are not casual viewers who just happened to watch one of her videos. She further elaborates on this viewer/vlogger relationship and sense of familiarity when she hopes “you’re all doing well” (line 1), thanks them in line 2 for the support she received, and acknowledges an interaction with them through Vlogtober, Twitter, and the comments posted on YouTube.

Through Allisen’s complex greeting and Alysha’s elaboration on the video’s backdrop and story preface, both women are able to delineate and address a specific group of viewers. In doing so, they separate the “insiders and outsiders, friends and foes, valuable and non-valuable interactants” (Duranti, 1997, p. 71). But aside from bringing the audience closer through the use

of greetings in their introductions, vloggers also acknowledge them as an important part of the vlogging process. One way of accomplishing this is with the use of specific language that entails accountability. Excerpt 6.3 illustrates how Karen’s prefacing video and her oral narrative target a specific subset of the viewers, those who have been following her and know of her whereabouts, and she addresses them as part of an in-group.

Excerpt 6.3: Selecting the viewers through language (Karen’s vlog - First loss)

a. Prefacing video, title: SAD UPDATE!!



Hello Ladies!! As you can tell
by the title and the lack of a
pregnancy vlog, something
went terribly wrong....

b. Oral narrative

- 1 Karen: Hi you guys. So I’m finally getting around to go ahead
- 2 and do my miscarriage story video,

The use of language that indexes a preceding event in the title of the prefacing video and in the introduction of her oral narrative (e.g., “update” in excerpt 6.3.a and “finally getting around” in excerpt 6.3.b) denotes Karen has a target audience in mind when producing these videos: a selected group of people who follow her posts and who are aware of what the journey to motherhood entails. As when Alysha mentioned in excerpt 6.1 she wanted to “update you guys on how I’m doing” (line 7), in excerpt 6.3.a an *update* can only be understood if the recipient is informed about Karen’s pregnancy vlogs. Indeed, the first slide of the video confirms this presupposition, overtly making reference to the title as an understanding of the resolution of the story—“As you can tell by the title” in the first two lines. Thus, a viewer with no knowledge of her

history could only guess the video is about a tragic and/or unexpected event, but not specifically a miscarriage. Furthermore, when she recognizes the lack of a pregnancy video she had previously promised (“the lack of a pregnancy vlog”), she is also assuming the viewers are aware of this delay too. On the other hand, the language in excerpt 6.3.b (“finally getting around”, line 1) emphasizes her commitment to her viewers to post videos on a regular basis and the notion that based on the previous video (i.e., the one depicted in excerpt 6.3.a) viewers are waiting for a more elaborate narrative of her loss. C. Goodwin (2013) highlights this process of performing operations on a previous public substrate to build new action as central to human action. In this case, Karen uses the information shared previously in her videos as the starting point for what she tells in the current one.

Holding the viewer accountable for the information previously provided encourages audience loyalty and interaction with the vlogger. The audience then plays a crucial role in the process of making a video, as the vlogger has to take their knowledge and background into consideration to produce a recipient-oriented narrative. In fact, Nardi, Schiano, and Gumbrecht (2004) confirm that “consciousness of audience is central to the blogging experience” (p. 225), which is always present in this project’s data. But the information available to the viewer does not have to be necessarily provided by the vlogger; it can also be from personal experience. The next excerpt illustrates how Karen describes the emotional and physical pain she suffered during her miscarriage by bringing the viewers into the narrative as co-participants through their own lived experiences.

Excerpt 6.4: Co-experiencing the narrative with the viewers (Karen’s vlog - First loss)

1	Karen: .hh But anyways, so	Tuesday I started bleeding really heavily.	.hh uhh	Story preface
2	(0.6) I can’t even tell	you guys how painful that was like, (.)	not just emotionally but physically.	Launches narrative
3	.hh The cramps were h::orrible:, the bleeding was bad, it-			
4				

5 I compared it, the best way to compare it is if you had a baby before?
6 is (.) those first few days after having a baby?
7 .hh where you're bleeding really heavily,
8 you're passing some clots, (.)
9 uhm you're getting some cramping,
10 like (.) from your uterus contracting down,
11 .hhh an:d uhh (0.4) you just overall feel s:ore,
12 like it was h:ard to walk. .hh
13 That's how it was for about the first two or three days for me.

Selects subset of the audience to co-articulate the trauma

Relates own trauma to viewers' past experiences

After setting up the story in line 1, she launches the narrative of the physical and emotional pain with “I can’t even tell you guys”, in line 2. The address term *you guys* in this phrase denotes the beginning of Karen’s recipient-designed discourse. The telling is clearly directed at those who follow her on YouTube, addressing them with a certain degree of familiarity, which sets the stage for a more personal connection. Additionally, this line prefaces the story and forecasts that regardless of how she describes the episode, words do not suffice (“I can’t even tell you”, line 2). The viewers can then anticipate an event so traumatic that even the narrator, who lived through it herself, cannot describe. Nonetheless, she launches the description in line 4 with a very emphatic “h::orrible” to describe the cramps. After enumerating only two symptoms, she interrupts herself to reformulate the description in the form of a comparison with postpartum at the beginning of line 5. With the second person pronoun *you* in lines 5 through 11, Karen involves her audience and requests them to draw from their own personal experiences to understand the narrative. To successfully involve her audience in the co-construction of meaning, she first carefully selects a fraction of the viewers (“the best way to compare it is if you had a baby before” in line 5) that is capable of accessing this specific substrate: i.e., postpartum pain.

The experience of physical pain is unique to each individual; moreover, each pain episode can be recounted in innumerable ways, and even pain scholars do not agree on specific categories to accurately describe pain (see Dudgeon et al. (2005), Fernandez and J. Boyle (2002), Melzack (1975)). As Kleinman, Brodwin, Good, and DelVecchio Good (1992) remarks,

pain “occurs on that fundamental level of bodily experience which language encounters, attempts to express, and then fails to encompass” (p. 7). This inability to verbally conceptualize pain renders painful experiences, such as pregnancy loss, difficult to evaluate and report. Although pain affects one’s body, its exogenous quality renders pain an Other that interacts with the Self as an external entity (Throop, in press). In Karen’s narrative in excerpt 6.4, in an attempt to understand, conceptualize, and share with others her pain experience of miscarrying, she relates the cramps and pain she felt with postpartum pain. The emotional experience of miscarriage is very different from giving birth; nevertheless, the biological mechanisms involved in both are very similar as the uterus has to contract back to its normal size after both instances. By claiming the pain Karen felt can only be understood by mothers, she also makes those viewers accountable for drawing from their own expertise to co-construct with her this experience she cannot otherwise convey, thus guiding them through the process of building an empathetic alignment despite not being able to achieve a complete overlap of shared experiences. Karen displays a desire to be understood by making an effort to describe an occurrence that she cannot verbalize, and it is through the combination of this desire of being understood and the viewers’ willingness to understand her that an empathetic alignment could arise. Since she is already a mother, she utilizes this lived experience, shared with a selected group of viewers, and performs a transformative operation on it to create new action: the description of her physical pain after losing her pregnancy. Once the viewers have been selected, she proceeds to recall her own experience after birth but from the vantage point of the viewer, by asking them to recall those events as their own memories, “those first few days after having a baby?” in line 6. Here she performs two simultaneous operations on the substrate; on the one hand, she transforms her own personal experience after birth into the viewer’s recalled experience, and on the other she transforms the viewers’ postpartum experience into the pain she felt after miscarrying. This notion of shared physical pain is overtly recognized in the last line of the excerpt “That’s how it was for about the first two or three days for me.” At this point

she concludes the connection between her own loss with this slightly more generic postpartum feeling, and she reaffirms the importance of the audience-designed narrative in the description of her own loss. Furthermore, by using the present continuous tense as she describes these bodily feelings, she denotes, in the words of Capps and Ochs (1995), the pain “as an entity not contained in the past, but which continues to invade her life” (p. 110), which also brings a sense of presentness to the viewers’ co-construction of the pain.

In addition to the physical pain, there is another kind of pain she touches upon but never fully elaborates: the emotional pain. She is able to co-construct the physical experience with her audience because she calls upon mothers who lived through childbirth; however, employing the same technique for the emotional pain would not be possible unless she re-selects her target audience as those who have lost a pregnancy. Instead, by mentioning the emotional aspect and then elaborating a vivid physical description, she brings the viewer to a moment of pain within a happy life experience (i.e., having a baby) only to juxtapose it with the loss she experienced and the emotional pain she suffered, thus conveying implicitly the emptiness and grief felt and evoking understanding from her audience. Capps and Ochs (1995) point out, “we create meaning as we narrate our lives with others” (p. 175); so by calling upon the viewers’ knowledge and involving them in the experience, Karen is also able to make sense of the loss. This reason for sharing personal stories is common among vloggers in this community. In fact, when one of the other vloggers analyzed in this project, Jordan, was asked in a comment in response to her vlog why she shared such an intimate story publicly, she began her answer by saying “because it is therapeutic for me to get it all out there.”

Sharing Advice with the Viewers

Vloggers attempt to create a relationship with their viewers in order to increase the popularity of their videos and the number of subscribers they have, and in some cases to build and maintain an online community. Those who belong to the parenthood/family/pregnancy

community share personal stories and often reach out to their audience by offering advice based on their own experiences. The next three excerpts represent the most common instances of advice found in the data—i.e., suggestions given to the viewers for before, during, and after a loss. Women who have experienced a pregnancy loss know there are hundreds of thousands of women with access to YouTube in similar circumstances, yet as vloggers record their videos they are unaware of the temporality of others’ experiences. Some women watch pregnancy and family related vlogs before becoming pregnant; some seek answers while in the midst of a loss; and others attempt to grieve past losses by watching other women’s stories and understanding they are not suffering alone. Vloggers are aware of this diversity in their audience, which is also reflected in the diverse temporality of the advice given. Excerpt 6.5 illustrates how vloggers can connect with those who have not yet faced a pregnancy loss by advising them on how to be prepared ahead of time.

Excerpt 6.5: Before - Do your research (Monik’s vlog)

1 Monik: I’m saying this to say that (.) **do your research**
2 **if you’re pregnant,**
3 **uhh if you’re planning on becoming pregnant,**
4 **know that a miscarriage is possible,**
5 uhm a lot of women.
6 a lot of women go through miscarriages,
((52 sec. omitted))
19 **I wanna say this. (.) Do your research, (0.4) uhh (0.4)**
20 **Talk to your doctor, (0.2)**
21 **Make sure you ask a bunch of questions,**
22 **If you are going through a natural miscarriage or blighted ovum,**
23 **.hh uh know what your options are=**
24 My doctor did give me my options and I chose what I chose,
25 .hh I probably wouldn’t choose this again
26 (.) If- if this were to ever happened >God forbid<
27 .h I probably would not choose to do a natural miscarriage
28 because it was .hh (0.6) the physical pain (.) only s:-
29 make the emotional pain more swollen and bigger
30 (.) .h Because you have to deal with this: for months..

Target audience:
(future)
pregnant women

Advice:
unmitigated imperative

Re-selects
target audience

In lines 2 and 3 of excerpt 6.5, Monik selects a subset of the viewers that includes pregnant women and women who are planning on becoming pregnant. Her goal is to bring awareness to this topic so they understand the high incidence of pregnancy loss and miscarriage in particular. Although approximately 20% of recognized pregnancies are lost (Fretts, 2005; Regan & Rai, 2000; Ventura et al., 2012), most women are not aware of this statistic. The topic of miscarriage is still today considered taboo in American society. Recently, more celebrities have come forward telling their pregnancy loss stories; nevertheless, most of them agree on the stigma pregnancy loss carries. In fact, Mark Zuckerberg, co-founder of Facebook, posted on his Facebook page on July 31, 2015 regarding the three miscarriages he and his wife endured, “It’s a lonely experience. Most people don’t discuss miscarriages because you worry your problems will distance you or reflect upon you—as if you’re defective or did something to cause this. So you struggle on your own” (Zuckerberg, 2015). By addressing those who have not been affected by miscarriage, Monik brings them into a conversation centered on pregnancy loss that is also relevant to those who are experiencing or have already experienced a loss. A dialogue focused on the high incidence of pregnancy loss and the struggles associated with it sheds light on the physical and emotional challenges to overcome such loss and also helps destigmatize the topic. In lines 1 through 6, Monik focuses on those potential grieving mothers and urges them to seek out information on pregnancy loss in general, without giving them many more details aside from “a lot of women go through miscarriages” in line 6. Since unsolicited advice is not always welcomed, in order to relate with the viewers and validate the importance of researching on the topic of miscarriage ahead of time, she connects this advice with her own experience. In line 22, she shifts the focus of her recommendations to those who are in the midst of a loss, and she mentions the importance of understanding the different options for managing a miscarriage. She adds that, even though at the time she understood all of the options available, in hindsight she feels she made the wrong choice, which caused her great emotional trauma. Without overtly stating which the best solution is, Monik conveys which one was the wrong solution for her and

the reasons why, suggesting viewers should take this into consideration in the event of a loss. By presenting the advice first, she brings the audience on to the stage as the main actor in the interaction, responsible for receiving and acting upon her suggestions. She then shifts the focus to herself as a means of connecting the advice on a more personal level, which is emphasized by the language used.

Advice can take many different forms, each one pertaining to a different level of politeness. Particularly advice given in the form of direct directives or unmitigated imperatives constitutes a face-threatening act and lacks negative politeness. Direct directives are requests in which “its locutionary aspect (linguistic features of utterance) and its illocutionary aspect (social act performed intentionally by the speaker when he or she produces the utterance) coincide perfectly” (Bernicot & Legros, 1987, p. 347). Therefore, requests such as “Do your research” or “Talk to your doctor” (excerpt 6.5, lines 1 and 20 respectively) are regarded as face-threatening acts as they do not give the listener the opportunity to deny the request. As a speech act, directives have been extensively examined in relation to their social components and distribution (Bellinger & Gleason, 1982; DeCapua & Dunham, 1993; Ervin-Tripp, 1976; M. H. Goodwin, 1990; Hudson, 1990; Premo & Stiles, 1983). Ervin-Tripp (1976) first revealed that in English, imperatives such as “Open the door” are most frequently found in rank-marked relationships (e.g., an employer giving an order to an employee) or in familiar relationships (e.g., husband-wife). Furthermore, Premo and Stiles (1983) developed a ranking system to determine the familiarity of human interaction in which the mode advisement was scored as the most familiar. They define *advisement* as imperatives or utterances in the “second person with verb of permission, prohibition, or obligation” (p. 212) whose communicative intent is to attempt to guide behavior, suggest, or offer advice (Premo & Stiles, 1983). Although it could be argued that the directives found in the YouTube vlogs represent instances of rank-marking, where the vlogger is positioned at a higher epistemic status than the viewer and therefore can offer advice without considering it a negative face-threatening act, there is evidence to the

contrary. On the one hand, research on the social distribution of directives has revealed that in rank-marking relationships unmitigated imperatives are much less frequent than mitigated forms (Kendall, 2003; Thonus, 1999). Looking at excerpt 6.5, Monik only employs unmitigated imperatives (e.g., “do your research” in lines 1 and 19, “talk to your doctor” in line 20, and “make sure...” in line 21), which is similar to the format of the advice offered in the other two excerpts in this section. In excerpt 6.7, Brittany also produces only unmitigated imperatives. In excerpt 6.6, Allisen does begin her advice with a modal directive (“I would suggest going to the ER), but she immediately switches to unmitigated imperatives, which she only softens with a repetitive “So please please please” in line 11. The high frequency of this type of directives indicates the lack of request-mitigating devices does not pose a face-threat in these interactions, which is also often observed in relationships where a strong bond between the interactants allows for a more direct communication (Jones, 1992). On the other hand, other resources used in the videos posted (e.g., requesting, acknowledging, and appreciating viewers’ support) show the vloggers attempt to build a relationship of peers and community with the viewers and not present themselves as superiors. Moreover, most vloggers display this devotion to their viewers and the online community through the content of their vlogs, the linguistic features used (e.g., familiar address terms such as “you guys”), and even more overtly, by stating their goal is to be part of a community on YouTube. Therefore, the frequent use of unmitigated directives as advice to the viewers represents the vloggers’ attempt at creating a strong bond with them and with the YouTube pregnancy/family community in general.

Many vloggers acknowledge how helpful it was for them to watch videos of others overcome similar traumas when they were undergoing their pregnancy losses. Taking this into consideration, a large percentage of them offer advice directed at those who are experiencing a loss while watching these vlogs. Although Monik in excerpt 6.5 begins her advice by talking to those who are not pregnant yet, she concludes with recommendations for those who “are going through a natural miscarriage or blighted ovum” (line 21). Similarly, in excerpt 6.6 Allisen

addresses solely those who suspect they are experiencing a miscarriage by offering them advice on how to proceed under those circumstances.

Excerpt 6.6: During - I would suggest going to the ER (Allisen's vlog)

1 Allisen: I would (.) .h suggest going to the ER or _____ Advice mitigation
2 if you have a doctor that's open at the time? .hh (modal verb)
3 Uhm if that were to happen just go straight there. Unmitigated
4 Get your: blood work done, and find out you know if- imperative
5 what you're hormones are;,
6 .h so you know because not-
7 I- al- almost considered staying at home but not knowing is terrible.
8 .hh Just playing a guessing game and waiting.
9 And then you could- something- you could lose too much blood,
10 or something like that. Advice mitigation
11 So please please please. ("please")
12 .hh uhm you know if you are going through that and Unmitigated
13 >you think it's not that bad< imperative
14 go straight, don't even think about it j(h)u(h)st g(h)o there.
15 .hh Because you have a peace of mind (.)
16 .h knowing exactly what it is. Whether it's bad or good news.

Much like Monik's suggestions in excerpt 6.5, Allisen also invokes her personal experience in order to substantiate the advice she gives in two separate sections of the excerpt. In lines 1 through 5, she suggests viewers how to proceed if they find out they are bleeding while pregnant, and she even suggests medical tests that should be requested when visiting the emergency room or a doctor's office. As it was previously mentioned, Allisen begins this advice with a mitigated directive by incorporating a modal verb in her discourse ("I would suggest going to the ER", in line 1). She then selects a subset of the viewers who will receive this advice when she states, "if that were to happen" in line 3 before she offers her recommendations by means of unmitigated imperatives (e.g., "just go straight there" in line 3, "get your blood work done" in line 4, etc.). Contrasting with Monik's presentation of her own experience, Allisen introduces an alternative option—i.e., not going to the doctor after finding out one is bleeding—as she mentions why she did not choose this option (lines 6 through 10). This explanation

supports her first advice and also the second section of recommendations that starts in line 11. This second section replicates the format of the first advice section, in the sense that the unmitigated imperatives are preceded by a more polite form. The phrase “So please please please” in line 11 marks the consequentiality between her own experience and what is to follow—i.e., the second advice section. Furthermore, *please* at the beginning of an utterance—in this case reinforced by its repetition—indicates a directive is to follow (Ervin-Tripp, 1976), which is the actual advice in the form of direct directives. Although the directives in this second section are unmitigated imperatives if taken in isolation, they are softened as a whole by the conditional prefacing (“if you are going through that and you think it’s not that bad” in lines 12 and 13) and the presentation of the positive outcome of following her advice, “you have a peace of mind” in line 15. By connecting the both sections of directives with her own experience, Allisen attempts to bring the audience closer to her as a vlogger and as a member of this pregnancy/family community. Another way of achieving this connection in the context of pregnancy loss is by sharing the road to emotional recovery after the trauma.

Aside from providing advice for before and during a pregnancy loss, several vloggers in the data also offer support for after a miscarriage or stillbirth, when women are attempting to grieve and make sense of the experience. Excerpt 6.7 reflects how Brittany transforms her own experience into encouraging words for those who have to overcome the psychological burden of a miscarriage.

Excerpt 6.7: After - Don’t blame yourself (Brittany’s vlog)

- 1 Brittany: That’s the one- (.) one big advice I can tell you.
 - 2 Don’t do: if you find out something’s wrong.
 - 3 Don’t think it’s your fault.
 - 4 (0.2) Don’t- don’t sit there and blame yourself because
 - 5 I wasted s:0 many nights crying my eyes out blaming myself.
- Advice:
unmitigated
imperative

6 .hh uhm (0.2) So just don't. (0.2)
 7 Don't do that to yourself.
 8 You're just gonna make yourself hurt more. (0.2)
 9 So just you know stay calm and just know- just- (0.6)
 10 you know (0.2) you- there's nothing you did wrong.

Advice:
unmitigated
imperative

As in the previous two excerpts in this subsection, in excerpt 6.7 Brittany also connects her own experience and attempt at sense-making with the advice she gives to the viewers. In this case, through direct directives she urges the women watching her to not blame themselves for their losses like she did. Monik in excerpt 6.5 also advises against what she did. She mentions she would not have a natural miscarriage again, but she never takes a stance for or against any of the other possible pregnancy loss management options, thus leaving it up to the audience to decide for themselves what is best. Brittany's advice is different because aside from guiding them, she encourages them and offers support so they can have a better grieving experience than she did. Peer support is highly regarded as a resource for overcoming trauma and making sense of a loss (Côté-Arsenault & Mason Freije, 2004; Ussher et al., 2006), and many women resort to YouTube as a place to exchange their traumatic experiences with other peers in order to feel validated and begin to cope with a loss. Although Brittany is not able to interact with the viewers face-to-face to encourage them, she does—like the other women in the previous two excerpts—attempt to make a connection with the viewers as a peer and someone friendly who they can trust. She presents her own struggles with overcoming her stillbirth in line 5 (“I wasted so many nights crying my eyes out blaming myself”) as an experience others should avoid and a lesson for others to learn from. By placing the agency of the actor doing the hurting on the viewers in lines 7 and 8 (“Don't *do that to yourself*” and “You're just gonna *make yourself* hurt more” respectively) she empowers the women to take action in their own grieving processes. In her discourse, she defines the viewers as being patients and agents simultaneously, where the patient is being hurt and the agent is doing the hurting. Thus, through the understanding of the self as the interaction of these two entities, if the viewers choose to blame themselves they are

also hurting themselves, as opposed to being the recipients of an emotional pain from an unknown agent. Consequently, this distinction between agent and patient allows the women who are also struggling with guilt and blame² to understand how to overcome the psychological sequelae of the loss. By accepting they were not at fault in the loss of their babies, the women who take into consideration Brittany's advice can then relieve themselves from that pain and begin to heal emotionally from the trauma.

In these three examples of advice through unmitigated imperatives, the vloggers address the viewers with a high degree of familiarity. They talk in the videos with the understanding that the bond between them and the viewers has already been created and as if the community—even though present in an open public space such as YouTube—is a tight close circle of peers. Therefore, the language used reinforces the connections these women attempt to create in their videos through content and through actively tending to the physical space in YouTube, which is examined in the next section of this chapter.

YouTube as a Semiotic Ecology

Aside from incorporating features from face-to-face interaction into their videos, as discussed in the previous section, vloggers also need to be sensitive to YouTube's unique environment. When creating videos, vloggers take into consideration oral discourse, previous information shared with the viewers, and also the technology and the environment where the edited video will be displayed. As illustrated in figure 6.1, YouTube offers users the ability to embed videos within the videos, include descriptions and external links, and receive comments and respond to them, among other features.



Figure 6.1 The YouTube layout (as of November 2015)

YouTube is a rich and unique setting, and those who successfully create a connection with an audience have to understand how to manipulate this environment in order to maximize traffic and interaction with viewers. Having a strong relationship with an audience is particularly important for those channels that center on pregnancy or family and aim to build a community. This section analyzes the role this setting plays in the interaction between vloggers and viewers. On the one hand, vloggers can manipulate the physical space of their videos and the YouTube layout to create an interactive experience for their audience. On the other hand, vloggers invite viewers to become involved in this dialogue and formation of an online community; furthermore, they acknowledge and appreciate audience participation to ensure the continuation of a dialogic interaction between the members of this semiotic ecology.

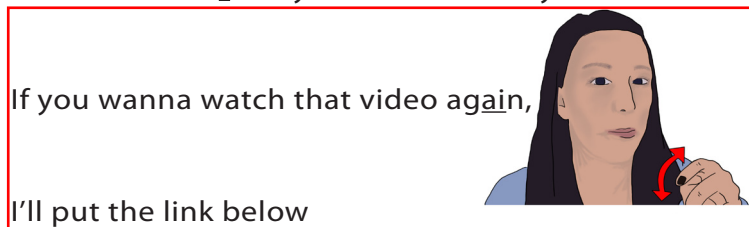
Spatial Awareness and Manipulation of the YouTube Page

When attempting to create a relationship with another person, it is important to foster the communication channel to and from that person. The last section of this chapter explored how vloggers give advice to their viewers and recognize them as fundamental actors in the interaction. In contrast, this section focuses on how vloggers hold viewers accountable for following them and watching their vlogs on a regular basis. The most common way for vloggers to demonstrate this expectation of viewers' loyalty is by recalling information previously available to the viewers, making them accountable for having acquired such information, and performing transformative operations on previous videos. This expectation of audience loyalty is a common denominator in all of the videos in the data. Additionally, because YouTube is an open setting where new viewers can access videos every day, and people subscribe to channels on an ongoing basis, vloggers have to make that information posted in past videos available also to newcomers. The next excerpt illustrates how Karen manifests this mutual understanding between her and her subscribers, who she presupposes diligently watch her videos.

Excerpt 6.8: I'll put the link below (Karen, second loss)

1 Karen: .hh So (0.6) I was told you know (0.3)
2 "You're gonna miscarry again" so,
3 (.) that was on Friday and I was still only having spotting
4 .hh which was totally different that my last mis:carriage like (0.2)

5 If you wanna watch that video again,
6 I'll put the link below
7 but (1.2) .hh so h. uhm I was really upset you know
8 I took it- I took this one a lot harder I think (.) which:
9 (0.2) I don't know why.



Previous
public substrate
(Goodwin, 2013)

As Karen describes how the second pregnancy loss progressed, in line 3 she comments on the state of her bleeding, which she compares with her previous loss in line 4. This


evaluation, however, is significant only if the relevant substrate she indexes is actually available to the viewers, as she states these two events were different but not exactly how. For those viewers who had watched the previous video and recalled the narrative, evoking there was a difference in the bleeding might have been enough information to remind them of the last time she bled heavy before the doctors confirmed the miscarriage. By incorporating in her narrative knowledge the viewers should have already acquired, she demonstrates she expects the audience to be loyal and to watch her weekly vlogs. This is emphasized in the following phrase as she makes a parenthesis from the narrative and directly addresses the viewers in line 5 with “If you wanna watch that video again.” The use of “again” in this utterance clearly expresses her expectations that viewers have already watched her previous video before watching this one. Moreover, she reverts back to the previous video as an object produced for an audience as opposed to a narrative of her experience. In this case, this object serves also as a new version of memory as she can now recall the original video instead of making a reference to its contents.

In addition to the verbal incorporation of the video, she physically incorporates the previous video in lines 5 and 6 as she says “I’ll put the link below” while pointing to the location where the hyperlink appears once the vlog is uploaded on the YouTube page. As illustrated in figure 6.1, YouTube allows for hyperlinks to other websites or even other YouTube videos to be included in the description section that appears below each video. Through this indexical incorporation of the link and the video, she conceptualizes herself in a particular space within the larger YouTube ecology, and most importantly she demonstrates her ability to understand the viewers’ perspective. As Frobenius (2013) remarks when analyzing pointing in vlogs, “while the referent is invisible to her, she actually directs her index finger toward the floor” (p. 15) in order to create a deictic gesture that viewers can extrapolate in order to find the hyperlink mentioned. Then this is not just a matter of telling her story to the camera, but doing so with the overt intention of making it relevant only in the YouTube space. Consequently, her narrative is

embedded within that particular template and technology, and it can only be understood in such a context.

Vloggers have different methods for incorporating previous videos in their current ones. Excerpt 6.8 illustrates how this was accomplished mostly around 2011. Since then, the YouTube interface has evolved and uploaded videos have become more interactive. Nowadays, it is possible to embed hyperlinks directly onto the videos, thus creating a separate semiotic ecology within YouTube where the previously available public substrates are embedded directly onto the new videos. This new way of embedding information is depicted in excerpt 6.9, where Allyshia recalls a video where she describes her threatened miscarriage experience at the emergency room.

Excerpt 6.9: I will link it right here (Allyshia's vlog)

1 Allyshia: >I mean< I guess it started around 6 weeks 3 days pregnant_
2 when we went to the ER:
3 and had that whole thing (0.8) at the hospital
4 where they told us that we were probably miscarrying.
5 .hh And if you guys want to watch that video,
6 I will link it right here? 

Verbally indexes previous public substrate

Physically indexes previous public substrate

As Allyshia begins the narrative of her miscarriage, she indexes information she had already made available to the viewers in a previous video, “had that whole thing (0.8) at the hospital” (line 3). This indexing of previously available information, although syntactically different from Karen’s reference to her previous vlog, also presupposes viewers have already watched the video in question. In this case, the demonstrative pronoun *that*, in “that whole thing”, indexes an event only available to those who have watched the vlog Allyshia is referring to, and it cannot be extrapolated from the context of the current vlog. Viewers have access to knowing she went to the emergency room where she was told she was “probably miscarrying”

(line 4) but no further details. Unlike in Karen’s vlog illustrated in excerpt 6.8, Allyshia’s assumption of the audience’s loyalty is not explicit. Karen invites the viewers to “watch that video again” (excerpt 6.8, line 5), whereas Allyshia simply mentions the video is available and embedded onto the current video, which she physically indexes by pointing up to where the video can be accessed, illustrated in figure 6.2.

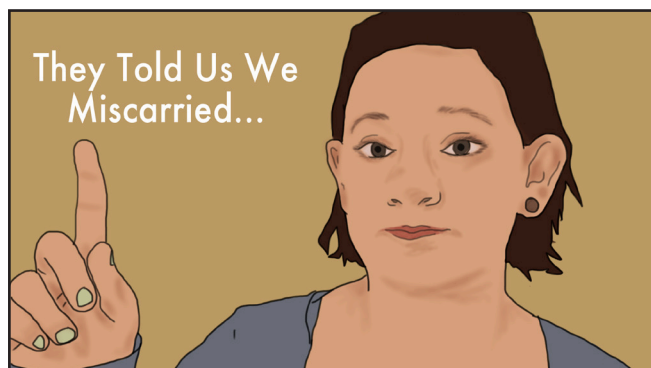


Figure 6.2. Screenshot of Allyshia pointing at the embedded video

Allyshia’s deictic gesture demonstrates her understanding of the viewers’ perspective, as it was the case with Karen. However, by embedding the previous video onto the current one, she also transforms the environment and turns her vlog into an interactive semiotic ecology. As it can be seen in figure 6.2, during the editing process Allyshia added text onto the video as a new semiotic layer, which is now physically embedded onto the narrative. From the viewers’ perspective, she is pointing at a specific object or referent that is still available even if the video were to be removed from the YouTube layout. In this setting, the “gesture that 'points at' such a [referent] simply inserts it, and its relevant features, into the current universe of discourse” (Haviland, 2000, p. 19). However, this referent is only existent from the viewers’ perspective. When Allyshia recorded the video, she was pointing at the air, with the understanding the empty space in that area is a placeholder that will become significant in the editing process. In a similar manner, when Karen recorded her video illustrated in excerpt 6.8 she pointed towards the floor. However, when viewers watch Karen’s video, they have to project the referent by physically

extrapolating the end of her pointing finger to the object mentioned—i.e., a hyperlink in the description section. In both cases, the editing process is also an embedding process where the vloggers physically embed semiotic layers onto the space—in the video or on the description section. Thus, the discourse production process is extended until the editing is completed and the vlogs are posted in the setting they were created for. Consequently, YouTube becomes the only proper location to watch these videos. If taken out of context (i.e., downloaded and watched elsewhere, or distributed before being uploaded onto YouTube), these deictic gestures lack the referent and thus are not consequential in the discourse. It seems as though Allyshia’s referent is still embedded onto the video even outside the YouTube ecology (as depicted in figure 6.2); however, the information indexed in lines 3 through 6 is only available when viewers click on the active link. Therefore, when the video is isolated from the YouTube technology, the referent Allyshia points at becomes an empty placeholder with no value.

Through this complex lamination of knowledge and the incorporation of transformations of publicly available substrates, the vloggers are able to subtly compel the viewers to watch their vlogs regularly so as to not miss any important details of their stories. This creates the routine of viewers following and subscribing to the vloggers, which in turn develops into a relationship between the participants. To further solidify this relationship, vloggers also encourage viewers to participate in the conversation created, by means of comments, questions, or general feedback on the videos uploaded.

Inviting Audience Participation

As illustrated in previous sections of this chapter, vloggers aim to create a relationship with the viewers by producing recipient-oriented discourses and by showing viewers’ loyalty is expected and also appreciated. These resources aid in the formation and strengthening of the community and also encourage the dialogue. To further improve the communication with the audience, vloggers frequently acknowledge and appreciate the feedback received. These

questions or comments viewers post, or even the sharing of their own stories to show support, can be found in the comments' section on YouTube, below the videos (as shown in figure 6.1). As a way to invite audience participation in this online dialogue, it is common for vloggers to mention, encourage, and request feedback from viewers at the end of their videos as part of their closing remarks, as illustrated in excerpt 6.10.

Excerpt 6.10: Leave your questions below (Monik's vlog)

1 Monik: .hhh Anyway this video is already uhm long enough,
2 If you have any questions you can leave the m down below, m
3 or you can message me on my YouTube: account, ((points down))
4 .hh An:d I'll talk to you guys ↑later.
5 .hh Bye guys.

Invites audience participation

The format and content of Monik's goodbye message are common on many videos on YouTube. Particularly videos from channels not focused on family or pregnancy follow this impersonal or detached, almost commercialized, format for saying goodbye to their viewers at the end of their videos. Monik's channel claims to focus on hair, make-up, fashion, and lifestyle. Although this particular video touches on a more personal subject, her relationship with the viewers is not as familiar as the relationship formed by those who belong to family or parenthood communities. Most of Monik's videos are tutorials on make-up and fashion. Therefore, although she attempts to create a relationship with her viewers in order to gain visibility and subscribers, thus increasing the monetization of her videos, she does not intend to create a personal relationship with those viewers, as she rarely posts vlogs or videos of personal matters. Consequently, her invitation for audience participation is very direct and short. She gives the audience two options for contacting her: leaving questions below the video (line 2) or sending her a message on YouTube (line 3). Furthermore, he does not request any type of emotional support or shows appreciation for previous comments or feedback received. Conversely, excerpt 6.11 illustrates how Amanda, whose channel focuses on her and her

husband's journey as parents, depicts a much more affectionate way for encouraging audience participation.

Excerpt 6.11: I'll answer anything you need me to answer (Amanda's vlog)

1 Amanda: If you have any question:s?
2 or: (.) you know need me to elaborate, or whatever.
3 .hh I'm happy to answer them.
4 I'm really not that shy about stuff
5 uhm I'm pretty honest.
6 .hh so (0.6) tsk I'll answer anything you need m(h)e to answer.
7 .h (0.2) but yeah hh. tsk that's our story.

Invites audience participation

Vlogger's positionality vis-à-vis viewers' questions

Amanda's invitation for audience participation in excerpt 6.11 is composed of two elements: the actual invitation and her positionality vis-à-vis the viewers' questions. Comparing Amanda's discourse with Monik's, there is a clear difference in the affect displayed in both invitations. Monik's invitation is direct and short, whereas Amanda's invitation is not as direct. They both begin with the exact same antecedent: "if you have any questions" in line 2 of excerpt 6.10 and line 1 of excerpt 6.11. However, the intonations are notably different. Monik utters this phrase as part of a full conditional sentence, telling viewers what exactly they have to do (i.e., the consequent clause) if they have any questions (i.e., the antecedent clause). The slight rising intonation at the end of line 2 in excerpt 6.10 indicates the continuation of the discourse, and it does not signal any affective stances or marks of positive politeness. Conversely, Amanda's invitation is filled with hedges—e.g., the pronounced rising intonation at the end of line 1, the elongated conjunction *or*, and the use of the vague term *whatever* in line 2. These hedges serve as mitigating agents in the invitation or request for questions. In fact, the imperative portion of the conditional sentence (i.e., the consequent clause where she could tell viewers what to do) is implicit as she never mentions the comment section of YouTube or how viewers can voice their questions. This indirectness creates a perceived level of positive politeness, inviting the viewers to ask her questions but not making them feel obligated to do so. To further create a sense of

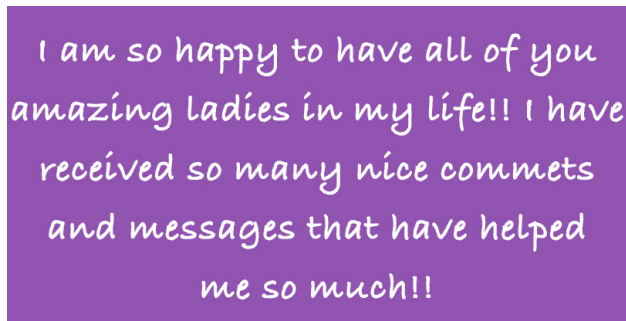
familiarity and amicability with the viewers, she proceeds to explain why she welcomes questions. In lines 3 through 6, she positions herself as someone open to viewers' questions and "happy to answer them" (line 3). To justify why viewers should not feel constrained when asking her questions on the topic of her vlog, she explains that she is honest and not embarrassed to talk about pregnancy loss (lines 4 and 5). She then reiterates her position by transforming her utterance from line 3 into an emphatic one. The demonstrative pronoun *them* from line 3 is transformed to "anything you need me to answer" (line 6), emphasizing her openness and willingness to share any information on the topic of miscarriage.

Amanda's excerpt exemplifies how most vloggers from family/parenthood communities finish their vlogs; it is very common for them to invite the viewers to post questions or comments. Particularly in response to videos related to pregnancy loss, viewers post words of encouragement or support and even share their own personal stories. Although the analysis of the viewers' written comments was not the focus of this project, it is relevant to mention that a large number of viewers who share their own personal stories pride themselves on having the ability to be more understanding than those who have not experienced such trauma. In chapter 4 it was pointed out that interviewees perceived women who have lived through similar experiences as more empathetic. This connection between shared knowledge and understanding of another's loss is a recurring theme that surfaces throughout the data from the perspective of the one being understood and also the one doing the understanding. In this case, viewers believe the share knowledge they have acquired through their own losses enables them to recognize and understand anyone else's loss. However, these "relatively homologous lived experiences (may) hinder our abilities to gain insight into one another's lived realities. Homologous experiences may reveal aspects of another's existence to us in one instance, but they may also serve to conceal aspects of it in another" (Throop, 2010, p. 771). In fact, many comments posted that mention a personal experience express understanding by comparing the vlogger's narrative with their own experience. This comparison of experiences frequently leads to a focus shift from the

vlogger to the viewers, thus leaving the reader uncertain of whether the commenters' intention was to show empathy to the vlogger or to present themselves as co-members of the pregnancy loss community, more deserving of imparting support than those who had not lived through a similar experience.

Regardless of the format and content of the comments, most vloggers mention in their videos this connection with the viewers. The acknowledgement and appreciation of the support received is another resource vloggers very frequently use to promote the audience's involvement, as represented in excerpt 6.12.

Excerpt 6.12: I have received so many nice comments! (Karen's vlog - First loss)



I am so happy to have all of you amazing ladies in my life!! I have received so many nice comments and messages that have helped me so much!!

The discourse in excerpt 6.12 shows a clear inclusion of Karen's audience by treating the viewers as part of the in-group, by appreciating the viewers' affiliation, and by showing herself vulnerable to them. She expresses her gratitude to "all of you amazing ladies", addressing her audience as someone close to her. Referring to the relationships built in interaction, (Schutz, 1967) defines "We-relationships" as the "face-to-face relationship in which the partners are aware of each other and sympathetically participate in each other's lives for however short a time" (p. 164). He further elaborates on the concept of *consociates*, which Carrithers (2008) describes as "people we grow old with, whose lives we participate in, whom we know intimately and in their own terms... those we have touched, smelled, and with whom we share mutual times ... and mutual experienced emotions" (p. 6). In excerpt 6.12, although the viewers are unlike the prototypical consociates, since Karen has never touched or smelled them, nor shared mutual

times with them, she does treat them as consociates. Drawing from the language Karen uses and the familiar tone in all of the vlogs in the data, viewers are *pseudo-consociates* to the vloggers. The similar lived experiences and the emotions they have in common act as a bonding agent and the central focus of a community of experience they create on YouTube. And by the nature of the publicness of YouTube vlogs, those who have not lived through similar experiences can still be part of the circle of pseudo-consociates by following the vloggers diligently and creating a dialogic interaction through the comments. Furthermore, this screenshot from Karen's video presupposes an audience whose members want to show their compassion and understanding; and the gratitude she displays compels them to continue commenting on her vlogs.

A second element to appreciate viewers' interaction is the referents used for the feedback received, which exposes an upgrade in affiliation from the term *comment* to *message*, aligning with the idea of the viewers as pseudo-consociates. A comment is "a statement of fact or opinion, ... a remark that expresses a personal reaction or attitude" ("The American Heritage Dictionary," 2011), whereas a message is a "short communication transmitted by words, signals, or other means from one person ... to another" ("The American Heritage Dictionary," 2011). Focusing on the agentic aspect of the recipient in both definitions, a message targets a specific subject, whereas a comment does not necessarily invoke the recipient. Similarly to the vloggers' discourse, viewers who respond with a message produce a recipient-oriented discourse and encourage the continuation of a dialogic interaction with the vlogger. On the other hand, a comment that directly addresses the vlogger is more likely to involve emotional support and affiliation. Thus, the appreciation shown for the feedback received, and particularly the upgrade from comments to messages, encourages her viewers to become part of the in-group, to give more feedback on the vlogs, and even to share their own personal stories, which strengthens the community of experience in YouTube.

A third and final element relevant to feedback elicitation in excerpt 6.12 is Karen's vulnerability. This is illustrated at the end of the screenshot when she presents herself as the

sufferer who needs the help of the viewers to overcome the grief. On the topic of motivation and emotionally charged content, Nardi, Schiano, and Gumbrecht (2004) state that “it was the release of emotional tension *with an audience* that was especially powerful for vloggers” (p. 227 emphasis in original), which brings back the idea of a recipient-designed discourse previously mentioned. Going back to Schutz (1967) notion of consociates, the discourse in excerpt 6.12 establishes Karen’s character as someone who reaches out to the viewers, who is close to them, almost a friend. Lange (2007) adds that “many video vloggers argue that it is precisely by putting these intimate moments on the internet for all to see that a space is created to expose and discuss difficult issues and thereby achieve greater understanding of oneself and others” (p. 1). The vloggers then get the public visibility and shaping of those kinds of experiences through sharing them. Even though not everyone has a pregnancy loss at the same time, with these videos the experience can be frozen and made relevant to other members or new members when time is appropriate, thus motivating the continuation of the community on YouTube.

Connecting with Other Vloggers

Aside from eliciting feedback from the audience, another way to ensure viewers’ participation and the preservation of a strong community is by narrowing the scope of the target audience. Vloggers can shift their focus from pseudo-consociates to consociates and replace inchoate pronouns with people’s names. Targeting a smaller audience creates a sense of intimacy and a greater connection with the community of experience, which is illustrated in excerpt 6.13, where Jordan recounts what helped her cope with her miscarriage.

Excerpt 6.13: I've been messaging back and forth with Karen (Jordan's vlog)

1 Joan: .hh talking with (0.8) people that've actually gone through it
2 has r:eally been helpful uhm: (0.8)
3 I've been messaging back and forth with Karen,
4 .hhhh (0.2) Karensky and (1.4)
5 I mean she's been through it twice so,
6 (1.6) She really knows what I'm going through.
7 And that's been helpful and you know.
8 (2.2) Jessica JKSou's she's: (.) gone through it so.
9 .hhh (1.0) >you know< (.) that's what's really been helpful for me
10 (1.2) a:nd uhm (0.2) been hopeful for the future (.)
11 and trying again so, (.)
12 If you have any questions, ask. (.)
13 Ask away you know, I'll answer just about anything.
14 .hhh And that's it.
15 That's my extremely lo::ng hh. uh: (.) miscarriage story so,
16 (1.0) I hope this helps somebody in the future,
17 (0.2) Alright bye guys.

Relationship with other vloggers

Relationship with other vloggers

At almost 35 minutes long, Jordan's narrative is the longest one in the data set analyzed. After giving a very comprehensive account of the loss, medical encounters, and emotions, this video concludes with her acknowledging how this community of experience helped her through the grieving process. In lines 3 through 6 she mentions connecting over messaging with Karen Karensky—the vlogger that has been analyzed in several instances in this chapter. Moreover, in lines 8 through 11 Jordan mentions Jessica JKSou's, also a YouTube vlogger whose channel focuses on pregnancy, family, and natural birth. Even though Jordan does not explain the nature of her relationship with Jessica, by mentioning her in the vlog, viewers perceive a connection between these women that exists beyond YouTube. This indexicality requires a specific audience acquainted with the family and pregnancy community and its members to fully understand Jordan's message; for any other viewer cannot recognize who Karen or Jessica are or why they are relevant. These two women Jordan mentions also lived through similar life experiences in their journeys to motherhood and shared their stories also on YouTube, yet Jordan refers to them in her video as one would talk about friends within a group of friends, or

at least acquaintances, without evoking their vlogs or even their relationship to YouTube. Here the substrate available to the members of the community is their names—and not the titles of their channels—which is what Jordan uses to perform sequentially organized actions and transform those names into the key players of her grieving process. Karen and Jessica are mentioned not as the creators of videos that she watched, but as members who lived through similar experiences and whom she contacted outside of the YouTube environment. Nardi, Schiano, and Gumbrecht (2004) also recognizes this type of relationship continues beyond written blogs as “blogging extend[s] social interaction into other forms of communication” (p. 225). In this case, when Jordan shares she was “messaging back and forth” (line 3) with other members, followed by her offer to answer “just about anything” (line 13), she implicitly extends the opportunity to the viewers to help her in the same manner Karen or Jessica helped her grieve. This invitation then affords the opportunity for any of the viewers to possibly create an offline connection with Jordan, which in turn would expand even further the reach of the community of experience.

The idea of the viewers and the vloggers as members of one community is highlighted in the last lines of excerpt 6.13 when Jordan remarks “I hope this helps somebody in the future” (line 16). This utterance vividly encapsulates the main interactive and emotional function of pregnancy vlogs, as vloggers seek to build relationships with the envisioned Others that could potentially watch their YouTube vlogs. In fact, Jordan explicitly mentions this future possible viewer by stating “somebody in the future” (line 16) as the envisioned recipient of her narrative. As she records her video, she is aware of the disjointed temporality between her discourse and the imagined Others for whom she produces the narrative. Unlike in face-to-face interaction, on YouTube the relationship between interlocutors can be materialized over a long period of clock-time as viewers watch the vlogs and post comments. Although this video was created as part of her regular updates on her life and family, Jordan’s miscarriage narrative is mostly self-contained, as viewers do not need to have watched previous videos or place the story in a specific

time frame to understand it. This atemporal quality of her video makes her vlog relevant even years after it was posted, thus supporting her desire of helping other women in the future through her narrative. In this vlog, Jordan seeks to provide comfort to others who might experience a similar loss to hers, and approximately 50% of the vloggers analyzed also express the hope to help other women by sharing their stories and letting them know they are not suffering alone. This concept of pregnancy loss as an isolating traumatic experience is related to the perception of miscarriage and stillbirth as a taboo topic people try to avoid. Even medical personnel at times claim pregnant women should not be preoccupied with the high rate of pregnancy loss, depriving them from important information on incidence, reasons, and management of pregnancy loss. This lack of knowledge results in the stigmatization of pregnancy loss and the reason why so many women feel isolated, particularly when they discover they miscarried. By sharing their own traumatic experiences publicly on YouTube, these vloggers attempt to destigmatize the topic of pregnancy loss and promulgate an online and an offline dialogue on miscarriage and stillbirth.

Offline relationships between vloggers are relatively common, as Jordan pointed in excerpt 6.13 when referring to how she communicated with two other vloggers via text-messaging. The next excerpt also illustrates the acknowledgement of an offline relationship with another vlogger. In this case, however, the relationship is taken a step further as Brittany meets the other vlogger in person. From what can be inferred from the video, Brittany's baby, Kylee, was diagnosed with Turner's syndrome, fetal hydrops, and a cystic hygroma after the first trimester. Given this diagnosis, Brittany was told she needed a more detailed ultrasound to determine the severity of the conditions and that the pregnancy was probably not viable. Nevertheless, she chose to keep the pregnancy because she knew of babies who survived similar circumstances. One of these cases was Vanessa's daughter, Lily, who was a healthy toddler at the time Brittany was pregnant. When Brittany went in for the detailed ultrasound, her husband Korey and Vanessa went with her for support. Vanessa's presence at that moment was

particularly important for her, as she explains in excerpt 6.14, because she was familiar with the medical conditions since she had the exact same diagnoses for Lily.

Excerpt 6.14: I had Vanessa from 2011teenagemom (Brittany's vlog)

1 Brittany: uhm For the ultrasound I had Korey go with me,
2 and I had Vanessa from uhh 2011teenagemom,
3 because you know she kinda dealt with the same thing.= Introduction
4 Automatically I contacted her or she already knew I was pregnant.= of vlogger
5 Her and Britney both, ————— Unknown referent
6 .HH so I (0.2) contacted her,
7 and told her kinda what was going on, cause I wanted to compare.
8 I mean I know (.) no babies are alike and no stories are alike or whatever.
9 I mean they're similar but (0.2) .hh no case is like the exact same.
10 But (.) I know Lily had a lot of the same things that (.) Kylee had.
11 (0.4) Such as a cystic hygroma and hydrops.
12 Which I'm about to get to.
13 So Vanessa was a support system that day,
14 and she: >you know< (.) knew some things that helped me.
15 Like ask for the doctor and stuff that-
16 .h cause that day I was just so out of it,=
17 I didn't know what I was gonna ask,=
18 I didn't know what to even- I didn't know.
19 (0.2) .hh (0.6) uhm so she met us up there,

Brittany's introduction of Vanessa is very different from Jordan's introduction of Karen and Jessica. Although Jordan does mention their full names, at no point does she allude to YouTube or even the online sphere. Contrary to this, Brittany clearly indicates Vanessa is a YouTuber as she clarifies who she is by stating the title of her channel, 2011teenagemom, in line 2. This introduction is followed by an explanation of why this actor is relevant in the story as she claims, "she kinda dealt with the same thing" (line 3). Although there is a brief mention of a possible second vlogger, Britney in line 5, she does not expand on who this person is, where she knows her from, or how does she fit in the story. Therefore, it is not possible to infer from the information provided in this narrative if the Britney she mentions in line 5 is a personal friend or someone from the online community—although further examination on YouTube revealed Britney is in fact another vlogger who has even collaborated on videos with Brittany. What

separates Brittany's incorporation of another vlogger from Jordan's example is the fact that Brittany met in person with her. This would suggest that the community of experience built on YouTube not only can expand from online to offline when members start contacting each other, but it can also become a community in the traditional sense of the term. Consequently, Brittany and Vanessa surpass the level of co-members of a community of experience based solely on lived experiences and inhabit a community based on geographical space and physical interaction with each other.

Brittany's incorporation of Vanessa in her narrative and Jordan's reference to her communication with Karen and Jessica reflect the importance of this community of experience as an active source of emotional support. Most vloggers state at some point in their vlogs of pregnancy loss that the reason for sharing their personal stories is to help others who might undergo similar traumas. In fact, several even acknowledge having watched other vlogs of pregnancy loss when they were undergoing their own losses, which is how Jordan initially learned about Karen's channel. Therefore, the overt admission of an offline community based on YouTube is evidence that these vlogs are not only an integral part of the sense-making process for many women, but they are also essential for the creation and perpetuation of an online community of experience.

Conclusion

This chapter analyzed the strategies vloggers use in their videos to increase traffic to their channels and foster an online community of experience centered on pregnancy and family. Although 40% of the videos examined did not belong to such a community, these videos ranked high in popularity, following the selection process described in the methods chapter of this dissertation. This high popularity means that viewers searching for videos on pregnancy loss frequently watch these non-family-community videos as much as they watch other videos on pregnancy loss from those who claim to be part of the pregnancy/family YouTube community.

Therefore, these videos also become relevant within the community and provide support and comfort even though the authors are not officially members of it. Furthermore, these videos include linguistic resources similar to those created specifically for the online community of experience, thus rendering them equally valid for their analysis. Two main facets of the vlogs collected were analyzed: how these discourses compare to face-to-face interaction, and how they exist and take form within the unique ecosystem of YouTube.

The first section of this chapter revealed how through recipient-oriented discourse, vloggers are able to foster a relationship with the viewers through greetings and offering advice. An integral part of greeting the viewers is to recall previous information given in past vlogs in order to maintain a sense of continuity in their vlogs and make past stories relevant. C. Goodwin (2013) attributes the transformation of resources provided by a public substrate as central to human action, and this also proves to be the central method for building a community of shared experience within the YouTube environment. Vloggers not only recycle the materials available to their viewers from previous videos, but also incorporate the viewers' experiences into their narratives. By performing transformative operations of previous stories in the new vlogs, vloggers are able to covertly encourage viewers to watch their past videos. For most viewers raising the number of views per video carries an economic motive since the income received, for those who monetize their videos, is directly proportional with the number of views. The upside for the online community of this financial motivation is that audience loyalty also drives the perpetuation and expansion of this community of experience centered on family and pregnancy. In addition to modifying previously available substrates from past videos, vloggers also urge viewers into participating in the telling of their stories by bringing their own past experiences to the present. Karen demonstrated in excerpt 6.4 how to promote audience participation and co-narration of the trauma. She asked a select portion of her viewers to recall their own experiences in order to understand her own experience. This request for audience accountability and participation entails a twofold purpose. On the one hand, it selects from the greater YouTube

audience a subset of women who share the same experiences as the vlogger. A community is by definition a subset of a larger society, so by selecting only some viewers who can participate in this interaction, the vloggers are able to create a somewhat private community within the larger public YouTube sphere. On the other hand, the request for accountability brings into the present those past experiences the women who are watching the vlogs have lived through, as a way for them not only to understand and empathize with the vlogger but most importantly to participate in the narration of her story.

Reaching to the viewers through recipient-oriented discourse can also be achieved by providing them with advice. Often, particularly in cases of pregnancy loss, viewers watch vlogs in search of answers to their own problems or to see if others have gone through similar experiences and what the outcome was in those cases. Because of the taboo veil that covers pregnancy loss, women often find themselves isolated from family, friends, and sometimes even their partners. An online forum provides a plethora of cases where women can anonymously watch others in their same circumstances. This sense of camaraderie, even with people whom they have never met, brings comfort and removes the isolation factor that could affect their sense making process. The vloggers' advice solidifies this idea of a connection and provides possible answers to otherwise unresolved questions and doubts. As I illustrated through several examples, the form mostly use for offering advice in these vlogs is through direct directives. Through the use of these particular unmitigated commands, vloggers speak to their viewers as friends. In their narratives, they move beyond sharing their personal stories and reach into the audience's personal stories. By focusing specifically on those who are experiencing a loss—in the present, the past, or the future, depending on how the given advice is structured—vloggers introduce themselves as co-participants in the viewers' experiences. They offer the women in the audience the opportunity to be part of their stories by suggesting how to handle medical situations, how to take care of themselves after a loss, or even how to cope with the fetal demise. In these cases, as important as the content of the suggestions is the form used—i.e., unmitigated

imperatives—as it creates a sense of familiarity unlike other more polite forms that can be perceived as distant and tentative.

Tending to the viewers and actively harvesting a relationship with them through discourse is as important as creating narratives that are relevant in the space. YouTube is a unique setting and offers several layers of semiotic content outside the frame of the videos. Vloggers who successfully capture an audience understand how to incorporate this ecosystem into their videos. The second section of this chapter illustrated how through deictic gestures vloggers manipulate the physical space where the videos are posted and incorporate external semiotic resources into their own videos. By pointing at embedded videos, links posted on the description section of the video, or the comments box, vloggers create a more interactive experience with the viewers. This facilitates an active participation where the audience has access to other resources such as past videos or external websites. This new network of videos created within one singular video then allows new viewers to access the past information that vloggers indexed and on which they performed operational transformations when creating new meaning. Furthermore, incorporating all of the available YouTube resources in the videos affords viewers the possibility to create a dialogic interaction with the vloggers by means of feedback, comments, or questions.

For a community to be alive and thrive, members have to interact with each other; the communication channel has to be open between its members and has to flow to and from each member. Vloggers understand the importance of this interaction and encourage audience participation through comments and general feedback. It is possible here to see the difference between those vloggers in the community and those who are not. Those who are not part of the pregnancy/family community and who regularly upload videos for other purposes tend to incorporate a more formulaic way of asking for input from viewers. Excerpt 6.10 illustrated how YouTubers outside the pregnancy/family community request feedback in an impersonal manner, soliciting viewers' input but not offering any type of personal connection with them in

exchange for it. Conversely, vloggers in the pregnancy/family community who seek to build a relationship with the viewers and even other vloggers, present themselves as friendly and willing to have a conversation with them. This potential conversation is unlike face-to-face interaction. Its temporality is not related to clock time as turns can take minutes, hours or even days; multi-party interactions normally take place in the comments' section since several viewers leave comments simultaneously; and there is no competition for the floor since the comments box is available to everyone at the same time. Nevertheless, viewers have the possibility of asking questions and showing support, and vloggers in turn have the possibility of responding to those messages and comments. Similarly to face-to-face interaction, the communication between vloggers and viewers can result in relationships in which empathy is explicitly foregrounded. In the YouTube environment, however, empathy presents unique characteristics as vloggers desire to be understood by anticipated imagined Others, who at the time of the telling are not concrete Selves. As they produce their narratives, vloggers create a recipient-oriented discourse for an envisioned target audience that has not yet been materialized. This type of interaction mirrors the process of writing letters that Schutz (1967) mentions when explaining the process of establishing and interpreting meaning. When writing a letter, the writer not only conveys an objective meaning but also a subjective meaning that he attempts to convey given the positionality and of the intended reader. Schutz further explains that "in interpreting the subjective meaning of the signs used by someone else, or in anticipating someone else's interpretation of the subjective meaning of our own signs, we must be guided by our knowledge of that person" (Schutz, 1967, p. 129). In this case vloggers are not familiar with "that person" but select a particular audience that fits into what they expect "that person" to be. Conversely, viewers who respond to the vlog with understanding create an empathetic relationship with a tangible, yet absent, Other. This relationship, however, comes into being only when the viewers respond to the vlog with written comments, for all other forms of understanding never reach the vlogger, rendering those empathetic intentions unfinished since the vlogger will never be aware

her desire of being understood was materialized. An online conversation, whether it leads to an empathetic relationship or not, is crucial to maintain an active community, and at times it even leads to offline relationships to be formed. Such was the case of Jordan and Brittany, who in excerpts 6.13 and 6.14 respectively described the connections they had built with other vloggers, thus showing their viewers how these public videos can develop into private communities and even personal friendships.

Notes to Chapter Six

1. The other key terms found in the titles were: *baby, including pictures, advanced maternal age, TTC* (i.e., trying to conceive), *passing the baby, after first IUI* (i.e., intrauterine insemination), *lost our baby, infertility, and emergency room*.
2. For a greater analysis of how women struggle with guilt and responsibility for the pregnancy loss, see chapter 3.

Chapter Seven

CONCLUSION

I don't want to forget the experience. It's part of me, and I still remember it, but I have to look at what was my lesson out of that. How does that point to shape my life? How does that point to be a gift to me? (Reilly)

Making sense and overcoming a pregnancy loss does not imply forgetting the experience took place; it means understanding and accepting the demise. When narrating their losses, women have the opportunity of analyzing what they have endured and piecing their stories together, thus coming to terms with the loss and a shattered envisioned future. Despite all the benefits of storytelling after such a traumatic event, a large number of the women interviewed expressed never having had the opportunity to tell their full stories before. In fact, some of them indicated the interview was the first time since their losses where they felt safe to openly talk about their experiences, fears, and emotions. This consistent lack of opportunity to vocalize the trauma endured is concerning since it obstructs the women's psychological recovery process. Although the possibility to talk about a pregnancy loss experienced is readily available at counseling sessions and other similar settings designed to provide post-loss support, even in larger cities the groups or counselors who specialize in miscarriage or stillbirth are few and far between. Furthermore, several women interviewed who attended counseling sessions expressed discontent due to a perceived lack of understanding, as they felt they could not freely express their emotions or fears that emerged after the loss. Conversely, all women manifested how talking to others who lived through similar experiences and sharing with them their stories was helpful and cathartic.

Regardless of whether a connection with someone who has also experienced a pregnancy loss is achieved through formal peer-support groups or informal conversations, women

frequently consider interactions with these peers as understanding and empathetic. The qualification of these relationships as empathetic is mostly based on the women's perception and not necessarily a reflection of the true nature of the relationship. Throop (2010) reflects on his own perception of others' reaction to imminent loss after having himself lost a close friend. He discusses how sharing a similar lived experience can actually hinder the understanding for someone else's experience, as "homologous experiences may reveal aspects of another's existence to us in one instance, but they may also serve to conceal aspects of it in another" (p. 772). Having lived through a stillbirth could make a woman interpret a miscarriage as a lesser loss, even though both of them are pregnancy losses, since the baby had a greater chance of surviving outside the womb and was closer to his due date. In fact, some of the women interviewed, who experienced a stillbirth, reported believing second and third trimester pregnancy losses were more dramatic than miscarriages, as the mothers had bonded with the unborn child for a longer period of time and created a physical relationship with the baby, especially those who had felt the fetus move inside the womb. Conversely, other women suggested a miscarriage could be more drastic than a stillbirth since the lack of a physical body to hold and mourn after the loss prevents them from coming to terms with the loss and reaching closure. Lovell (1983) confirms that "contact with a dead baby had been an emotional but positive action and seen as important in helping to face and accept the loss. These mothers were better able to mourn" (p. 759).

Although it is not possible to access others' consciousness to determine if empathy and understanding is accurate, these testimonies illustrate how some women who lost pregnancies at different stages think about other pregnancy losses. This comparison of pregnancy losses and the judgment of its traumatic effects, based solely on the length of the pregnancy, shows that there are several layers of understanding another's experience, and only the one doing the understanding and empathizing can honestly assess its accuracy. It might be the case that women who have experienced a pregnancy loss understand the pain of losing a child better than

others who have not suffered such trauma, yet this is only a superficial layer of understanding. For there to be a deeper level of understanding that can lead to an intersubjective relationship between peers, I have to “assume that if you were in my place you would see it the way I see it” (Duranti, 2010, p. 21). As Throop (2010) points out, merely sharing a similar lived experience does not give someone access to another’s lived experience and can actually impede understanding the other’s trauma. In this particular case of pregnancy losses, the women’s perception of being understood by their peers could arise from their own need for a space to share their stories without being judged. These women are attempting to make sense of their losses in order to regain a sense of normalcy in their lives, which leads them to find a safe place to narrate their experiences—thus moving forward with their sense-making process—even when they do not reach the true understanding they are seeking.

Chapters 4 and 6 focused on this peer interaction and the creation of a relationship centered on a shared similar experience of loss and pain. Pain, whether it be physical or emotional, can be difficult to interpret and articulate. Often people attempt to describe a painful experience by comparing it to a similar event that the recipient might have access to. “To understand and interpret pain is to a certain degree an individual process, but it generally also involves other persons: family, friends, colleagues and maybe also medical staff” (Hydén & Peolsson, 2002, p. 325). The difficulty in conceptualizing pain arises from its existence as an external entity affecting ourselves and our bodies. On this concept of pain as an other, Throop (in press) elaborates that,

[pain] is both my pain and not my pain. It inhabits my body. And yet it comes from elsewhere. It does not belong to me. I did not create it, nor do I control it. My pain escapes me. And yet, it is still of me. Indeed, pain experienced as “mine” often evokes a sense that my body is no longer now precisely my own. (p. 312)

Chapter 4 illustrated women narrating their experiences through a web of multimodal resources in order to trigger my involvement and co-narration. In this way, pain was accessed

simultaneously by different actors from their own perspectives to collectively articulate the narrator's experience. Although the trouble in the story did not necessarily lie on the articulation of pain, its presentness affected the teller as she attempted to recall emotional trauma. Such was the case for Laurie and Candra, for example, as they composed a multimodal discourse where language was not always at the forefront of their tellings. Through the interconnection of non-verbal semiotic resources, they invited me into their narratives as an active co-participant. Bringing into the moment of the telling my own conceptualization of the pain experienced, I was then able to co-articulate with them their experiences, thus helping them understand and dissipate the torment of this pain, that as an Other was invading their presentness.

Chapter 6 also focused on the recipient-designed discourse of women who attempted to create a connection with those who listened to their narratives; however, these interactions did not take place face-to-face but rather through YouTube vlogs. In this environment, vloggers can also bring an audience into a narrative by inviting them to co-articulate emotions and sensations that cannot be easily conveyed with words. This was the case in Karen's vlog in excerpt 6.4, where she selected a specific subset of her general audience—i.e., women who had experienced childbirth—in order to co-construct with them her experience of the physical pain of miscarriage. By substituting the joy of a successful and healthy birth with the emptiness of a miscarriage, Karen attempted to seek understanding of her physical pain and emotional stance simultaneously. Although most of the women interviewed for this project manifested the importance of talking to peers to recount their stories and advance their sense-making process, Youtube presents a very different ecology than face-to-face interaction and also presents new possibilities for those who do not have access to peers to share their losses. The videos analyzed revealed vloggers employ many of the resources often found in face-to-face interaction, e.g., greetings and address terms to create a recipient-designed discourse, unmitigated imperatives to give advice, and the incorporation of previously available substrates within their discourses to denote continuity in the tellings, among other features. Nevertheless, the relationship with the

recipient is strikingly different than in face-to-face interaction, since when the women produce their videos, they are speaking to an imagined audience that does not become an Other until the viewers materialize themselves through the messages posted on the comments' section below each vlog.

This separation between the narrators and their viewers creates a very secluded yet vulnerable context in which these pregnancy loss narratives are told. On the one hand, vloggers can create their videos alone, in the safety of their homes, and without anybody judging them as they express their fears or deepest emotions. The lack of face-to-face interaction could affect this narrative process, and consequently the sense-making process, if they are not able to verbally communicate to their audience their experience. Chapter 4 illustrated how the incorporation of non-verbal semiotic resources into the narrative allowed co-participants to co-articulate otherwise difficult moments to conceptualize. The lack of an Other when recording these narratives for the YouTube sphere could affect this process of understanding the lived experience. However, the freedom of being able to pause at any time in the story and reflect on what happened gives vloggers the opportunity to analyze their own experiences, verbally communicate them to their audience, and advance their sense-making process. It is through the production of complete and coherent stories that people can understand the trauma endured and ultimately overcome the loss (Mattingly, 1998a; Tuval-Mashiach et al., 2004). On the other hand, when creating their videos for YouTube, vloggers have the opportunity to edit what they have recorded before posting their vlogs, thus deleting any fragments of their narratives they might deem too personal for public viewing. The data collected showed most women choose to edit their videos before sharing them publicly, as most videos included signs of a gap in continuity—e.g., unnatural continuation in the prosody due to a missing segment in between, image shift, added visual transitions in between segments of the story, etc. In this setting, this self-censoring is expected as vloggers are aware that once their videos are uploaded onto YouTube and become publicly available, anyone can watch them and criticize them. This

dichotomy between a safe-space and public exposure is manifested within the larger frame of YouTube as a place where vloggers seek to capture viewers' attention in order to increase the number of views for their vlogs and channels. Therefore, the nature of YouTube as a public space requires that vloggers create their narratives for a more general audience than just peers who have lived through similar experiences of loss. This is reflected in Karen's excerpt 6.4 as she attempts to create a co-participant relationship with mothers—who not necessarily have lost a pregnancy—in order to attain their understanding of her pain. Consequently, the vloggers' intentionality, when producing recipient-oriented narratives, results in the creation of a community on YouTube centered on pregnancy (loss) and parenthood. Vloggers entice viewers to continue watching their videos and even participate in a dialogic interaction by means of written comments to the videos, which in turns motivates vloggers to continue posting engaging videos.

The relationship between vloggers and viewers often starts as a casual interaction, and at first the channel of communication might flow only in one direction if viewers do not post written comments in response to the videos. However, in time a deeper relationship emerges between both parties, and vloggers sometimes even forge offline friendships with other vloggers, as Jordan and Brittany illustrated in excerpts 6.13 and 6.14 respectively, thus strengthening the community of experience in this environment. The peculiarity of these relationships is that they emerge in response to these women's need to find compassion and empathy as they attempt to understand their own experiences. The empathetic alignment that women can find in this setting results in viewers becoming pseudo-consociates to the vloggers, as discussed in chapter 6. The shared similar lived experiences create a bond, which is the driving force for this community of experience. The women interviewed agree that one of the main problems they faced when grieving their losses was isolation, and this online community brings to those segregated a sense of belonging and camaraderie. Many women claim that when telling the news of the fetal demise to friends or even family, people frequently attempt to encourage them and

give them hope for future pregnancies. “It happened for a reason”, “At least you can get pregnant”, and “You are young, you can still have another baby” are some of the most common phrases women agreed to have heard. Although the person who utters these phrases might feel s/he is being cheerful and optimistic, none of these phrases acknowledges the loss as a traumatic experience or the devastating effects it has on a woman. Lovell (1983) further elaborates that “ejected into the community, [a women who lost a pregnancy] found that people wished to forget and enjoined her to do the same. In the ordinary course of events, most people need daily conversation. Ironically, at life crises, when this may be doubly necessary, not only is the ‘normal’ ration of talk not provided but it is drastically cut” (p. 760). The lack of recognition for the traumatic emotional consequences of the demise carries deeper consequences when conveyed by doctors or the medical personnel surrounding the patients as they experience the loss.

Doctors, nurses, midwives, and other medical personnel deliver the news of the embryonic or fetal demise and play a crucial role in the emotional impact of the women’s experience. Chapter 5 revealed how practitioners’ detached and impassive bedside manners causes patients’ dissatisfaction, which in turn can affect their recovery from the loss. Anger and guilt are common after a pregnancy loss, especially after a miscarriage, and are aggravated when women feel abandoned or dismissed by medical personnel (Brier, 1999; Murphy & Merrell, 2009). If left unmonitored, grief and post-loss stress can develop into depression that requires more intensive interventions (Brier, 1999). Through a rich intertwined layering of language, prosody, and gestures, women in this study portrayed manifestations of discontent as they embedded a series of emotional and epistemic stances onto the medical interactions reported. This dissatisfaction arises from a misalignment between the patients’ needs and the doctors’ understanding of those needs (Friedman, 1989), particularly in issues related to their emotional wellbeing or the acknowledgement of the demise as a traumatic loss. A large percentage of women are unaware of the high incidence of pregnancy loss—5.99 stillbirths per 1,000 live

births (MacDorman & Gregory, 2015) and 20% of miscarriages among all clinically recognized pregnancies (Tulandi & Al-Fozan, 2012). This lack of knowledge, due in part to the stigmatization and taboo status of this topic, contributes to the sense of helplessness many women feel regarding their medical treatment. In most cases, poor bedside manners is listed as the main complaint. Those women who find out during an ultrasound their embryo no longer had a heartbeat during their first trimester, do not always receive the necessary information to decide which method for passing the products of conception is best for them. Moreover, those who choose to miscarry without surgical intervention often discover in shock the level of physical pain of miscarrying is very similar to giving birth—as Karen points out in excerpt 6.4—since contractions are sometimes equally if not more painful. In fact, several women during the interview indicated that had they known what entailed to miscarry at home unassisted, they would have chosen to have a D&C instead. Finally, women who deliver their babies in a hospital setting often complain of the uncomfortable environment post-delivery, as they lay in the maternity ward surrounded by crying babies in adjacent rooms, and are in the presence of nurses who do not know how to address the situation. Medical personnel’s inability to openly talk about the emotional aspects of a pregnancy loss contributes to the perpetuation of the stigma surrounding miscarriage or stillbirth. Not knowing how to confront the emotional rollercoaster they have to face once they return home, many of these women attempt to cope with their losses alone and fail to do so.

The etiology for most miscarriages and even some stillbirths is unknown or vague (Laferla, 1986; Tulandi & Al-Fozan, 2012). Faced with this ambiguous loss (Boss, 1999), women place blame on themselves or their bodies with the hope that finding a reason for the loss—even if not truthful—will help them understand it and overcome the trauma. However, self-blame in fact disrupts the process of sense-making and leaves the women in limbo, blaming themselves for what transpired even though they know they were not at fault. The continuous self-disparagement and guilt impacts their sense of self, changing the constitution of these women at

their core as they question their motherhood and even womanhood identity, as Stella and others illustrated throughout chapter 3. In excerpt 3.7 Stella remarked, “motherhood is such a definite sign of womanhood in my mind, and also in our culture, in our world.” Framing the ideal woman as one who can become a biological mother is one of the main reasons why the psychological recovery from a miscarriage or stillbirth can last for years. A pregnancy loss carries within more than the loss of a child; it also contributes to the dissolution of dreams and the disintegration of an envisioned identity. The pressure to quickly grieve and overcome the death of the unborn child also involves the rapid reconstitution of the woman’s identity. Without a place to openly talk about the trauma endured, women find themselves trapped with shatter identities and lingering emotional pain. It is only through the continuation of this dialogue centered on pregnancy loss that more women will find a safe space to share their stories and make sense of their losses.

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