

## **Using Narrative to Empower, Educate, and Make Sense of Reproductive Loss**

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### **Abstract**

Reproductive loss is a common, yet often silenced, event that can disrupt the lives of all those involved. Individuals who experience reproductive loss must find ways to make sense of and cope with what has occurred. One way to do this is through crafting and sharing their stories. In this chapter, we argue that narrative has the power to transform people's understanding of loss, their identity in relation to loss, and their relationships with those around them. Using narrative as a tool for sense-making and educating others is empowering for both the person telling the story and for those with whom it is shared. We offer evidence-based suggestions for empowering storytellers to share their stories and for storylisteners to encourage such disclosures.

*Keywords:* reproductive loss, empowerment, community narrative, communicated narrative sense-making

### Using Narrative to Empower, Educate, and Make Sense of Reproductive Loss

*Bethel's heart ached as she replayed the evening in her mind. She had been filled with joy and anticipation for the arrival of her first child, only to have her world turned upside down by the sudden onset of intense cramping and bleeding at 9 weeks gestation. Fear had gripped her as she rushed to the emergency room, the sterile hospital environment adding to her anxiety. Everything felt like a blur, and she became increasingly scared, unsure of what was happening. The providers spoke around the issue not saying exactly what was transpiring or why, and they used medical jargon Bethel did not understand. As anxiety built within her, Bethel unexpectedly shouted, "I do not understand what is going on! Please, I need you to tell me. I need to know what is happening with my baby." At her insistence, a provider finally said, "You are having a miscarriage. I'm sorry, but there is no longer a viable heartbeat." Not knowing what to do, she called her mother. "Mom, I'm at the hospital; something's wrong," she whispered, her voice trembling. Her mother, Elyse, responded with a quiet understanding. "Oh honey, I'm so sorry. I'm so glad you called me. I know there is nothing I can say to fix this, but I've been there too, with my first pregnancy."*

*As Elyse listened to her daughter, she fought back tears as she tried to comfort her (and herself) by telling Bethel: "This isn't your fault. You did nothing wrong. Please know that I am here for you; you are not alone. I can come over and make you dinner. How does that sound? Or I can just sit with you and listen to anything you want to talk about. I'm here for whatever you need, whenever you need it. Okay?"*

*Bethel broke her silence: "I don't really know what to do Mom. What should I do? What did you do? I mean will you tell me about what happened to you so I know what to expect? That is, if you are comfortable talking about it."*

*It was then that Elyse shared, for the first time, with her daughter about how when she was just 21 years old and pregnant for the first time, she began spotting at 8 weeks. She explained, "When I went to the doctor, he told me that miscarriage was normal, not something I should worry about because now at least I knew I could get pregnant, and he told me that God had other plans for that baby. I never talked about it because that's just not what you did back then. Come to think of it, even though he said it was normal and common, I didn't completely understand what was happening in the moment and I don't know if anyone I knew ever had a miscarriage. Hearing your story about how the doctors weren't really telling you anything at first made me realize how not much has changed in the last 30 years, but I'm so proud of you for standing up for yourself to get those answers. I wonder how things might have been different if I wouldn't have been too scared to do that, or even if I would've just talked to Grandma when it happened. I want you to know that I don't want you to go through this alone. We'll get through it together."<sup>1</sup>*

Bethel and Elyse's stories are excellent examples of how narratives help individuals make meaning of their experiences (Koenig Kellas, 2018), refine their identities (Fairchild & Arrington, 2023), and support one another (Johnson et al., 2020). This is true in various contexts but relevant to this chapter is how this occurs in health communication contexts, especially when

discussing reproductive health. Beyond these functions, we argue that narratives “tell us not only who we are but who we have been and who we can be” (Rappaport, 1995, p. 796) through empowerment. To do this, we highlight previous literature on reproductive loss and narrative theorizing, propose areas scholars should research in more depth to further advance our theoretical understanding, and translate evidence into practice for the benefit of those affected by reproductive loss.

### **Narrative Theorizing**

One framework to understand the complex experience of reproductive loss is narrative. Narrative theorizing, or the study of how stories help individuals make sense of the world, examines how individuals create shared meaning through narratives, or culturally and socially mediated stories (Bruner, 1990). Bruner (1990) hypothesizes that humans “story” experiences using narrative structures such as plot, characters, act, setting, and scene to organize and make sense of their lives. There is not one singular narrative theory, but rather an overall narrative framework that guides current narrative and health research. For example, McAdams (1993) explores narrative identity, Harter et al. (2005) narrative problematics, Pennebaker (1997) expressive writing, and Koenig Kellas (2018) communicated narrative sense-making, which is touched on later in the chapter. Stories can be told (Koenig Kellas, 2018), written (Pennebaker, 1997), illustrated (Willer et al., 2018), and enacted (Cutting, 2016). They are often constructed, shared, and revised throughout time (Harter et al., 2005) to create a guide for the world and oneself. Often these stories are told, heard, and repeated intergenerationally within families and cultures (Fivush, 2019).

Repeated stories can become dominant narratives<sup>2</sup> (i.e., “culturally shared stories that guide thoughts, beliefs, values, and behaviors,” McLean & Syed, 2015, p. 323) about topics or

groups of people. They are widely known narratives perpetuated by cultural institutions, mass media, and social networks that evoke specific images, often stereotypes (Rappaport, 2000). This is seen throughout history when looking at the dominant narrative of pregnancy and birth, for example. Women, particularly heterosexual married women, are expected to want to be pregnant, get pregnant easily, stay pregnant, and have an easy birth and a healthy baby. Reproductive loss is a disruption of the dominant narrative for pregnancy and birth because women are unable to fulfill their expected role as childbearing mothers and thus must account for their deviation from that expectation (Horstman & Morrison, 2021). Yet it is difficult to counter the dominant birth narrative because of the privacy rules imposed on individuals who experience reproductive loss (see Bute et al., 2019). As noted by Willer and colleagues (2020), the dominant narrative of perinatal loss is that it is a “non-event” because those experiencing that loss are expected to move on quickly and not burden anyone with their grief.

### ***Dominant Narrative Disruption: Reproductive Loss***

Even though society may view perinatal loss as a “non-event,” millions of families in the United States experience reproductive loss every year (Buskmiller et al., 2023). Reproductive loss includes various pregnancy loss experiences such as miscarriage, stillbirth, abortion, and infertility (Earle et al., 2008). Each type of loss is unique, but still often traumatic (Krosch & Shakespeare-Finch, 2017). Research suggests that individuals and families who experience reproductive loss may suffer from grief, depression, anxiety, guilt, self-blame, and post-traumatic stress (Farren et al., 2020; Robinson, 2014). The effect can be so significant that among women who have experienced reproductive loss and then went on to have a successful live birth, 35% were more likely to receive postpartum psychiatric treatment for mental health concerns than women who had not experienced a loss (Reardon & Craver, 2021). This suggests that

reproductive loss can have prolonged health effects. Those affected by reproductive loss must find a way to make sense of and cope with their experience and who they are (and want to be) using various social, emotional, and communicative strategies. Empowerment through narrative is one such way.

### **Narrative as Empowerment**

Empowerment is a complex concept with multiple definitions. For our purposes, we build upon the work of Khorasani Baghini et al. (2023), Cornwall (2016), and Castro Lopes et al. (2022) to define empowerment as the capacity to enhance one's quality of life through increased self-confidence, self-efficacy, and critical consciousness. The process of empowerment affords individuals the opportunity to “mak[e] sense of their worlds, their relationships, their assumptions and beliefs, practices and values with potentially transformational effects” (Cornwall, 2016, p. 344). When individuals are empowered to share their stories, those stories can educate others to open dialogue about these difficult experiences. Inherent in this process of empowerment is the transformational effect of the process of questioning and potentially changing the status quo (Castro Lopes et al., 2022), or in this instance, the dominant narrative. Thus, we pose that narratives as empowerment are key for overcoming the dominant narrative disruption of reproductive loss. As such, we recognize the complexity inherent in narrative and note a few complementary narrative functions that are foundational to our conceptualization of narrative as empowerment: agency, resilience, and sense-making.

### ***Narrator Agency***

Agency, especially in the context of a significant life event, can function as a way for the narrator to get better rooted in their own strength (McAdams et al., 1996). In the story at the beginning of the chapter, Bethel restored some agency that was lost during her miscarriage

experience by highlighting her strength in that “blurred” moment. Early research (McClelland, 1975) describes how empowerment functions as part of narrator agency and is exhibited in stories where an individual is enlarged, enhanced, or made better within themselves or through connection with another. Bethel choosing to include how she demanded information in her narrative empowered her during a disempowering time. She reclaimed her voice in that moment of self-advocacy and continues to reclaim her agency by narrating her experience to, and for, others.

Privileging muted voices (especially those of women whose pregnancy stories do not fit the dominant narrative), in and of itself, is empowering because, beyond the content of the story, the metacommunication of “listening to and giving respect to the stories of people’s lives” is an experience that changes people’s roles and relationships (Rappaport, 1995, p. 801). This was evident in the opening narrative when Bethel’s mother, Elyse, listened to her daughter and then recognized, and was proud of, her daughter’s ability to express her agency by advocating for herself. This affirmation likely helped empower Bethel to continue to share her story. Similarly, Elyse, by sharing her story with her daughter, regained some of the power she felt she lost when the doctor silenced her during her miscarriage.

The experience of reproductive loss is inherently tied to narrator agency. When experiencing reproductive loss, an individual can feel disempowered and lacking agency (Rogers, 2021). When using narrative expression through metaphors and illustrations, individuals who experience reproductive loss described their experience as feeling like a “flawed machine,” being a “fertility Guinea pig,” or having “broken eggs” (Venkatesan & Chinmay, 2020). These expressions highlight the feeling of lack of agency over their bodies and experiences. Some work (e.g., Chaudhary, 2019) describes how cultural scripts (i.e., dominant

narratives) around pregnancy and pregnancy loss further entrench these feelings of powerlessness and silence around reproductive loss. With lack of agency and disempowerment held so deeply within an individual's beliefs and life story (Rogers, 2021), there becomes a clear need for narrative empowerment to reignite the feeling of agency and move through this challenging experience, much like Bethel and Elyse were beginning to do.

### ***Narrative Resilience***

Resilience is a dynamic process that can occur after experiencing a stressor, such as reproductive loss, where the individual works to reintegrate after loss (Buzzanell, 2018). Bethel's self-advocacy and reclaimed agency demonstrated her resilience during this intense disruption in her life. Narrative resilience is the process in which an individual reworks and reintegrates their story following a disruption (Horstman, 2019). Meaning and sense-making are central components of narrative resilience and are connected to one's ability to cope with loss or hardship (Hauser et al., 2006) or to protect oneself (García-León et al., 2019; Kinser et al. 2021), especially within marginalized groups (Felix et al., 2019). Narrative resilience is connected to mental health and well-being, especially when individuals focus stories of difficulty on ideas such as taking action and finding strength in others (Butauski & Horstman, 2020; Horstman, 2019). Bethel sensed her mother's strength in her story as Elyse had to overcome patriarchal attitudes and patronizing behaviors from a medical professional. The restoration Elyse conveyed demonstrated resilience to Bethel and gave her strength to move forward.

The experience of reproductive loss is a "trigger" to which an individual and family can choose to enact resilience. Individuals (Horstman, 2019), dyads (Butauski & Horstman, 2020), and communities (Buzzanell & Houston, 2018) can all enact resilience. For example, Bethel and Elyse helped each other be resilient in the face of tragedy. Highlighting the dyadic nature of

resilience, couples who experienced reproductive loss found that their resilience processes were supported by their relationship structure, emotional attunement, and dyadic coping strategies (Hiefner, 2021). Community resilience occurs when groups “interact successfully to adapt to changing circumstance” and involves the collective “bouncing forward” (Buzzanell & Houston, 2018, p. 3), which is relevant to the collective experience of reproductive loss. Though scholars have investigated resilience for decades (e.g., G. E. Richardson et al., 1990), narrative resilience is a newer yet crucial concept. We argue that engaging in narrative resilience is likely especially beneficial for those experiencing reproductive loss as enacting narrative resilience can function as a reason for, or result of, positive relational outcomes (Horstman, 2019). The narrative resilience illustrated in women’s stories led the mother and daughter to strengthen their bond as they supported one another to “get through it together.” Having an ally helped each woman move forward and share her story.

### *Narrative Sense-making*

Making sense of one’s experience, which can be achieved by reflecting on our stories, is foundational to empowerment. Communicated narrative sense-making (CNSM) theory posits that individuals tell stories to make sense of challenging life experiences, such as reproductive loss. CNSM organizes storytelling behaviors into three heuristics – retrospective, interactional, and translational storytelling (Koenig Kellas, 2018). Research in reproductive loss has primarily investigated retrospective storytelling, or telling stories about the past (e.g., Holman & Horstman, 2019; Horstman et al., 2020, 2021). Interactional storytelling, or observing the process of relational partners telling stories, has not yet been holistically tested in the context of reproductive loss. Yet, research on one element – communicated perspective-taking (CPT) – has shown links between couples’ CPT and mental and relational health (Horstman & Holman,

2017). The current chapter outlines some potential pathways for translational storytelling, or the creation of narrative-based interventions for improving people's lives.

CNSM research grounded in the retrospective storytelling heuristic has focused on the context of reproductive loss, which has highlighted the importance of considering reproductive loss as a relational – not an individual – issue. Holman and Horstman (2019)'s study on heterosexual married couples, found wives who told stories with positively framed themes of “time healing” and receiving “helpful support” after their miscarriage reported less perceived stress than those who told stories focused on hope lost. In studies on non-miscarrying partners' sense-making about miscarriage, Horstman et al. (2020, 2021) uncovered metaphors and memorable messages used by non-miscarrying, cisgender partners in heterosexual relationships to make sense of and cope with their loss. This work can help empower storytellers of reproductive loss to make sense of their loss, recover and regain agency after the disruption, embrace their evolving identity, and share stories of their experience. For example, sharing her reproductive loss story with her mom empowered Bethel to organize and process her own experience. Because storytelling functions to connect people (Koenig Kellas, 2018), Bethel realized that she was not alone in her loss. She found hope in having her mom's support to help her make sense of what had happened and who she was.

Hearing stories can also empower storylisteners to better understand their own experiences while supporting those affected by loss. As Elyse provided support to Bethel, she helped her daughter co-construct her story of loss. In doing so, Elyse reflected on her own experience. She realized that by going through her loss alone, she now knew how to support her daughter in her loss. Her story could help others, and that was validating. As Bethel and Elyse

shared their stories with each other (and others who have experienced reproductive loss), they not only supported each other but also created a community narrative to heal together.

### **Community Narratives as Empowerment**

One way to overcome reproductive loss and empower oneself to move forward is to challenge the “non-event” dominant narrative of loss through *community* narratives. A community narrative is a narrative that is shared by a group of people, bound by a commonality that is verbally and nonverbally communicated with each other to help tell important things about community members (Rappaport, 2000), which can serve as a counternarrative to misrepresentative dominant narratives. For example, Bethel’s and Elyse’s common stories of miscarriage countered *both* the dominant narrative that pregnancies result in the birth of a baby and that miscarriages are a “non-event.” Although each person’s experience with reproductive loss is distinctive, collective stories suggest common experiences that, taken together, form a community narrative that demonstrates the patterned behaviors inherent in reproductive loss stories. Similar to Humphreys’ (2000) narrative analysis of another stigmatized topic – alcoholism, personal stories of reproductive loss interact with developed community narratives so that each shape the other *and* the world around them.

When shared, a community narrative can challenge the dominant narrative to influence both personal and social transformation (Rappaport, 1995, 2000). It has the potential to counter dominant cultural narratives by destigmatizing silenced topics, which benefits individuals and communities as a whole. Bethel and Elyse’s contributions not only fostered their own healing by empowering themselves but also others by encouraging them to add to the community narrative. A shared narrative that is common among individuals who experience reproductive loss (i.e., a community narrative) can call into question the overlearned stories society perpetuates about

reproductive loss being a “non-event” (i.e., dominant narrative). Community narratives collate different perspectives of loss (i.e., counterstories) to resist the dominant narrative that reproductive loss is a “non-event.” This is especially important for individuals who may be experiencing shame or stigma because of the silence surrounding reproductive loss. Creating a community narrative that compiles silenced or marginalized voices to resist the dominant narrative legitimizes individuals’ experiences (L. Richardson, 1990). Giving voice to Elyse’s silenced narrative legitimized not only her experience but also that of her daughter’s. These counterstories coalesce into a community narrative that resists dominant narratives that have restricted the storyteller’s agency and identity (Nelson, 2001).

For those experiencing loss, creating a community narrative validates a shared experience and brings the understanding that reproductive loss is not a “non-event.” It is a very real event that affects not only the millions of women who embody such a loss (Stoyles, 2015) but also their partners, families, and support people who experience the loss alongside them. As noted by Rappaport (1995), everyone can benefit from a community narrative that supports their personal story, especially if their story is being rewritten as is often the case when someone experiences reproductive loss. For those listening to a community narrative, it is a way to understand the effects of a shared experience on individual lives (Rappaport, 2000). Storytellers and storylisteners collaborate to construct community narratives for personal and social change (Rappaport, 2000). By adding to the creation of a community narrative, all those affected by reproductive loss help empower each other to challenge the status quo. The shared experience expressed through community narrative likely gives others confidence to join the experiential process because they are no longer silenced, stigmatized, shamed, or judged for wanting to talk about their loss.

Rappaport (1995) noted that the goals of empowerment are recognized when individuals create a collective narrative that supports their personal stories. Thus, creating a community narrative about reproductive loss that acknowledges the shared, yet unique, experience enhances empowerment. Working together to assist each other in sharing stories, both individually and collectively, is part of the process of empowerment development (Rappaport, 1995). Creating this community narrative is especially important for potentially traumatic reproductive loss narratives because as Rappaport (2000) claimed, “*It is possible to turn tales of terror to tales of joy, but it is much easier to do this, perhaps even necessary to sustain it, as part of a community, rather than as a lone individual*” (p. 7). As Elyse noted, she wondered how her experience would have been different if she had the community she needed. Thus, community narratives provide the opportunity to enhance personal agency, resilience, and sense-making, which empowers narrative participants. For example, telling personal stories and contributing to community narrative fosters narrator agency by connecting people (McClelland, 1975). Creating community narratives is relational in nature, and enacting narrative resilience occurs both individually and relationally (Horstman et al., 2024). Finally, sense-making is often done collaboratively (Epstein & Street, 2011), and therefore, community narratives can aid this process. While previous work has provided tools for those experiencing pregnancy loss to utilize, there may also be external, systemic effects that might take additional support and effort to overcome.

### **Systemic Effects of Reproductive Loss on Family and Community**

Much of the previous research about reproductive loss has centered on the stories of those who have embodied the physical experience of loss (e.g., women’s experiences of miscarriage), and thus, there is limited understanding of the collective experiences and effects of reproductive loss. Although it can affect multiple parties, reproductive loss has traditionally been studied

individually (e.g., Brann, 2019) or sometimes dyadically (e.g., Bute & Brann, 2015; Holman & Horstman, 2019). A more systemic view of the effects of reproductive loss on the family unit in general is needed, including exploring effects on relational dyads, grandparents, and children. In this chapter, we explored the mother-daughter dyad illustrating the complexity of silenced stories. For example, when Bethel called her mother to tell her about her miscarriage, she did not expect to learn that her mother had a similar experience, yet she did. Bethel's willingness to share her story empowered Elyse to also share her own experience, but more than that, it gave Elyse an opportunity to reflect on both her and her daughter's losses. Some scholars have illuminated the experiences of romantic relational partners, including Horstman and colleagues' (2020) study of men's sense-making after miscarriage and Bute and Brann's (2015) dyadic interviews with heterosexual couples who had coped with miscarriage. This work exposed that men's stories have revealed not only their deep grieving after reproductive loss, but also their desire to be strong for their partners, which can result in men feeling that their stories are ignored, neglected, or less important than their partners' and that their communication with their partners must be supportive in nature. This silencing of men's stories speaks clearly to the need for their community narrative to counter the dominant narrative of reproductive loss being a "non-event" or the mixed message that it may be an event, but it is a "woman's issue," and a man's role is only to support his partner instead of tending to his own grief.

Similarly, grandparents (i.e., parents of adult children who experienced loss) have reported hiding their emotions to protect their adult children from further pain while simultaneously grieving the loss of potential grandchildren (Lockton et al., 2023). In the opening narrative, for example, Elyse "fought back tears" as she comforted her daughter. Lockton and colleagues' analysis is one of the few studies that includes family stories captured decades after a

loss occurred and suggests that the effects of loss on family members are ongoing. As such, they draw attention to the need for narrative research that investigates the long-term effects of reproductive loss on the family unit. In the opening narrative, Elyse reiterated that Bethel was not at fault for her miscarriage, and it was clear that she spoke those words to provide comfort and understanding for both her daughter and herself – for both the loss of her child 30 years earlier and this new loss of a grandchild. Scholars should consider methodological approaches that allow for deeper understanding of how stories evolve over time as a way of uncovering the prolonged effects of reproductive loss on family units. If intergenerational storytelling is encouraged, multiple participants may benefit through the sharing of their experiences. In fact, this intergenerational storytelling is important not just for grandparents but also other children in the family. Children are often aware of the impending addition of a sibling to the family, yet little is known about the stories of children coping with the death of a sibling due to reproductive loss, even though research suggests that bereaved siblings can experience intense and complicated grief (Tillof et al., 2024). The intergenerational sharing of stories empowers family members to develop a community narrative that benefits support persons.

Understanding the systemic family effects of reproductive loss must also be studied in minoritized families whose voices have often been marginalized in the extant literature. As Lacci-Reilly and colleagues (2024) noted in their scoping review of miscarriage and healthcare communication, “existing studies are composed mainly of non-Hispanic white, highly educated participants who were trying to conceive” (p. 6). The current literature on narrative approaches is no exception and is largely characterized by heteronormative assumptions that overlook the stories of LGBTQ+ families (e.g., Peel & Cain, 2016). Moreover, most studies are based on homogenous samples that do not account for the ways that reproductive loss can be shaped by

race-based healthcare disparities and health outcomes (e.g., Evans et al., 2023) as well as cultural and religious beliefs and traditions. Health communication scholars must attend to these neglected stories and consider critical approaches, such as critical race theory (Evans et al., 2023), to offer a fuller picture of the potential for narratives as sites of empowerment after the trauma of reproductive loss.

While the majority of research has been focused on individuals and their family relationships, other communities may be involved in the systemic effects of this loss. There are many implications for experiencing the dominant narrative disruption of reproductive loss as an individual, couple, family, and system at large. With consideration to the previous literature, we pose that narratives, both individual and community narratives, can be used to empower marginalized, silenced, or struggling populations, such as those experiencing perinatal loss, to share their voice to heal. To do so, individuals need to feel confident sharing their stories, others need to know how to encourage those stories, and all need to work together to co-construct the community narrative of reproductive loss.

### **Empowerment in Action**

Focusing on the role of narrative as empowerment in individual and community stories can provide practical tips for overcoming barriers related to reproductive loss. As noted throughout this chapter, narratives and storytelling of loss function as a way to process complex emotions, establish identities, and empower individuals to make sense of their – and others' – loss. Additionally, when individuals share their stories of loss it may reduce the silence, shame, and stigma that often accompanies reproductive loss (Brann, 2011) and create space for voices that are often silenced due to race, culture, gender, and/or (dis)embodied experiences for future generations.

Although patterns exist in stories of reproductive loss, everyone has their own experience with loss and how they grieve, so each person's approach to narrative should fit with their own personality, needs, and comfort level. Still, assessing narrative as a tool of empowerment can lead to general practical tips while honoring people's stories; thus, we offer evidence-based recommendations for both storytellers and storylisteners to encourage the sharing of stories. For example, when people ask, "What should I say to a friend who is dealing with infertility?" or "How do I talk to children about sibling loss?" or "How do I best support my partner who had a miscarriage?", those who have been privy to community narratives can share past stories to comfort and provide advice. To help mitigate some of the challenges discussed and to provide a starting point that can be tailored based on each circumstance, we offer several suggestions for both the storyteller (e.g., anyone who has been touched by reproductive loss) and the storylistener (e.g., support persons, health practitioners, interventionists) to empower them to engage with narratives of reproductive loss in a meaningful way. We provide detailed suggestions in the next sections and an infographic for easy-to-access information.

### ***Empowering the Storyteller***

Although there may be socio-cultural scripts for experiencing pregnancy, storytellers must remember that there is no one "right script" for pregnancy loss or even for "normal" or healthy grief, and the timeline for grieving, healing, and sharing their story varies as was evidenced by Bethel sharing her story in the midst of her loss and Elyse waiting 30 years to share hers for the first time. It is important that storytellers, and others, know that they are the ones in control of their story, that their experience matters, and while it often takes vulnerability to share about reproductive loss with others, it may also allow them to feel less alone and even connect to a community of support and empathy (Palmer-Wackerly & Krieger, 2015). The following

evidence-based suggestions for storytelling are offered to empower individuals to share their story.

First, storytellers should *tell their story when and how they want*. For example, it is normal for storytellers to want to maintain some privacy as the owner of their story (Jackl, 2022), much like Elyse did by waiting for 30 years before sharing her story, and storytellers should feel comfortable sharing their story or parts of their story, which may evolve over time, when ready. Elyse encouraged Bethel to share her story when she was ready by stating that she was willing to listen any time she needed. When deciding how to tell the story, it is also important to recognize that stories of disruption may not have a clear beginning, middle, and end, but they are still important and meaningful to share. Telling messy, often emotional stories, may help storytellers (and others) make sense of the loss and grief (Frank, 2013; Koenig Kellas, 2018). Through the sharing of their stories, Bethel and Elyse began to make sense of their losses. Finally, sharing stories can be done through multiple different outlets, and storytellers should decide how to express their stories in ways that feel best for them. It does not have to be through traditional oral communication methods but instead could be through journaling, remembrance drawings, poems, lyrics, or other creative art (see, for example, Willer et al., 2018).

Second, it is important for storytellers to *find a “safe” person or outlet* to share their stories. As previously noted, individuals often feel vulnerable when sharing their reproductive loss story. This can be because social support messages from others, while from well-intentioned places of caring, can serve to invalidate an individual’s reproductive loss experience (Meyer, 2016). Therefore, it is important to find a person who will offer social support that honors the story and engages in empathetic communication and active listening as well as respects the storyteller’s boundaries. Bethel believed her mother to be a “safe” confidant and trusted that she

would support her, which is why she chose to share her story with her, and Elyse provided that support by listening and asking questions, for example. Although not the only audience for storytellers, individuals who have similar experiences surrounding reproductive loss may be a safe community to listen and provide desired support.

Third, storytellers need to *embrace their story*. This involves recognizing that although two reproductive loss stories may be similar, they do not have to be the same. For example, one's story of loss may vary from others they have read online, heard from friends, or was told by their partner experiencing the same loss. It is important to acknowledge that although there may be evident patterns in stories of reproductive loss, these stories do not need to sound identical. Storytellers can benefit from telling their own story and should not worry about feeling like it needs to be the same as someone else's, even someone who experienced the same loss. Although both Bethel and Elyse experienced a miscarriage and may have felt dismissed, at least initially, their stories are unique in terms of what happened, where and when it occurred, and how and when they chose to share their stories. Previous research (Holman & Horstman, 2019) has shown that romantic partners benefit when telling their own stories and not feeling pressure to have the exact same story as their partner who embodied the loss. Embracing one's own story and validating that each other has a personal, yet shared, experience while coping with the emotions together can help build community narrative.

This leads to our fourth and final suggestion, which is for storytellers to *develop a community of stories*. By sharing original stories of shared experiences, storytellers build a community narrative, which was exactly what Bethel and Elyse did. This community can be built through telling stories to members in one's personal network, sharing experiences in support groups, or even communicating about reproductive loss on social network sites. The

development of a community narrative is particularly important for reproductive loss to counter the existing dominant narrative of loss not mattering, much like Brown and colleagues (2019) were able to do with countering the stigmatized dominant narrative of mental health focusing only on violence or deranged behaviors. Not only is it empowering to share one's own story, but by contributing to a community narrative about reproductive loss, storytellers are also empowering others to add to that narrative to reduce silence and stigma and to educate others about how reproductive loss is a very real event that affects many people.

### ***Empowering the Storylistener***

Narrative is empowering not just for those who tell their stories but also for those who listen and support the storytellers (Rappaport, 1995). By actively participating in the narrative construction through storylistening, the storyteller and the community narrative are validated. To encourage the empowering of storytellers, we provide the following suggestions to empower storylisteners. However, with the systemic effects of reproductive loss, it is important to remember that the storylistener may be experiencing their own grief (e.g., Bute & Brann, 2015) like Elyse was when she heard Bethel's story. Therefore, although the following recommendations provide an ideal guide for storylistening, the listener should also take into account their own capacity and emotional state before, during, and after this process.

First, it is imperative that storylisteners *listen actively and with empathy*. Active listening involves not only paying attention to what the storyteller is saying but also responding by providing appropriate feedback that is free of judgment (see Weger et al., 2014). During this process, storylisteners should listen to understand others' experiences; ask open-ended questions if appropriate; and refrain from passing judgement, offering unsolicited advice, or making an individual feel guilty or responsible for their loss. After Elyse first heard Bethel's story of loss,

she immediately reaffirmed that Bethel was not at fault so that she would not feel guilty or judged and then went on to ask open-ended questions to help her daughter process her story. In essence, storylisteners should show empathy instead of sympathy to the storyteller. This can be done through nonverbal (e.g., hug, head nod, sitting next to them) or verbal communication. Renowned narrative therapist Micheal White (2007) suggests individuals are multi-storied and thus, storylisteners should always listen for the subordinate stories, or stories where the person's underlining values, hopes, dreams, and fears may emerge.

Listening for these stories is helpful for our second suggestion for storylisteners:

*Acknowledge storytellers' loss and validate their feelings.* By recognizing the significance of the storyteller's loss and emotions, listeners validate experiences. When doing this, one should avoid downplaying, minimizing, or dismissing the storyteller's experiences, which is disempowering. Phrases such as "It just wasn't your time;" "Good thing it happened now before it was a real baby," or "You're so much better off," while may be communicated in an attempt to be supportive, only create harm and should be avoided (Meyer, 2016), which was what Elyse experienced 30 years earlier when the doctor stated that "at least now she knew she could get pregnant" and that "God had other plans for her baby." Instead, storylisteners should validate the emotions storytellers are feeling so they know that they are not so alone in them. This could be done by simply saying something like "I don't even know what to say right now, but I'm so glad you told me," "I can understand why you feel this way," "This must be really hard," or "I'm here for you." Elyse acknowledged and validated Bethel's loss by listening to her and letting her know that she not only understood but that she was also there for her daughter on her terms.

Our third recommendation is to *engage in communicated perspective taking*. Employing strategies that demonstrate understanding of a relational partner's point of view is a process

identified in CNSM as perspective-taking (Schröder-Abé & Schütz, 2011) and is crucial during times of stress (Koenig Kellas et al., 2013). For example, as noted by Horstman and colleagues (Horstman et al., 2021; Horstman & Holman, 2017), findings on CPT have demonstrated the need for both miscarrying and non-miscarrying relational partners to consider their partner's perspective after a miscarriage as it affects both affect and relational satisfaction. This amplifies the importance of understanding reproductive loss as a relational – not an individual – issue, which makes CPT even more important for understanding and support. By asking Bethel how she was doing or Elyse if she wanted to share, the mother and daughter were offering support and demonstrating care that is important for positive relational outcomes. Previous research (Koenig Kellas et al., 2021) has also demonstrated a positive relationship between CPT and the storylisteners' communication behaviors including validating partner identity and affective tone.

Finally, storylisteners should always *respect storytellers' privacy, autonomy, and grief process*. It is important to understand that everyone's privacy and grief process may differ, which affects how, when, and what they share (Basinger et al., 2016). Storylisteners should allow storytellers to tell their stories in their own time, much like how Elyse told Bethel to share only when she was ready and Bethel asked Elyse if she would be comfortable sharing. It is also important to note that the grief process is not linear, and individuals experience aspects of grief at different times and in no particular order. One way to honor the grief process is by acknowledging anniversaries or due dates through a simple text, card, or in-person conversation as these can be particularly challenging for individuals and families who have experienced reproductive loss. This may be just what they need to feel empowered to share their story during a time that many people often overlook.

## Conclusion

Our argument for narrative as empowerment, especially within health contexts like reproductive loss, can extend narrative theorizing. Within the context of CNSM, interactional storytelling (both with those in their community and those outside the experience of loss) can empower individuals to make sense of their loss. All those involved in reproductive loss (e.g., patients, partners, family members, support persons, health care providers) can benefit from sharing stories. By telling stories and then listening to the voices of the people who share their stories, participants can learn “what it means to be empowered in their particular context” (Rappaport, 1995, p. 799); therefore, it is important to be sensitive to such voices.

Storytelling, and storylistening, rooted in narrative theories, perspective-taking, supportive communication, and empathy may be a powerful tool to help individuals cope and empower them to connect with others following reproductive loss to build community narratives. In fact, community narratives that are empowering are a useful strategy for promoting well-being for all involved in the narrative process because they raise awareness of critical challenges (e.g., silenced reproductive loss concerns) (Brown et al., 2019). Constructing, sharing, and listening to narratives may be used in various practical ways to support individuals and families who have experienced reproductive loss as well as provide guidance for individuals (e.g., partners, family members, friends, health care providers) who bear witness to these stories. It is through narrative that all these individuals can be empowered to overcome some of the barriers and challenges related to reproductive loss and be able to write the next chapter of their lives.

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## LET'S TALK MORE ABOUT REPRODUCTIVE LOSS

Reproductive loss commonly refers to experiences of miscarriage, stillbirth, infertility, abortion, and more broadly to the loss of 'expected' reproductive experiences.

Sharing narratives about reproductive loss can empower individuals, families, and communities to cope, communicate, and connect.

It's important to tell reproductive loss stories to grieve, educate, receive support, and reduce social stigma.



### Tips for Empowering Stories of Reproductive Loss:

#### Empowering the Storyteller

- 1 Tell your story when and how you want:** It's your story to tell so when you decide to share your story, it's okay if it feels disorganized or "messy." That's often part of the grief process. You can share your story when you want in any way you want such as journaling, writing poems or lyrics, or creating art.
- 2 Find a "safe" person or outlet to share your story:** When you are ready to share your story, it is important to find individuals or outlets that honor your story. Look for someone who is empathetic, listens, and respects your boundaries.
- 3 Embrace your story:** Recognize that no two reproductive loss stories are exactly the same. Your experience is valid and real. While other stories shared within your community may differ from yours, you can still express your emotions, create shared understanding, and cope together.
- 4 Develop a community of stories:** By sharing your story, you build a community narrative with others who have similar experiences. This is empowering for you and for others. This process can reduce silence and stigma and educate others about how reproductive loss is a very real event that affects many people.

#### Empowering the Storylistener

- 1 Listen actively and with empathy:** Empathy is feeling *with* others. You can listen actively and with empathy nonverbally (hugs, head nods, sitting close) and verbally. Refrain from passing judgement and sharing unsolicited advice, or making an individual feel guilty or responsible for their loss.
- 2 Acknowledge storyteller's loss and validate their feelings:** You can validate another's experiences by recognizing the significance of their loss. Saying something like "this must be really hard" or "I'm here for you" can mean a lot to someone going through a loss.
- 3 Engage in communicative perspective-taking:** It is important to consider another's point of view, especially during times of difficulty and stress. One way to do this is to engage in communicated perspective taking, where you "put yourself in their shoes." This communicates that you see their perspective, care about their story, and are doing your best to understand.
- 4 Always respect storyteller's privacy, autonomy, and grief process:** The grief process is not linear, but you can show your respect by being available when they are ready to share. Consider honoring their grief process by acknowledging anniversaries or important dates with a text, card, or in-person conversation because these days can be particularly difficult.



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### Footnotes

<sup>1</sup>This composite narrative is based on the actual experiences of women who have graciously shared their miscarriage stories with us in multiple research studies.

<sup>2</sup>Although previous research may elect to use the term “master narrative,” we have chosen to use “dominant narrative” to call attention to the sexist and oppressive language the former may evoke. Especially when referencing women’s reproductive health, which has a long history of repressive acts, we challenge the dominant narrative that has been perpetuated by those in authority for centuries, namely privileged White men.