

Meredith Grey and Me: A Nested Autoethnography of Miscarriage

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ABSTRACT

The present study details an autoethnography of miscarriage, the author's personal experience nested within the mediated pregnancy loss story of Meredith Grey in the long running television series, Grey's Anatomy. Through the lens of Burke's framework of equipment for life, various themes emerge surrounding miscarriage communication and experience through several roles in personal and professional circles. The linear and complex timeline of these roles in pregnancy and pregnancy loss factor into the influence of varied life equipment garnered within different stages of womanhood and within various dichotomies in relationships and experiences in this health context. Implications for patient-centeredness and miscarriage communication and experience, as well as the employment of Burke's concept of life equipment in health settings, are detailed. Meredith's mediated story of miscarriage provides cultural equipment that aids in better understanding and defining the author's lived loss experience. This work may aid in exploring autoethnographic, media-based analysis and offer others another script or story in pregnancy loss. Further, it may offer an expanded way to employ Burke's concept in health settings.

KEYWORDS: Autoethnography, Burke, equipment for life, miscarriage, illness narratives, media

I wake up to a new day, relatively easy, giving exams, meetings. It's early, before I have to wake for the day, so I tap my alarm and head to the bathroom. I see blood. A small amount. I didn't bleed at all in my first pregnancy. I dismiss it as spotting—it's normal. This pregnancy is different. All pregnancies are different. I get ready for work, grab some extra pantliners for my purse. I drive to work, drink coffee from my travel mug, and feel normal.

Later that morning, I give an exam in research methods. After I answer a question about sampling, I feel some wetness and leave for the restroom down the hall. I see that there are small clumps in the blood and one is the size and shape of a kidney bean. I remember, with a mix of dread and denial, from one of the numerous pregnancy books I pored over during my first pregnancy, that the fetus is often compared to various fruits and vegetables to offer an approximation of size over various stages of development. A kidney bean approximated size at 10-12 weeks, the then length of my pregnancy.

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That morning was several years ago, and I, like many patients, stepped onto a stage “without a script” (duPre, 2010, p. 71) as I had a miscarriage, the loss of a pregnancy before 20 weeks’ gestation (Walker & Walker, 2015; Curtis, Linares, & Antonewicz, 2014). The experience I was having then would shape and would be shaped by my experiences as a daughter, mother, and woman. Personal health narratives, as well as media, have the power to offer experience and guidance to others in various stages of illness and health (duPre & Overton, 2021; Tompkins, 1979; Gerbner, Gross, & Signorielli, 1984; Murphy, Hether, & Rideout, 2009; Kaiser Family Foundation & Pew Center, 2009; Singhal & Rogers, 1999; Wright, Sparks, & O’Hair, 2009).

Silverman (2015) suggests that mediated health presentations may be used in consciousness raising support groups to share personal stories via viewing and discussion of fictional ones. This insight began my autoethnographic examination of my experience in part through the lens of a fictional miscarriage story, specifically that of Meredith Grey, the titular character in the series, *Grey’s Anatomy*. This is a first step in testing Silverman’s suggestion in a small way, sharing and better understanding my story, and the stories of other pregnancy losses, as Charon (2006) has eloquently stated, to help others “share their stories and escape dominion by them.” Through autoethnographic analysis guided by Burke’s (1973) concept of “equipment for living,” I examine my own story as I take in Meredith’s, as a bridge to connect my story with themes that may be resonant with the cultural experience of pregnancy loss. Burke notes that we think in universals and feel in particulars (1968). Our life equipment, our particulars that we may or may not assume are universals, may influence and inform our roles as women, our experiences and view of motherhood and miscarriage, along with public and private stories and discourse. *Grey’s Anatomy* as a text (a series in its 21st season on network television, and streaming in its entirety) (IMDB, 2025) is “equipment for living” seen by many and a fruitful space for connection to personal and cultural meaning.

The analysis here details dialectical tensions, opposing but coexisting dichotomies in relationships and communication experiences (Montgomery & Baxter, 1998; Foster, 2005), involved in pregnancy/miscarriage and in various roles as women (linear/nonlinear, open/closed, mediated/personal, public/private, choice/no choice, control/lack of control, hope/realism, certainty/uncertainty); these tensions are shaped by equipment for living examined to fully understand these experiences, as well as to have agency, to expand the cultural narrative, the universals from the particulars, in miscarriage experiences. This examination also is a dialectical tension of the mediated and the interpersonal. It is an act of sense making and reappraisal of a stressful health experience that may lead to lesser stress and more positive peace (Lazarus & Folkman, 1984).

Meredith’s mediated story of miscarriage provides cultural equipment that helps me to better understand and define my lived loss experience. This work may aid in exploring autoethnographic, media-based analysis and offer others another script or story in pregnancy loss. Further, it may offer an expanded way to employ Burke’s concept in health settings.

Literature Review

Health Presentations in Media: Women’s Health

Entertainment media may change behavior, attitudes, or knowledge (duPre & Overton, 2021; Wright, Sparks, & O’Hair, 2009; Gerbner et al., 1984; Singhal & Rogers, 1999). Some research suggests that TV specifically minimizes harmful health behaviors (Kaiser Family Foundation & Pew Center, 2009; Kinslera, et al., 2019) or promotes myths (Foss, 2013; Moyer-Guse, Woods, Rader, & Tran, 2020), but other work has revealed more positive portrayals such as

in patient–provider communication and social support (Arrington & Goodier, 2004; Gray, 2007; Jain & Slater, 2013; Hoffman et al., 2020; Rideout, 2008; Ye & Ward, 2010). The genre also arguably contributes to the portrayal of miscarriage (Gerbner et al., 1984; Silverman, 2015).

Women’s Stories of Miscarriage and Burke’s Equipment for Living

Silverman (2015) discusses several instances of televised portrayals of miscarriage, including that of Meredith Grey, in her call to utilize such mediated stories. In the same volume, Silverman & Baglia (2015) argue that there is a dearth of stories about communication in miscarriage, particularly what is most supportive, and to begin to fill this void, several stories of loss are featured, including those discussing time constructions (Meyer, 2015) and the father’s role (Walker & Walker, 2015) in miscarriage. As an answer to both calls, I attempt here to analyze my own experience with miscarriage in conjunction with that of the fictional Meredith. I aim to fill a gap in stories of miscarriage, gauge themes that resonate through the combined approach of analyzing the personal with the mediated and explicate how Burke’s concept of equipment for living may guide in sensemaking in health contexts such as pregnancy loss.

Burke’s (1951; 1973) concept of equipment for living guides this exploration. His sociological criticism characterizes literature and language as such equipment; humans create and recall phrases, strategies, tropes, and situations as need arises. Having “a name for it” helps us to understand and shape our worlds with a sense of order (Burke, 1973, p. 293). Our equipment helps to shape our experience, provides choices to be made, contributes to our worldviews, provides attitudes toward the world, helps us to solve problems, offers us comfort, and shapes our ways of living and relating to others. Brummett (1984) modified Burke’s concept to discourse, allowing an extension into media (Burke, 1973; 1951).

Life equipment may be phrases, strategies, stories, and other concepts from media or personal experience that become prominent pieces of sensemaking in our life experiences. These offer a social or practical function or may shape our identities and communication within various areas of life, including our health. Media about health and interactions we have with others about health may offer not only entertainment or socialization, but also suggest attitudes and frameworks for navigating communication, provide insights, and offer paths of action within health experiences. Prominent and recurring patterns of related concepts and ideas that appear to influence identity and communication within the miscarriage experiences of both me and Meredith (our parallel equipment for living) were analyzed in the present work.

Also, in another sense, media-based equipment for living serves as a kind of cue to action, as posed by the Health Belief Model (Janz & Becker, 1984; Skinner, Tiro, & Champion, 2015) and a kind of mediated form of support; it can be a reminder of other parts of a personal story that aid in sensemaking. We may compare equipment to our own stories and explicate and appraise our experiences further. Media-based and other discursive ideas and concepts (equipment) shape interpersonal interaction and our ideas. Catharsis and validation, as well as reduced stress, also may come in awareness of other stories (Charon, 2006; Holt-Lunstad & Ucino, 2015; Lazarus & Folkman, 1984).

This framework goes hand in hand with the idea that autoethnography is analysis of personal experience situated in (and influential on) the larger culture of media (which are part of equipment for living), literature, and extant research. More than one idea or point of view (my experience, media experience, others’ experiences) can lead to rhetoric, ideas, and perspectives that transcend the individual ones, becoming part of the cultural narrative. Ideas may remain unknown and silent if we are not made aware through stories, mediated and interpersonal (Burke, 1973;

1951). Though life equipment has been conceptually employed in some work (i.e., Foster, 2005), it is not extensively utilized in health communication contexts.

Given the literature above, the following research question is posed: What themes surrounding life equipment in miscarriage communication and experience may be garnered from an autoethnographic analysis of mediated and personal pregnancy loss?

Method

My nested media and interpersonal project is rooted in autoethnography, an analysis of researchers' personal experiences (Porter, 2004; Ronai, 1992; Tillman, 2009) to explore larger phenomena (Ellis, 1991; Hollman-Jones, 2005; Rambo, 2005; Spry, 2001; Ellis et al., 2011). A researcher examines unique life experiences considering social and cultural institutions as well as extant research, concepts, and theory (Andrzejewski, Forbes, & Hogan, 2026; Jones et al., 2013; Raab, 2013; Sell-Smith & Lax, 2013). Ellis (1991) suggests that the method allows researchers to reflexively examine the many layers of experience. I took steps to carefully code my experience in viewing Meredith's story with my personal story in mind (Andrzejewski, Forbes, & Hogan, 2026).

"I systematically storied and explored my lived experience" with miscarriage (Tillman, 2009, p. 100) reading notes and writing from memory in the present and then exploring my past notes and journal entries from my pregnancies and miscarriage. I used these themes to reflect on the past. I took note of several prominent, recurring concepts that seemed to shape my understanding and experience of my miscarriage, and these appeared to be related to my roles as a woman (mother, daughter, professional, wife, etc.). As a viewer of the series, I recalled Meredith's repeated use of the term "hostile uterus" and how that influenced her pregnancy and miscarriage communication and experiences and began to consider how my pregnancy and loss experiences may have parallel influential conceptual "equipment." These ideas were the beginnings of a coding scheme of life equipment within various female roles in the context of miscarriage.

With my recollections in mind, I began to explore the miscarriage storyline of Meredith Grey (in the season finale of the sixth season, as well as the first and second episodes of the seventh season) in *Grey's Anatomy*. I took notes through repeated viewings of the noted episodes as connected to my own miscarriage story. As I noticed a prominent concept (equipment) that was influential in shaping a particular role within Meredith's mediated miscarriage story, I would note connections between my current and past notes for parallel frequently influential ideas (equipment). Again, as a viewer of the series in general, when I would recall other scenes in the series that related to the life equipment concept, I would review that scene content via the Internet Movie Database (IMDB) to assure accuracy in recall. A pattern of dichotomies within these various roles and equipment also appeared to emerge within the parallel stories. I analyzed my transcribed notes to sort the identified themes into groups (Sharf and Friemuth, 1993), as threads between the televised and personal stories. I applied the coding scheme until I felt that the most important elements of both stories were well represented, achieving narrative completeness and cohesion, frequently examining my own past and current notes and journal entries for biases, and examining notes/journal entries and the *Grey's* episodes again after coding. I viewed these coded connections as equipment for living, manifested as concepts/strategies/ways in which I could further understand and contextualize my own experience, particularly within various potential roles and identities of women.

Analysis and Discussion

Various equipment for living, useful and burdensome, constitutes parts of Meredith and me. The analysis process led to dividing up our mutual stories into our parallel roles as well as pieces of equipment for living that shaped the pregnancy loss experiences, exhibiting several dichotomies within. Meredith's story offers reminders of mine that aid in sensemaking. In this analysis, equipment for living in Meredith's and my experiences are reflected upon through multiple identities, navigating the text of these episodes as well as my own experience as broader social significance.

The analysis here details dialectical tensions involved in the experience of pregnancy/miscarriage and in various roles: linear/nonlinear, open/closed, mediated/personal, public/private, choice/no choice, control/lack of control, hope/realism, certainty/uncertainty. These dual processes are shaped by equipment for living. In each section, I detail the specific theme of both Meredith's and my corresponding life equipment within a parallel role, explicating a particular dichotomy within, focusing on the function of the parallel life equipment in shaping and making sense of our stories.

Mother as Daughter Woman (Linear/Nonlinear): Meredith- "Amazing Surgeon", Me- "Amazing Mother"

Meredith Grey and I were both daughters before we became mothers; specific conceptualizations of our mothers have shaped our identities as mothers, which in turn shapes our communication, decisions, and behavior in our pregnancies and miscarriages. For Meredith, her mother, an "amazing surgeon," was a presence in her life and in her idea that she had very little knowledge of what a good mother should be. For me, my mother, an "amazing mother," is a strong example of a "good" mother, and my idea of what kind of mother I could be. These pieces of life equipment shape our stories in the present in linear ways, in that our experiences in miscarriage and pregnancy are indeed linear timelines, but the presence of past ideas of mothering from our own childhoods hover in a nonlinear manner. I begin considering these timelines as I enter Meredith's story:

"While it's quiet, my daughters are in school, my husband is teaching, and I'm working from home for the day, I navigate over to Netflix and click on *Grey's Anatomy*. Meredith and Derek have exited the doctor's office, and she is talking about her lack of a maternal example. Her mother is a large figure in the series, even though the actress portraying her isn't on screen a great deal. The predominant association the character seems to have is "amazing surgeon." This is her story and the story, or equipment, Meredith takes with her on her journey to being a mother herself".

Meredith's mother had a storied medical career; she was noted in the series to be a "terrible" mother, but an "amazing surgeon." These concepts are so palpable for Meredith that they are practically pieces of medical equipment she carries with her through the series. Viewers regularly see Meredith's deceased mother and incidents from her childhood in flashbacks. Her mother's professional accolades hover over Meredith's own career. Her mothering does as well. Richard, then chief of surgery, who was very close to (and later is found to have had a child with) Meredith's mother, remarks on how it pained him that no one paid attention to Meredith, "this beautiful, intelligent child." From small incidents like not understanding basic bathroom etiquette like cleaning a sink after brushing one's teeth (She is surprised to learn "every time!" and her close friend, Christina Yang [her "person"] remarks that it isn't "her fault" as "no one raised" her.), to

the very serious incident in which she as a child saves her mother from a suicide attempt, Meredith's relationship with her mother is best described as a child who worshipped her mother but did not really know her. She wasn't sure she could be a mother given her career aspirations and model of her own mother. She then feels like she wants to be everything her mother was as a surgeon but also much more than she was as a mother.

Pregnancy is linear in medical terms but is not linear as well, as eloquently stated by Meyer (2015); for example, mothers are given milestones and stages in pregnancy, though previous pregnancy experiences are also hovering during these prescribed medical stages. In addition, mothers of mothers may shape the understanding of pregnancies and miscarriages and parenting in the present with their actions and personhood from the past. Her mother's neglect, career focus, and unhappiness shaped her understanding of her ability to mother, but also her goal of being an amazing mother and surgeon. Meredith was doubtful of her ability to parent, colored by her maternal history, but also, she was cautiously hopeful for another outcome.

I think about my own mother. Mom hasn't had a career and is an "amazing mother," unlike Meredith's. She is incredibly intelligent, creative, and gifted, with extraordinary executive function skills. My dad always says that she could run a Fortune 500 company. She went to a two-year nursing program out of high school but ultimately decided not to finish as she wasn't sure she wanted to pursue the profession any longer. She told me that she "didn't want people's lives in" her "hands." I think about how young she was when she had children; she was 21 years old when she had me, and my siblings were born soon after. She had a couple of part-time jobs after we all had started high school but was largely a stay-at-home mom. She read to us, spearheaded art projects, headed up little trips to flea markets, and picnics at the park. I remember eating McDonald's hotcakes at picnic tables and then going up and down on the swing sets. I'm very close to my mother and though I did not always see myself this way, after I had my first child and she saw me caring for her in my fledgling state, termed me "a natural." I remember how affirming this felt.

From my family, I had a model of motherhood though not a model of how to navigate academia. As in Meredith's experience, time is linear with development of the body during pregnancy, but the past also shapes that present development and the present end of a pregnancy (Meyer, 2015). I had a model of motherhood as well as support from my mother as I had children of my own.

Like many women, I struggle with balancing the personal and professional areas of my life (Shelling & Silverman, 2015) and have found that I need to let go of some things in each area to be better at one or the other; my example of "amazing motherhood," I realize is part of my equipment for life, in that it has served me well but it also may lead me to different and possibly unrealistic expectations given that I have very different, and potentially many more, roles in my life than my mother had while raising her children.

I recall when Mom had her hysterectomy when I was a kid and I didn't understand it, as I knew she didn't want more children. The grief over the death of the possibility of children was the thing. I feel like it must have been much like people saying things like, "You can try again" after a miscarriage. I don't think you can understand unless you experience it yourself or vicariously through narratives.

My mother felt a loss over the possibility of more children even though she and my father did not plan on having any more; I feel like this helped her understand my experience somewhat

given the potential or idea of a child. If I had talked with my mother more about her experience, I may have been able to help her process that loss, better understood my own, and been able to better support other women experiencing these kinds of losses.

Sharing stories and making sense of health experiences (Charon, 2006) may help the past to more positively shape the present (Meyer, 2015). Part of that understanding is the life equipment that contributes to identity in pregnancy, pregnancy loss, motherhood, and professional life. The female role of Mother as Daughter Woman, in both my personal story and that of Meredith Grey, are shaped by our life equipment, the conceptualizations of our own mothers, that influence our present and our past experiences in the linear and nonlinear timeline of pregnancy and pregnancy loss.

Professional Woman (Open/Closed, Linear/Nonlinear): Meredith- “Beautiful, Incredible Mind... He’s Not the Sun–You Are”, Me- “She Doesn’t Know How Intelligent She Is”

Meredith and I are professional women, her a medical doctor, and me a doctor of philosophy and teacher-scholar. Our senses of competency, intelligence, and control in work are informed by past models and present relationships (linear and nonlinear pieces of our narratives). These pieces of equipment also inform our ideas of ourselves as healthy pregnant women and mothers as well as how open or closed we are about these parts of ourselves at work. Such decision-making influences our pregnancies and miscarriages:

“Meredith is at work. She’s more confident here. But, then again, sometimes, she’s not. She’s with Christina, her “person.” I think about when Christina was leaving Seattle, when offered a dream position outside of the country; she tells Meredith that she has a “beautiful, incredible mind.” She further tells her that her longtime significant other, and later husband, Derek (early in the series run, nicknamed, “McDreamy”) “is very dreamy, but he is not the sun–you are.”

Meredith is a gifted surgeon, successful in the realm of career, though she often feels a comparison to her legendary surgeon mother. She did not initially wish to pursue medicine, given a desire to step outside of her mother’s shadow, both professionally and personally. Her later desire to begin her medical pathway and these shadows lead to sometimes insecurity on Meredith’s part, a doubt of her abilities and judgment, even in the face of success. Her upbringing colors her perception of herself–she is the “sun”, but she doesn’t know it, because she was not treated as such by her mother. She compares herself to her mother, and, to her love interest, Derek, the latter particularly in his confidence in decision making. She is sometimes reminded of her “worth” through the supportive interactions she has with friends, mainly in her professional world of hospital medicine.

Due to her medical training, she knew about miscarriage clinically, including its common nature, and knowledge could make it better or worse. Physicians are often cited as mentioning the common nature of miscarriage (20% of pregnancies end in loss [Curtis, Linares, & Antoniewicz, 2014; Mayo Clinic, 2021]) in delivering bad news in this context (Borrisoff & Merrill, 1998) and may not address patients’ accompanying emotion (Abboud & Liambutong, 2005; Gold, 2007). Women have been shown to be unlikely to receive such information well (Brann, 2015; Laci-Reilly, et al., 2023). Meredith was also doubtful of her judgment in dealing with the emotional aspects of her miscarriage experience. She did not have a typical workplace situation in which she was choosing a procedure for a particular condition. The miscarriage, however, happened at work (during a mass shooting); the first to know was a colleague because she saw it physically happen [blood ran down her legs, as noted by Silverman (2015), a first for TV], then Christina, and then

providers treating her condition with a dilatation and curettage (D&C). Derek, the father, didn't know until later. She has no control, little certainty of her ability as a parent, and doubts her professional capabilities at times. She does not, though, have to explain her loss to most of her colleagues. The miscarriage becomes an obstacle professionally. Having an out-of-control experience at a place where one strives for control is less than desirable; it may have been particularly difficult to disclose (open communicatively) as miscarriage and pregnancy are often taboo workplace topics that muddy the idea of gender neutrality (Norrman-Virgil, 2015). Stories shared are less likely (closed communicatively) due to such taboos, even though they can be helpful to others (Buzzanell & Ellingson, 2005).

Acknowledging the lack of control is part of how she goes back to work. She was forced to be cleared by a counselor before returning. Once she told the counselor, "My husband was shot, I had a miscarriage, and clear me or not, because I can't control any of it," she was again allowed to operate. Meredith's disclosures were under some of her control, however, as she had not shared her pregnancy or miscarriage widely in her workplace. With pregnancy and miscarriage many asymmetrical disclosures at work are likely given the need for leave and other human resources issues (Steimel, 2021).

"She's a highly educated, professional woman. Meredith is successful. She's still doubtful at times. This sounds a little like me. I remember writing my first birth plan and thinking, "I have no idea what I want here," but that I could write up an IRB application with no problem. A few days later, I could run across a professional context where I at first feel I'm at sea".

Though I am educated, have completed a Ph.D., I have come to doubt my intellectual and professional abilities at times but not my work ethic or ability to adapt to varied or new tasks and settings. I grew up with equipment phrasing surrounding me like "she doesn't know how intelligent she is" or "she'll do well wherever she goes" or "she works really hard, but her sister is smarter." I was on the borderline for testing into what were then "gifted and talented" courses in high school. I did not initially think of going into academe, as I had no real perspective on it from my upbringing. I have some doubts still at times about my suitability for the realm I am in, despite indicators of success (Hayes & Locke, 2024), much like Meredith. Laying out lists of small tasks, creativity, organization, critical thinking, and learning help, but I carry those bits of interaction that help me operate. The equipment from my past is carried with me and shapes my roles in the present and future:

"Meredith takes a pregnancy test and sees that it's positive. I think about knowledge and its positives and negatives. She's given test results to patients many times and she carries her personal and professional experiences into her interpretation of this over-the-counter test. Knowledge of the miscarriage possibility was maybe a curse in some ways—for me it could have been just a heavy period if I weren't so aware of the pregnancy. I was trying to get pregnant, and I was confident due to earlier pregnancy ease".

Given my health communication training, knowing could make my health experiences better or worse, such as in expectations of care. My pregnancy had to be dated because my periods were not regular at the time. I wondered if I had just waited on testing until they were regular, and if I had not known and just had a heavy period, perhaps there would have been no pain of telling of my pregnancy and then telling again of the loss (being open versus closed). I wanted to know everything, read everything I could, and took classes to manage my uncertainty and stress in

pregnancy. I had also prepared for workplace issues with leave and other human resources issues, necessitating early disclosures at my university.

My miscarriage happened at work as was the case with Meredith's, in another crisis of a kind for many students, midterm exam time. It happened during class, and I was concerned but still somewhat hopeful. The first to know were likely staff at my doctor's office from my initial call, then my husband, and then our department administrative assistants. I maintained professionalism and control in the office initially. I had been open in my disclosure but still tried to maintain some control:

"I'm in the hallway, after going to the bathroom and knowing what could be going on, but still with a tiny glimmer of hope. Maybe it's normal? I'm talking in a low voice given that classes are going on. After talking to my doctor's office, a nurse said I should come in, that "he [my doctor] would want to see me" when I described my symptoms. He can't see me right away, so I finish up my morning classes, trying not to think about the bleeding and then go to the front office of my department to drop off exams for my afternoon class. I ask one of our administrative assistants to proctor. I must have a tearstained face and be visibly upset. She is concerned and I tell her that I must go to the doctor. She knows I am pregnant. I mention the bleeding and she tells me that she is going to pray right now. I walk to my car, and I let go, crying hard, while driving to the doctor".

My intelligence somehow did not extend to the poor decision to drive myself to the doctor while I was so upset. I was thinking that this "was what needed to be done." I was an in-control professional. I "do well wherever I am."

I went back to work after a week of spring break; I was maintaining some control in revealing my pregnancy, arranging leave early, also because of my confidence in the health of said pregnancy, given a first healthy pregnancy experience. And, I may have tried to maintain some control and order in returning to work so soon. I think I thought about others more than myself in some ways. I thought of time in pregnancy (Meyer, 2015) a certain way; the pregnancy was a cause for leave, and if it was not happening, it was time to go back to work. The viewing of Meredith's "after" helped me see this. Was I ready? Did I have to quickly resolve the order and be professional? Should I have allowed the miscarriage to be an obstacle to returning to work? Did I need to maintain that role ("she'll do well wherever she is" equipment) instead of processing my grief? I remember drafting an email to students and to colleagues that were close so that they would not awkwardly ask me about the pregnancy and then would have to receive the news in person. Over time, I have been able to discuss the loss in person, and in my health communication courses.

In workplace settings, women have been found to find small gestures such as cards and brief acknowledgements of the loss helpful, affirming the loss as real; acting as if the loss did not happen, sometimes a strategy to minimize upset for a co-worker who experienced a miscarriage, can be seen as disaffirming and unhelpful (Steimel, 2021; Cutrona & Russell, 1990). It may be that never revealing the pregnancy or miscarriage at work may have further minimized the loss for my family, as it would be a setting where it was not quite "real." I may have minimized my own grief as well in maintenance of control and my identity in a professional setting.

The role of Professional Woman, for Meredith and me, is influenced by our sense of workplace abilities and our openness is sharing our personal selves in our professional settings. Our senses of professional talent are shaped linearly in present successes but also from past life equipment.

Pregnant Woman (Certainty/Uncertainty, Choice/Lack of Choice): Meredith- “Hostile Uterus”, Me- “Great Set-Up”

Pregnancies are all different, and Meredith’s and mine were dissimilar, partially based on how our bodies were conceptualized by medical providers. Meredith’s took the equipment of a “hostile” body for pregnancy, making her quite uncertain of its continuation to term and a clear understanding of her choice not to disclose her pregnancy. My equipment of a “great” chance of a term pregnancy led to certainty and choice to disclose and then forced disclosure when that certainty was shattered:

Meredith and Christina unknowingly walk into a locked down area of the hospital. This is where the shooter is. Meredith mentions her “hostile uterus,” when the subject of sex and pregnancy comes up. I recall that when Meredith and Derek decided to have children and were having difficulty becoming pregnant, she scheduled a checkup with an obstetrician-gynecologist (OB-GYN). Through this exam, she was told that she had a “hostile uterus,” and thus would likely have trouble becoming pregnant”.

Meredith felt that the odds were against her physically and many times would repeat this phrasing equipment, which greatly shaded her miscarriage, as well as later influenced her choice of adoption. Past health interactions and present perceptions of identity, shaped by our life equipment, may mold current health states, including pregnancy and miscarriage. Meredith is somewhat certain she wants to have a family but is uncertain she can become pregnant or be a good mother. She can choose to try to be a mother, but she really does not have control over whether she becomes one or not:

“Meredith is in the locker room and takes a pregnancy test. She finds that it is positive. She’s in a hurry, so she shoves the test stick in her locker and leaves. Her voiceover notes that this pregnancy may not “happen.”

She estimated the gestation at about 11 weeks, and due to her perception of her reproductive capabilities, she was hesitant to tell anyone. Later that same day, a mass shooter took over the hospital, retaliating against surgeons for the death of his wife. There was little time to tell anyone, even if she had been enthusiastic and hopeful.

Her colleague, April, was with her during the crisis, when she began bleeding from the miscarriage. Her choice to disclose was not a real choice. She had to disclose so April knew that she was not injured from a gunshot. Otherwise, no other co-worker would have known, save Christina, who Meredith told following the miscarriage. Her “hostile uterus” was her choice for blame, in the absence of any concrete cause for the pregnancy loss (Mayo Clinic, 2021; Silverman & Baglia, 2015). She blamed her body, and herself by extension (Goffman, 1963; Sontag, 1978; Curtis, Linares, & Antoniewicz, 2014; Kavanaugh, Trier, & Korzec, 2004). This life equipment from an earlier doctor’s visit was a certainty with which she could make some sense of the loss:

“I remember my first OB-GYN visit for my first child. My doctor tells me more than once that I have a “great set-up.” I came to learn that this means that I was very healthy and my reproductive odds were in favor of pregnancy. I tell him my family history, which also spoke well for genetics, given that my mother had three children, and my two grandmothers had seven and 13 children respectively. Based on my size (I am quite small in stature.), he predicts that I will have a six-pound baby”.

My first pregnancy was extremely healthy and ended with the birth of my oldest daughter. Given my “great set up,” I had a vaginal birth of a healthy, eight-pound baby girl who was “sunny-side up” (a deceptively cheerful medical phrase meaning that the baby is positioned with the skull

and spine against the mother's spine during a long and painful labor) (Mayo Clinic, 2021). This tough and healthful mothering story has become part of my life equipment and identity as mother and woman. My husband and I were certain that our second pregnancy, when our oldest was two years old, would be quite similar. Further, some scholars argue that there is a master birth narrative of an easy, always healthy pregnancy and birth that leads to unrealistic expectations (Horstman, et al., 2017).

Like Meredith, I found out about my next pregnancy with a home test, also in hurried conditions, but at a social event where I was caring for my toddler daughter. We told everyone our news, including friends, family, and colleagues. I began a process of seeking leave from work right away. With my "great set-up," and a healthy daughter, there was no expectation of anything going wrong. I chose to become pregnant again, but I had no real choice of the pregnancy resulting in a healthy child. I was certain of this result, but there was no definite outcome. We were blindsided by the miscarriage and had support from all who we told but also the pain of telling the story repeatedly:

"I think about when I went back to work. It is within a week of my miscarriage and colleagues know; I must tell them because I'd gotten the leave process in motion and we had to reverse all that. My chair had our dean halt the paperwork so I wouldn't have to deal with telling anyone else. A colleague cries with me and we talk about letting my students know via email before I see them again so that they could process it and avoid pain of me having to tell them in person or them asking about the baby or pregnancy and then my having to tell them about the miscarriage; I have a similar experience with a colleague I was working with prior to a meeting. Students write back to me—one calling me brave for talking about it and that this was something she thinks us "female warriors" go through that makes us strong. I think back on this and hope their brush with my experience helps them to support others and themselves in this context".

My healthy first pregnancy and inexperience with miscarriage in the past made for lack of support for others; the support during my own experience led to painful disclosures and the constant wondering of blame.

My doctor told me that there was nothing I could have done to cause the miscarriage, and that my body was "doing what it should do." He noted that there "was something wrong and the body accounted for this." Though some women have found statements like this about the body to be non-affirming (Steimel, 2021), I found it to be somewhat comforting, as "my body" was healthy ("a great set-up") and had carried a healthy pregnancy. Still, I had mixed feelings. Like Meredith, in the absence of a concrete cause, I desired answers. Our doctor was extremely sympathetic and acknowledged our shock and grief, while telling us that I was not the cause. I do not feel self-blame currently, but I did at one time, much more so than I was willing to admit to myself at the time:

"Meredith blames her "hostile uterus" for her miscarriage. Do I blame my body, and by extension, myself? For a long time, I felt like I didn't blame myself; I was sad for the loss and not angry about it. I still feel like the latter is true, but I feel now that I was in denial about self-blame for a lengthy time. With a "great set-up," back then, I was thinking that I must have made some choices that were different than in my first pregnancy. Was it a new fiber supplement? Did my thyroid condition change and lead to these consequences? Just as healthy pregnancy and "toughness" is part of my identity in terms of my health, so now is the miscarriage".

In some ways the miscarriage experience was a kind of tertiary illness identity (a label that defines an illness and our alignment toward it) (Pelters, 2024), but it was also a residual illness experience (an illness experiences that colors other symptoms and conditions) (duPre & Overton, 2023). Pregnancy carries with it a layered and complex web of residual conditions (duPre & Overton, 2023) that influence future pregnancy, pregnancy loss, and parenthood (Lacci-Reilly, et al., 2023; Silverman & Baglia, 2015).

The Pregnant Woman role, in the mediated and personal stories shared here, are shaped by our life equipment, the weight of our body conceptualizations, which in turn shape our decisions of open or closed disclosure of pregnancy, the choices or lack of choice at loss disclosure, and the illusion of choice in a healthy term pregnancy.

Miscarriage Woman (Public/Private, Open/Closed): Meredith- “She Knows Because She Was There”, Me- “We Told Everyone”

Meredith and I shared different kinds of miscarriage experiences as well as disclosures of our losses. We both began our miscarriages at work but due to our life equipment surrounding the suitability of our pregnancy bodies, had different choices in disclosure of pregnancy and loss. We also took equipment related to disclosure with us into our future pregnancies. I was open about my pregnancy and thus had little choice but to be open about my loss, while Meredith was closed in her pregnancy sharing and had few such interactions. We both would carry equipment from the loss experience, she likely to continue her closed behavior, while I was to be much more cautious in my sharing.

Unsure of her ability to become pregnant, Meredith takes a pregnancy test in the locker room at the hospital as she’s getting into her scrubs. She finds that it is positive and does not tell anyone because she does not think her “hostile uterus” could carry a pregnancy to term. The reveal could offer her support, but it would also be risky, in that everyone would know if there was a pregnancy loss, and pregnancy and miscarriage are difficult to reveal in the workplace given potential taboos and stigma (Steimel, 2021).

“Later that day, Meredith is in the middle of the mass shooting. She must operate on fellow surgeon, Owen Hunt. Her colleague, a surgical resident, April, is with her, assisting. Meredith begins bleeding, the blood seeping through her pants and down her thighs”.

Meredith tells Christina about the miscarriage, and answers April’s queries about how she is doing with the loss. Christina is somewhat taken aback and jealous of this disclosure, and Meredith assures her that she “only knows because she was there.” Meredith had not told Derek because she had not had the chance, and he too, was recovering from a surgery in the wake of the shooting. She, in this way, did not have much support for the pregnancy or the miscarriage, but she also did not have to reveal an unknown loss. Her pain is private and closed and only somewhat public and open, due to circumstance.

The audience of the series does not see a medical assessment of miscarriage but does see the beginning of an appointment in which Meredith has a D&C to remove tissue left behind after the miscarriage:

“Meredith doesn’t want anyone with her, even Christina, and she looks off to the side as the procedure begins off camera. She does exhibit some anger, blame on her “hostile uterus”; no cause is offered except the previous statement, which leaves Meredith as the patient to blame her body and by extension, herself. Viewers could infer that the highly stressful situation she was in that day could have been a contributing factor (Mayo Clinic,

2025). Causes are typically unknown (Curtis, Linares, & Antoniewicz, 2014). Her voiceover resignedly quips that sometimes “it’s not in the cards” as she angrily throws the pregnancy test, she had placed in her locker in the trash”.

My healthy first pregnancy made it seem that another was “in our cards.”

“I tell everyone about my pregnancy because of my previous healthy one. Telling others about the miscarriage is then necessary; I remember my mother-in-law being wary of us telling everyone about our first right away, and I recall saying, “We’ll share our joy and our sorrow, if need be,” and resenting her comments. I didn’t know what it would be like to share that sorrow”.

Sorrow came that morning, unexpectedly, in a campus bathroom. I had bleeding and abdominal pain, but no fever, all but one of the typical physical symptoms (Mayo Clinic, 2021). I met my husband at an emergency doctor’s appointment:

“They tell me they’d get me to the back right away, but it takes what seems like ages. There are pregnant women out there and it’s hard to be in their presence. Still crying, I look at the fountain in the waiting room. It’s soothing but always kind of made me need to pee while pregnant. My husband arrives and I tell him, “I think it’s gone,” and he quietly says “Okay, okay.” I don’t know why I said, “it.” Maybe it was protective, impersonal distance? From what we were later told in the office that day, it seemed there was no need for surgical intervention, and the blood and tissue would pass on its own”.

“I have a pelvic exam, and my doctor tells us that I “am highly suspicious for miscarriage.” He tells us that this is viewed as a bump in the road of pregnancy for some, and for others it is a child to be grieved. Our doctor expresses his sympathy and offers to give us counseling resources if we need them. He tells us, “I’m so sorry that this happened to you.” Our nurse, who has always been friendly with me, tells me about her own loss of a pregnancy at 20 weeks and cries with me. She tells me that “I absolutely deserve to have another child” and that she knows my (first) daughter “means everything to” me. I have an ultrasound appointment originally scheduled to date the pregnancy, but it is adjusted to confirm if the pregnancy is viable or not”.

The testing and exam confirmed a loss, and again, our doctor offered sympathy, as well as interpretations of miscarriage and support resources. My parents were in town and having my mother there helped me to feel supported and to grieve. Our doctor offering information to me and my husband that day in the office, giving different sides, sharing grief, offering sympathy when he saw how we see it, as well as our nurse offering her story, was all supportive. I was not asked to bring the remains to the doctor as I have heard others in stories I have read or been told—I cannot imagine doing this. My husband has said that he “really appreciated” how our doctor “offered information.” At times, patient-centeredness may mean offering information on various potential perspectives and then responding once a provider sees which one fits a given patient best. This may come with clinical experience, as well as narratives, education, and research, as well as sensitivity and attention to verbal and nonverbal cues of the patient (duPre & Overton, 2023; Lacci-Reilly et al., 2023).

Since we had told everyone about the pregnancy, we had to tell everyone about the loss, almost coercive disclosures (Steimel, 2021). We chose to be open and disclose the pregnancy but

did not have any choice but to disclose the miscarriage. This disclosure does, however, offer support and processing of the experience, and if others share their own losses, aids in their processing as well, with being understood and affirmed a likely pathway (Steimel, 2021; Bute & Brann, 2015). Meredith did not have a great deal of support but also did not have the myriad disclosures that we had:

“I think about how the day after the miscarriage began, I was supposed to cook for a group of friends. I still did this but let them know I wasn’t coming. I needed something to do; they all knew I was pregnant and I wasn’t ready to tell them or anyone. I didn’t want to volunteer to take care of kids/babies as I did each month and I asked a friend to help, saying that I wasn’t feeling well, and she covered for me. In later weeks, I told the friend group, and two other women told me they’d miscarried. One said she didn’t find it helpful for her doctor to say, “it was common—like having blue eyes” and “it sucked.” Another said that it “tore her up” for weeks and no one understood; a book she read likened a man losing his career and his identity to a woman losing a baby and losing hers—this didn’t sit well with her, or me”.

Family was a particularly difficult disclosure, as their closeness to my husband and I as parents, and the loss, made their reactions very open and emotional comparatively to friends and colleagues. My parents were especially hurt as it recalled a lengthy, serious illness I had as an infant:

“I decided to tell my parents before they set off on their trip to visit us, to help them process it before they arrived, but it was hard. Mom was originally coming with me to do an ultrasound to date the pregnancy; she was excited because she lives far away and hasn’t been physically present for many pregnancy experiences. The ultrasound date was kept confirming it was gone, and I went with my husband instead. On the ultrasound, there was nothing there. No image. No sound. No cute photos. I would be monitored for any symptoms showing that everything didn’t pass naturally but likely would since I was early on. I heard the term “a chemical pregnancy.”

“My parents were hopeful and cried before we left but said they knew what had happened by me face when we returned. I had some self-blame deep in the back of my mind, and sadness; did I do something in my self-care that hurt this pregnancy since the first one went so well? No cause, so self-blame. It was so difficult to see them so upset when we arrived home from the ultrasound”.

Our then two-year-old daughter was one of the hardest disclosures, as she both did and did not understand the loss. Young children don’t understand death as permanent (University of Rochester, 2024), and an unseen loss is arguably even more difficult to grasp:

“When I found out I was pregnant for the second time, I told *Ella (my then 2-year-old daughter) about the “baby in my belly.” She wanted to know if she had “toys in there.” We told her about the miscarriage, that “the baby went to heaven.” She didn’t know it was permanent, and it broke my heart when she would touch or lay her head down on my stomach and say, “baby belly?”

There is often a double bind of social support and disclosure in stigmatized conditions. The discloser brings up potentially difficult feelings and interactions through disclosure but is also

offered potential support and processing in/of the loss (Brashers, 2001; Holt-Lunstad & Ucino, 2015). The continued non-understanding of the loss as permanent made for multiple forced disclosures with my then preschool-aged daughter, given our choice to be open and disclose the pregnancy early to her.

The female role of Miscarriage Woman, in the stories detailed presently is formed by the past life equipment in disclosure that is chosen or forced, stemming from the conceptualization of our bodies (equipment we carry). We also take equipment from our disclosures that may shape future pregnancy and loss experiences.

Mother as Wife Woman (Control/Lack of Control, Open/Closed): Meredith- “You Haven’t Told Him?”, Me- “Afraid You’ll Bleed to Death”

Meredith and I are both married with professional spouses. As wives we were quite different in our sharing of pregnancy and miscarriage with our partners. With a successful previous pregnancy, my husband was a part of the pregnancy and loss, and as in my first pregnancy, took on a protector/supportive role and feared for my medical well-being during the miscarriage. Meredith did not tell Derek for a time and was alone for much of her loss experience. Our behavior and our spouse’s reactions were rooted in our past experiences/equipment of our bodies but also shaped our—and their—present control and sharing in our present losses.

Meredith was not open with Derek, the father, initially. He was not extensively involved because he did not know about the pregnancy. Meredith had only found out that morning with a pregnancy test and the crisis in the hospital came soon after. A colleague knew because “she was there” when her bleeding started. Once Meredith had told Christina, her response was an incredulous, “You haven’t told him?”:

“Meredith discloses to Derek after the miscarriage and the D&C. He looks concerned, and holds her, and offers support by saying, “I could have helped you.” He could have helped her then, during the physical process and early on, versus that he could still help her now in processing and grieving. The loss is seemingly in the past for them in his eyes. Meredith sees herself and pregnancy and Derek as very separate and once she tells him, he is then involved, but not intimately. Derek probably sees it as a past event that is a bump along the road to pregnancy and children, and some couples do see it this way (Curtis, Linares, & Antoniewicz, 2014). Miscarriage is very much part of their future pregnancies and children, however, as they choose to adopt versus try to conceive a child.”

They view the miscarriage differently, shaping their feelings of control in future family planning. Meredith must offer that she has no control over this loss or the near loss of Derek in the shooting as part of her counseling to return to work. This processing is done without her partner and is partially a professional hurdle. Derek may view the miscarriage as past and separate, but also, it becomes a reason from the past to guide their future family planning. Confirming, supporting, and attending to each other helps both spouses make sense of and cope with the loss (Horstman, Holman, & Johnson, 2001). Meredith and Derek may have been better able to cope with the miscarriage had they both been involved from the beginning. Understanding each other’s perceptions of the miscarriage may have also led to less stress for them both (Holman & Horstman, 2019).

I consider what the father, my husband, knew, and when. He was not closed off from the pregnancy. He grieved but seemed much more focused on my health:

“I cook to keep busy, and wear heavy pads for bleeding, feeling some mild cramping, *Nate is worried I will “bleed to death.” He asks our neighbor, *Emi, to come over and keep an eye on me and our toddler daughter in case I pass out, or worse”.

This mirrored his concern for me during the delivery process of our first child, when I was mainly concerned about taking care of the resulting infant. Men’s narratives of miscarriage experience have been shown to contain metaphors such as “the rock” and “guard,” phrasing suggestive of masculinity (Horstman & Holman, 2017). Men also often stay in the background of miscarriage grief (Horstman & Morrison, 2020). My husband was protective in this loss as he was in birth. His being there with me, in the doctor’s office, made the miscarriage real, but the loss was not as real to him as my pain and symptoms. The latter may be more what was in his power to control/mitigate/protect:

“He walks into the waiting room and hugs me. I think he had hope before he got to me in the doctor's office. In some ways, it was just like when we found out about our first baby and took several pregnancy tests. It didn’t seem real until we talked to a doctor where we were (in his tiny hometown where we were visiting) about how accurate those tests were. The doctor’s validation, even just sitting in the professional setting of a doctor's office together, made it real”.

He was working to protect me in his concern and to be more my support rather than my co-griever:

“We get home from the doctor’s office, and he must return to work. I am still bleeding significantly and he is fearful. Emi tells me that I “shouldn’t be running around,” as if it would stop if I stayed still. I tell her that nothing could stop it and then she tells me that she “lost a baby” and it was from “lifting things” over her head. She feels guilty about it, 40 years later, and I tell her that it was not her fault, there was nothing she could have done to stop it, and nothing she did to cause it.”

Meredith had some sense of miscarriage because of her health issues, her experience in medicine, and perhaps thought it a common occurrence; it is relatively frequent, though some individual women do not necessarily find comfort in this (Brann, 2015); I had some sense of the medical impact and the benefit sharing what I was experiencing could offer, even in the midst of my own physical and emotional pain. I was not focused on my bleeding as it was occurring:

“I think about cultural capital as I view Meredith’s disclosure to Derek again and think about when my husband first learned we’d lost the baby. I’ve shared stories with other women, and with my students. Emi’s pain over time was still evident; I wonder what her husband thought and shared with her? Was he involved in her experience of loss?”.

As in the birth of our first child, during the miscarriage, my husband feared for my current physical state, while I was concerned with behavioral action. Perhaps I was so out of control with my body that I had to focus elsewhere, whereas he focused on the visible, tangible at hand, my health state. We both may have been searching for some control to find support in our stress (Glanz, Rimer, & Viswanath, 2015).

Mother as Wife Woman is a role in Meredith’s and my stories that is colored by our sense of control over our bodies (ability to carry a pregnancy) which leads to certain kinds of disclosure to our partners. These decisions forged in part by life equipment in turn offered different elements of control and support for and from our partners within the loss context.

Miscarriage Mother Woman (Certainty/Uncertainty, Hope/Realism): Meredith- “Derek Knew Because He’s Derek”, Me- “I Feel Hopeful–I Bought this Christmas Stocking.”

Meredith and I are both mothers who have been Miscarriage Women. This offers us equipment we carry into future pregnancies, a delicate balance of hope in a healthy pregnancy and the lingering specter of the potential reality of another loss. We carry equipment related to certainty in our bodies and our family decision making, or our partners do, stemming from other equipment rooted deeper in the past.

Meredith and Derek experienced a pregnancy loss and moved toward adoption (though they did later have biological children).

“As Derek is hugging Meredith after learning about the miscarriage, I consider when they met their first adoptive child. Meredith tells Christina that she was unsure about adopting her, and remarked that, “Derek knew of course because he’s Derek.” Derek met the child at the hospital (She was an orphan brought in from Africa for surgery at Seattle Grace.) and immediately took to her and told Meredith that they should adopt her.”

She did not feel this certainty herself; she was a woman with a “hostile uterus” and “terrible mother,” after all, insecure in family and motherhood. In this case, the pregnancy loss shaped the idea of adoption, as did Derek’s certainty. Derek took the lead in finding their adopted child. He came from a large family with a very involved mother, having confidence in fatherhood and family. Meredith acknowledges her own timidity and Derek’s leadership in these matters.

Men and women’s narratives of miscarriage have common and divergent threads, which can be linked to differing levels of stress and relational satisfaction (Holman & Horstman, 2019). These differing threads may be linked in part to the life equipment they carry with them. Meredith did not feel Derek’s certainty in family planning and blamed her body for the pregnancy loss (her “hostile uterus”). Derek was not a part of the loss until later and had a very different sense of family and fatherhood. Investment in the father role further helps men in processing loss (Horstman, Holman, & Johnson, 2021); Derek may see the loss as in the past and can focus on (control) his father role in the future.

Our next venture into becoming new parents was about two years after our loss. Due to the miscarriage, I was hesitant about trying to become pregnant again for quite some time. Seeing Meredith discuss Derek’s certainty and Zen in adoption led to me to think about the day I found out I was pregnant again (with our younger daughter):

“I feel extremely peaceful and calm. It was mid-morning, and for some reason, I think that I could be pregnant. I am packing up our daughter’s things for a weekend father-daughter trip with my husband while I wait for the results of a home test. I see the “pregnant” and am cautiously optimistic. I tell my husband later that day, by showing him the positive stick test with a bow on it like a present. It’s near Christmas. We don’t tell anyone else until 12 weeks have passed”.

The end of the first trimester (first 12 weeks) is a threshold for when many disclose a pregnancy, as there is typically viability to term past this point (Mayo Clinic, 2021). We did not any longer believe in sharing our sorrow and our pain until we had reached a certain milestone of clinical marker and confirmed “if we should tell anyone”, with our doctor. The past loss shaped my current identity as a pregnant woman and mother (Pelters, 2024) and my willingness and timing of disclosure. I was embracing realism, but also some measure of hope:

“The week after the holidays, I peruse discounted decorations and see a lovely brocade Christmas stocking. I come home with it and hang it up on

the hooks above our fireplace, as my husband was reading in our living room. I tell him, simply, “I feel hopeful. I bought this Christmas stocking.” He knows that I bought it for our future family member. I’m not ready to disclose this news to others, but I feel hopeful enough to purchase a small token of hope for the next holiday season”.

I was and was not bracing my happy emotions; I was and was not a “pregnancy grinch” (Dalton & Gruber, 2022, p. 858). Perhaps leaning more into hope helped me manage the push and pull of negative and positive affect by claiming a certainty in a sea of uncertainty. Symptoms of illness are often the producers of uncertainty (Brashers et al., 2000) but in women pregnant after a loss, the lack of symptoms (save bleeding) may produce stressful uncertainty (Dalton & Gruber, 2022); for me, every little flutter, every bit of water retention, was a sign for hope of a healthy pregnancy and child.

I felt this myself, not coupled with my husband, though he was supportive of my purchase and its accompanying optimism. I had a measured certainty that all would be well. I still had my “amazing mother” and “great set up,” even with the pregnancy loss experience. To avoid the pain of telling others the good news and then having to tell them the bad news, and to avoid that pain for my parents again, we did not disclose the pregnancy until that clinical marker mentioned. A pregnancy is the present and future, linear and not linear, and pregnancy after a loss may be widely shaped by past and present life equipment (Meyer, 2015), particularly in identities within roles as women.

Miscarriage Mother Woman is a role for Meredith and me that carries the hope of future pregnancies but the shadow of potential loss. Our partners or we may be the holders of certainty and/or uncertainty in such hopes and decisions.

Limitations

The scope of this analysis of personal miscarriage experience, identity, and communication in conjunction with a mediated story of pregnancy loss has several limitations. My personal story is told through a single narrator, and the mediated narrative is from one storyline from a single series. There may be bias based in recall, and there may be other valid interpretations of my story as well as Meredith’s. Further research may find if the life equipment found here are resonant within a larger sample of miscarriage stories, personal and mediated. Further work may also elucidate if the employment of Burke’s concept is equally as fruitful in sensemaking in miscarriage and other health contexts.

Conclusion

Miscarriage is often called a clinically common occurrence in pregnancy (Mayo Clinic, 2021) but is by no means a common context for individuals. It comes with disenfranchised grief and sorrow (Doka, 1989), as well as depression and posttraumatic stress (Corbet-Owen & Kruger, 2001; Farren et al., 2016); support (Goldsmith, 2004) from loved ones, coworkers, and providers can be quite lacking (Brann, 2015; Lacci-Reilly, et al., 2023; Holt-Lunstad & Ucino, 2015; Modiba, 2008). There is a dearth of stories both mediated and personal. In the present study, I sought to add to the tales told, as well as seek insight through a complementary media narrative.

The findings here suggest that within female roles during pregnancy and pregnancy loss there may be concepts of us, life equipment, that shape and are shaped by one’s experiences. They may include dichotomous tensions within. Media-based health stories are a form of life equipment that may help to make sense of personal medical stories, as a bridge from frequently employed and

influential concepts (life equipment) in the mediated world of streaming to the domain of reality. In the present study, focusing on the connected life equipment between a mediated and personal story of pregnancy loss yielded themes of hope and realism in future pregnancies after a loss, certainty and uncertainty in family decision making, open and closed disclosures of miscarriage and pregnancy, control in disclosures and processing of loss and choices, and linear and nonlinear timelines of self-concept in pregnancy and loss. The themes found here may be resonant with others who have experienced miscarriage and offer additional life equipment that may help in processing loss and may be explored further.

My analysis of Meredith's Grey's and my personal experiences in miscarriage via Burke's life equipment reveals that words and their associated meanings and concepts may shape and help make sense of health experiences. Pieces of life equipment come in various segments of life, and within various roles. The roles taken on and thrust upon us are shaped by lives past, present, and future. They overlap with, complement, and conflict with each other, as do the dichotomies of experiences and relationships in the context of miscarriage; life equipment may shape the timeline of pregnancy, the open and closed communication and disclosures involved, the mediated and personal illness stories that we share and are influenced by, as well as our public and private selves, our sense of having choice and having no choice, and our seeking of control and our sense of lack of control. Our scripts enter our identities that offer us hope and realism, as well as certainty and uncertainty, in our health experiences. The equipment of my own past experiences and interactions as a mother, daughter, and wife, Meredith's mediated miscarriage journey, and my professional life, shaped my miscarriage story. Pregnancy is medically timed in a linear fashion, but it is really colored by the past in the present. This includes concepts of our mothers and the mothers we want to be, as well as our bodies, along with the phrasing and equipment granted through medical assessment. Examining these pieces of our identities is part of miscarriage coping and sensemaking (Horstman, Holman, & Johnson, 2021), to learn from the past and contribute positively to health through appraisal and reduced stress.

Women may walk out of a doctor's office, out of their childhood homes, from screens, with equipment that is carried through their health experiences as mothers, and as professionals. Patient-centeredness in offering equipment for life may be choosing words carefully, as well as conveying various perspectives and assessing which seem to apply to a particular patient. It may also involve suggesting that patients journal about their pregnancy and loss experiences, particularly in the frameworks of their various roles as women throughout. Training in patient-centered and miscarriage communication is lacking though patient-centered approaches are much desired (Lacci-Reilly, et al., 2023). The medical knowledge we receive can be a mixed bag as well, in that we may not realize how much certain phrasing may be carried as life equipment that may help or hurt our decisions, communication, and self-conceptualizations.

It may also be helpful to suggest that patients view media-based stories as a jumping off point for processing various stages of their personal health journeys. The equipment provided by such stories may aid patients in making sense of their experiences and figuring out the equipment gathered in their own lives that has shaped their identities and offered them strategies and scripts in their stories. The cultural capital of sharing stories and reflecting on the past can aid in future interactions. Then again, sharing and seeking support can be fraught with complications; sharing open joy may necessitate sharing deep pain.

The sharing and analysis of health experiences, particularly those not often shared and often stigmatized, may mitigate shame and improve health experiences with its offering of scripts for the patient stage. Though entertainment television may be dismissed, mediated narratives are part of the life equipment that may shape our identities and health experiences. Combining analyses of mediated and personal stories of health and illness, as well as considering life

equipment as a concept within health communication analyses, may offer new ways to explore various health contexts.

Future research may explore a larger sample of mediated miscarriage portrayals, leading later to studies of message effects, and may test combined autoethnographic and media-based approaches to pregnancy loss and other health areas. Later work could attend to more understanding of life equipment in the context of miscarriage, as well as other areas, such as in planned and unplanned pregnancy, and areas outside of women's health. Mediated health presentations may be a bridge to personal analysis of one's own experience, finding understanding and escaping dominion.

References

- Abboud, L., & Liamputtong, P. (2005). When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners. *Journal of Reproductive and Infant Psychology*, 23, 3-18. <https://doi.org/10.1080/02646830512331330974>
- Andrzejewski, C., Forbes, S., & Hogan, E. (2026). Intimacy in autoethnography: A framework for autoethnographic trustworthiness. *American Journal of Qualitative Research*, 10(1), 306-316. <https://doi.org/10.29333/ajqr/17873>
- Gray, J.B. (2007). Interpersonal communication and the illness experience in the *Sex and the City* breast cancer narrative. *Communication Quarterly*, 55(4), 397-414. <https://doi.org/10.1080/01463370701657889>
- Arrington, M.I., & Goodier, B.C. (2004). Prostration before the law: Representations of illness, interaction, and intimacy in the *NYPD Blue* prostate cancer narrative. *Popular Communication*, 2(2), 67-84. https://doi.org/10.1207/s15405710pc0202_1
- Borisoff, D., & Merrill, L. (1998). *The power to communicate: Gender differences as barriers*. (3rd ed.). Prospect Heights: Waveland.
- Brann, M. (2015). Nine years and still waiting: When healthcare providers social support never arrives. In R.E. Silverman and J. Baglia (Eds.) *Communicating pregnancy loss: Narrative as a method for change* (pp. 20-31). New York: Peter Lang.
- Brashers, D.E. (2001). Communication and uncertainty management. *Journal of Communication*, 51(3), 477-497.
- Brashers, D.E., Neidig, J.L., Haus, S.M., Dobbs, L.K., Cardillo, L.W., & Russell, J.A. (2000). Communication in the management of uncertainty: The case of persons living with HIV or AIDS. *Communication Monographs*, 67(1), 63-84.
- Brummett, B. (1984). Burke's representative anecdote as a method in media criticism. *Critical Studies in Mass Communication*, 1, 161-176.
- Burke, K. (1968). Counter-statement (3rd ed.). Berkeley: University of California Press.
- Burke, K. (1973). Literature as equipment for living. (pp 292-304). In *Philosophy of literary form*, Ed. 3. University of California Press. <https://doi.org/10.1525/9780520340978-010>
- Burke, K. (1951). Rhetoric: Old and new. *Journal of General Education*, 5, 202-209.
- Bute, J. J., & Brann, M. (2015). Co-ownership of private information in the miscarriage context. *Journal of Applied Communication Research*, 43(1), 23-43. doi:10.1080/00909882.2014.982686
- Buzzannel, P.M., & Ellingson, L. (2005). Contesting narratives of workplace maternity. In L.M. Harter, P.M. Japp, and C.S. Beck (Eds.) *Narratives, health, and healing: Communication theory, research, and practice* (pp. 277-294). New York: Routledge.

- Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. New York: Oxford University Press.
- Corbet-Owen, C., & Kruger, L. (2001). The health system and emotional care: Validating many meanings of spontaneous pregnancy loss. *Families, Systems, & Health, 19*, 411-427. <https://doi.org/10.1037/h0089469>
- Curtis, M., Linares, S.T., Antoniewicz, L. (2014). *Glass' office gynecology, 7th ed.* Philadelphia, PA: Wolters Kluwer Health.
- Cutrona, C.E., & Russell, D.W. (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B.R. Sarason, I.G. Sarason, & G.R. Pierce, *Social Support: An Interactional View*. (pp. 319-366). New York: John Wiley and Sons.
- Dalton, E.D., & Gruber, K. (2022). Being PAL: Uncertainty and coping in r/PregnancyAfterLoss. *Health Communication, 37*, 850-861. doi:10.1080/10410236.2021.1874641.
- du Pré, A. (2010). *Communicating about health: Current issues and perspectives*. (3rd ed.). New York: Oxford.
- duPre, A., & Overton, B.C. (2023). *Communicating about health (7th ed.)*. New York: Oxford.
- Doka, K. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Guilford: Lexington Books.
- Ellis, C. (1991). Sociological introspection and emotional experience. *Symbolic Interaction, 14*(1), 23-50. doi:10.1525/si.1991.14.1.23
- Ellis, C., Adams, T., & Bochner, A. (2011, April). Autoethnography: An overview. *Forum: Qualitative Social Research*. <http://nbn-resolving.de/urn:nbn:de:0114-fqs1101108>.
- Ellis, C., Kiesinger, C. E., & Tillmann-Healy, L. M. (1997). Interactive interviewing: Talking about emotional experience. In R. Hertz (Ed.), *Reflexivity and voice* (pp. 119-149). Newbury Park, CA: Sage.
- Farren, J., Jalmbrant, M., Ameye, L., Joash, K., Mitchell-Jones, N., Tapp, S., Timmerman, D., & Bourne, T. (2016). Post-traumatic stress, anxiety, and depression following miscarriage or ectopic pregnancy. A prospective cohort study. *British Medical Journal Open 6*, e0011864, doi: 10.1136/bmjopen-2016-0011864.
- Foss, K. (2013). “That’s not a beer bong; it’s a breast pump!” Representations of breastfeeding in prime-time fictional television. *Health Communication, 28*, 329–340.
- Foster, E. (2005). Desiring dialectical discourse: A feminist ponders the transition to motherhood. *Women's Studies in Communication, 1*, 57-83. <https://doi.org/10.1080/07491409.2005.10162484>
- Gerbner, G., Gross, L, Morgan, M., & Signorielli, N. (1984). Listening to television: The dynamics of the cultivation process. In J. Bryant and D. Zillman (Eds.), *Perspectives on media effects* (pp. 17-40). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Glanz, K., Rimer, B.K. and Viswanath, V. (2015) *Health behavior: Theory, research, and practice* (5th ed.). San Francisco: Jossey-Bass.
- Goffman, E. (1963.) *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster.
- Gold, K.J. (2007). Navigating care after a baby dies: A systematic review of parent experiences with healthcare providers. *Journal of Perinatology, 27*, 230-237. doi: 10.1038/sj.jp.7211676.
- Goldsmith, D.J. (2004). *Communicating social support*. New York: Cambridge.
- Hayes, S. D., & Locke, L. A. (2024). ‘White trash’ in the academy: Working-class women professors discuss their backgrounds and education. *American Journal of Qualitative Research, 8*(1), 107-132. <https://doi.org/10.29333/ajqr/14087>
- Hoffman, B.L., Cafferty, L.A., Jain, P., Shensa, A., Rosenthal, E.L, Primack, B.A., Sidani, J.E. (2020). Patient-centered communication behaviors on primetime television. *Journal of Health Communication, 25*(2), 1087-0415. doi: 10.1080/10810730.2020.1723040

- Holman Jones, S. (2005). Autoethnography: Making the personal political. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 763-791). Sage.
- Holman, A. & Horstman, H.K. (2019). Similarities and dissimilarities in spouses' narratives of miscarriage: A dyadic analysis of communicated narrative sense-making and well-being. *Journal of Family Communication*, 19(4), 293-310. <https://doi.org/10.1080/15267431.2019.1628763>
- Horstman, H. K., & Holman, A. (2017). Communicated sense-making after miscarriage: A dyadic analysis of husband and wife communicated perspective-taking, affect, and parenting role salience. *Health Communication*, 33, 1317–1326. doi:10.1080/10410236.2017.1351852
- Horstman, H.K., Holman, A., & Johnson, L. (2021). Men coping with miscarriage: How spousal emotional support contributes to the relationship between parenting identity and well-being about pregnancy loss. *Southern Communication Journal*, 86, 256-267. DOI:10.1080/1041794X.2021.1919918
- Horstman, H.K., & Morrison, S. (2020). Interpersonal communication surrounding fertility and miscarriage: Considerations under the gaze of the master narrative of motherhood. In A. Cooke-Jackson and V. Rubinsky (Eds.), *Communicating Intimate Health* (pp. 157-169). Lexington: Rowman & Littlefield.
- Holt-Lunstad, J., & Ucino, B.N. (2015). Social support and health. In K. Glanz, B.K. Rimer, and K. Viswanath (Eds.) *Health behavior: Theory, research, and practice* (5th ed.) (pp. 183-204). San Francisco: Jossey-Bass.
- Internet Movie Database (2025). *Grey's Anatomy*. Retrieved 5/14/25 from <http://www.imdb.com/title/tt0413573/>.
- Jain, P., & Slater, M. (2013). Provider portrayals and patient-provider communication in drama and reality medical entertainment television shows. *Journal of Health Communication*, 18, 703-722. doi: 10.1080/10810730.2012.757388
- Janz, N.K., & Becker, M.H. (1984). The health belief model: A decade later. *Health Education and Behavior*, 11, 1-47. DOI: 10.1177/109019818401100101
- Jones, S. H., Adams, T. E., & Ellis C. (Eds.). (2013). *Handbook of autoethnography*. Walnut Creek, CA: Left Coast Press, Inc.
- Kaiser Family Foundation, & Pew Research Center's Project for Excellence in Journalism. (2009). *Health news coverage in the U.S. media*. Kaiser Family Foundation and Pew Research Center.
- Kavanaugh, K., Trier, D., & Korzec, M. (2004). Social support following perinatal loss. *Journal of Family Nursing*, 10, 70-92. DOI: 10.1177/1074840703260905
- Kinslera, J.J., Glik, D., de Castro Buffington, S., Maland, H., Nadjat-Haieme, C., Wainwright, N., & Papp-Green (2019). A content analysis of how sexual behavior and reproductive health are being portrayed on primetime television shows being watched by teens and young adults. *Health Communication*, 34(6), 644-651. doi: 10.1080/10410236.2018.1431020.
- Lacci-Reilly, K.R., Brunner Huber, L.R., Quinlan, M.M., Hutchison, C.B., Hopper, L.N. (2023). *Health Communication*. Advanced online publication. <https://doi.org/10.1080/10410236.2023.2245205>
- Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Berlin: Springer. Mayo Clinic (2021). Miscarriage overview. Retrieved 1/22/21 from <https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298>
- Meyer, M.D.E. (2015). On the identity politics of pregnancy: An autoethnographic journey through/in reproductive time. In R.E. Silverman and J. Baglia (Eds.) *Communicating pregnancy loss: Narrative as a method for change* (pp. 135-150). New York: Peter Lang.

- Modiba, L.M. (2008). Experiences and perceptions of midwives and doctors when caring for mothers with pregnancy loss in a Gauteng hospital. *Health SA Gesondheid*, 13, 29-40. DOI:10.4102/hsag.v13i4.402
- Montgomery, B.M., & Baxter, L.A. (Eds.). (1998). *Dialectical approaches to studying personal relationships*. Mahwah, NJ: Lawrence Erlbaum.
- Moyer-Guse, E., Woods, K., Rader, K., & Tran Luong, K. (2020). Talking about TV: Mother-daughter viewing and discussion of an entertainment narrative about teen pregnancy. *Health Communication*, 35(10), 1200-1209. <https://doi.org/10.1080/10410236.2019.1623642>
- Murphy, S.T., Hether, H., & Rideout, V.A. (2009). *How healthy is primetime? An analysis of health content in popular prime time television programs*. Kaiser Family Foundation and University of Southern California Annenberg Norman Lear Center Hollywood, Health and Society Program.
- Normann-Virgil, I.H. (2015). Conceptualizing and articulating pregnancy loss through embodiment in peer interaction. *Language and Communication*, 45, 70-82. doi: 10.0116/j.langcom.2015.10.002.
- Pelters, P. (2024). I am what I am? An integrative review of understandings of health identity and illness identity in scientific literature. *Sociology of health and illness*, 1-23. <https://doi.org/10.1111/1467-9566.13771>
- Porter, N. (2004) CMA methodology: Autoethnology, computer mediated anthropology. An Online Resource Center. <http://anthropology.usf.edu/cma/CMAMethodology-ae.htm>
- Raab, D. (2013). Transpersonal approaches to autoethnographic research and writing. *The Qualitative Report*, 18(42), 1-19. Retrieved from <http://www.nova.edu/ssss/QR/QR18/raab42.pdf>
- Rambo, C. (2005). Impressions of grandmother: An autoethnographic portrait. *Journal of Contemporary Ethnography*, 34(5), 560-585. doi:10.1177/0891241605279079
- Rideout, V.A. (2008). *Television as a health educator: A case study of Grey's Anatomy*. Kaiser Family Foundation.
- Ronai, C. R. (1995). Multiple reflections of child sex abuse. *Journal of Contemporary Ethnography*, 23(4), 395-426. doi.org/10.1177/089124195023004001
- Sell-Smith, J. A., & Lax, W. (2013). A journey of pregnancy loss: From positivism to autoethnography. *The Qualitative Report*, 18(92), 1-17. Retrieved from <http://www.nova.edu/ssss/QR/QR18/sell-smith92.pdf>. doi: 10.46743/2160-3715/2013.1441
- Sharf, B., & Freimuth, V. (1993). The construction of illness on entertainment television: Coping with cancer on *thirtysomething*. *Health Communication*, 5, 141-160.
- Shilling, L.J., & Silverman, R.E. (2015). When the professional is personal: Case studies of pregnancy loss, my story of pregnancy loss. In R.E. Silverman and J. Baglia (Eds.) *Communicating pregnancy loss: Narrative as a method for change* (pp. 97-102). New York: Peter Lang.
- Silverman, R.E. (2015). Breaking through the shame and silence: A media-centered approach to consciousness raising. In R.E. Silverman and J. Baglia (Eds.) *Communicating pregnancy loss: Narrative as a method for change* (pp. 283-293). New York: Peter Lang.
- Silverman, R.E., & Baglia J. (2015). *Communicating pregnancy loss: Narrative as a method for change*. New York: Peter Lang.
- Singhal, A., & Rogers, E.M. (1999). *Entertainment-education: A communication strategy for social change*. Mahwah: Lawrence Erlbaum Associates.

- Skinner, T.S., Tiro, J. & Champion, V.L. (2015). The health belief model. In K. Glanz, B.K. Rimer, and K. Viswanath (Eds.) *Health behavior: Theory, research, and practice* (5th ed.) (pp. 75-94). San Francisco: Jossey-Bass.
- Sontag, S. (1978). *Illness as metaphor*. New York: Farrar, Strauss, and Giroux.
- Spry, T. (2001). Performing autoethnography: An embodied methodological praxis. *Qualitative Inquiry*, 7(6), 706-732. doi.org/10.1177/107780040100700605
- Steimel, S. (2021). Communication privacy management and pregnancy loss in interpersonal workplace communication. *Women's Studies in Communication*, 44(3), 397-418. https://doi.org/10.1080/07491409.2020.1843579
- Tillman, L.M. (2009). Body and bulimia revisited: Reflections on a "secret life." *Journal of Applied Communication Research*, 37, 98-112. doi.org/10.1080/00909880802592615
- Tompkins, S.S. (1979). Script theory: Differential magnification of affects. In H.E. Howe Jr. & R.A. Dienstbier (Eds.), *Nebraska Symposium on Motivation* (Vol. 26). Lincoln: University of Nebraska Press.
- University of Rochester (2024). A child's concept of death. Health encyclopedia. Retrieved 1/3/24 at <https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=90&ContentID=P03044#:~:text=Young%20children's%20experience%20with%20death,may%20feel%20guilt%20and%20shame>
- Walker, J.L.G., & Walker, B.M. (2015). Unscripted loss. In R.E. Silverman and J. Baglia (Eds.) *Communicating pregnancy loss: Narrative as a method for change* (pp. 59-71). New York: Peter Lang.
- Wright, K.B., Sparks, L., & O'Hair, H.D. (Eds.). (2009). Mass communication and health. In *Health communication and the 21st century* (pp. 155-178). Malden: Blackwell Publishing.
- Ye, Y., Ward, K.E. (2010). The depiction of illness and related matters in two top-ranked primetime network medical dramas in the United States: A content analysis. *Journal of Health Communication*, 15(5), 555-570. doi: 10.1080/10810730.2010.492564.

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