Research focus and questions

My research focuses on the nature of foetal-parental relationships, the implications for parental mental health when these relationships are unexpectedly severed and on medical metaphors that may risk undervaluing embryonic life and women's experiences.

My PhD will address the following questions:

1. What metaphors are used by doctors and patients when communicating about foetal death?
2. Is there a conflict between the way obstetricians imagine and describe foetal death and the way that women experience it?
3. How are parental-foetal relationships represented or denied through these metaphors?
4. How do these representations inform medical understanding of grief and maternal mental health?

Why this idea is important

One-quarter of all maternal deaths between six weeks and one year after childbirth are related to mental ill-health. One in seven affected women die by suicide. Miscarriage is acknowledged as a risk factor in perinatal mental illness, but the relationship between foetal deaths, postnatal depression and maternal suicide is unknown.

My first aim is to better understand the nature of foetal-parental relationships and the implications for parental mental health when these relationships are unexpectedly severed. My second aim is to study how prevailing medical metaphors run the risk of undervaluing embryonic life and women's experiences.

Recourse to military phrases, when applied to a woman's body, may evoke a sense of blame. The use of violent tropes in medicine run the risk of devaluing life (Bleakley 2014). Military metaphors may encourage 'aggressive treatment', an attitude that has, at times, led to unnecessary procedures as well as over-prescription of medication (Hodgkin 1985). War metaphors have been used to justify unethical acts, for example, efforts to win the 'war' on syphilis led to the deliberate infection of people for research, justified as 'normal exposure' (Reverby 2015).

Work which has led up to the project

Lived experience

My interest in miscarriage as one of myriad medical metaphors for the death of an unborn child, began as a patient of a recurrent miscarriage clinic, where obstetric jargon was often anathema to a mourning mother. Modern obstetrics uses 'miscarriage' to refer to the unplanned death of an embryo or foetus before survival outside the uterus is possible.

Medical Subject Headings (MeSH) are used by indexers to describe articles for Medline, a searchable medical literature. I looked at MeSH terms for 'miscarriage', finding: foetal death, pregnancy outcome, spontaneous abortion, miscarriage, intrauterine death, foetal demise, stillbirth, spontaneous abortion and pregnancy loss. None of these terms acknowledge parental grief, nor the personhood of the foetus. Miscarriage, literally 'to have carried incorrectly', attributes blame to women, conveying a sense of carelessness, as if an unborn baby had been misplaced, rather than mourned.

During my experience of recurrent miscarriages and an experimental medication regime to prevent miscarriage during a subsequent pregnancy, I noticed the language used by my obstetrician and kept a diary. Many of the metaphors he used were military, including 'invasive', 'aggressive treatment' and 'natural killer cells'.

Research background

During my 2017-18 Masters degree in Medical Humanities at King's College London, I carried out an analysis of themes, metaphors, similarities and differences in Buddhist, Neo-Pagan, Jewish and Anglican rituals of grief, remembrance and memorialisation after miscarriage. I found that the rituals, from different traditions and different times, share many themes. Their embedded metaphors focus attention on the personhood of the foetus and the emotional bonds that parents develop towards their unborn child. These constructions challenge the prevailing medical narrative, of miscarriage as a common, yet trivial event. These rituals suggest parental grief after miscarriage

is deeply felt. The existence of pre-natal parental-foetal bonds raises important research questions for the perinatal mental health of mothers previously bereaved by miscarriage.

These rituals make the socially invisible, often unspoken and unimagined narratives of mourning unborn-life, conceivable.I concluded that evidence from these rituals suggests that parents consider their embryo, not only as a potential person, but as an actual person. When grieving is minimised, hidden or unacknowledged, mourners are unsupported in their grief.

My hypothesis was that studying unborn children is embryo-centric, emphasised by presenting foetal specimens to medical students in jars. This pedagogy in pathology museums, peering at glass 'womb-tombs', contributes to the invisibility of women who expect to mother these children. Embryos are under the scientific spotlight, while the women carrying them remain in the shadows. I found evidence for the early existence of maternal-foetal relationships during pregnancy. It is my hypothesis that when these emotional ties are unexpectedly severed, unacknowledged grief may predispose some women to postnatal mental illness. It is also my hypothesis that professional language and metaphor may unintentionally contribute to unresolved grief and to melancholic cognitions.

I used Critical Creative methodology in my MSc to reconstruct the point of view of all parties to photographs I took of a series of murals painted by emotionally abandoned adolescents in a rural township in New Zealand, where I had worked as a psychiatrist, and to hold those points of view up to many different kinds of disciplinary scrutiny, including art-historical, psychological, psychoanalytic, ethnographic and postcolonial. This helped me to understand the impact of the murals on the townspeople's sense of themselves and of their possibilities in the world. Medical humanities methodology, applied to a personal and professional experience, gave me a new way of thinking about adolescence. I intend to use the same interdisciplinary, critical creative approach, to interrogate miscarriage.

Professional background

My background uniquely places me to undertake this PhD. I am a consultant child and adolescent psychiatrist with a longstanding interest in writing. I read Medicine at St Bartholomew's in London and trained in psychiatry at the Maudsley Hospital. For a decade, while working as a junior doctor, I had a parallel career in journalism, working both freelance and also as an editor at the BMJ, where I had editorial responsibility for a weekly supplement. During that time, I published six books on self-help for depression and parenting interventions for bullied children and children with emotional and behavioural difficulties. This background in editing and writing, alongside my formal training in family therapy, give me skills that have been useful in textual analysis.

Methodology

My proposed Medical Humanities PhD at UEA uses Critical and Creative Writing methodology to address the four research questions above.

The creative component will be a memoir about miscarriage, motherhood and madness. Entitled, From Here to Maternity, it will be about my experience of recurrent miscarriages between 2012 and 2014. My personal experience as a patient enabled me to see and reexamine things I had previously taken for granted in my professional experience. While experiencing miscarriages, I worked in a small team commissioned by the Family Court, to provide expert witness assessments of children who the local authority was applying to remove from their birth parents. Almost all my professional conversations were about motherhood and madness, about what makes a 'good-enough' parent and what causes harm. Away from work, I was preoccupied with the smallest physical signs of life and those signs that might herald impending foetal death. Increasingly, I noticed the oddity of the medical metaphors. These collisions, of private experiences as a woman miscarrying, and my professional experiences as expert witness and member of the judiciary made me curious about how stories are told by parents, by professionals and by the courts. I kept notes of those often incommensurate narratives and on how they seemed to be constructed. Being a

patient myself, albeit an obstetric one, made me construct expert assessments and judge things differently.

My obstetrician used military metaphors to describe his treatment plans. My immune system, he postulated, was ‘mounting an attack on embryos’, identifying them as ‘enemy invaders’. He suggested I had high numbers of cells called ‘natural killer cells’ and his proposed treatment was presented as a ‘counterattack’. I only saw the consultant in person twice, but his military language had the reach of a general. For example, his phrase ‘attacking natural killer cells’ was used on treatment protocols given to me by the midwife and registrar, in conversation with my own GP, by nurses and also by other women experiencing recurrent miscarriages discussing their treatment plans on internet forums. Throughout that pregnancy, I lived with my husband, an army officer, on a large military headquarters, passing a sniper guard every morning when I took my toddler to the forces’ nursery. The politics and poetics of war were part of my life during that pregnancy.

Structure
My memoir will be structured around three ‘trimesters’, with a fourth, ‘postpartum’ section, devoted to postnatal mental illness and its relationship with loss. There will be a forward chronology, tracing the pregnancy resulting in the birth of my second daughter, from confirmation of pregnancy to delivery. Also in the chronology, I shall describe fictionalised cases, typical of the real cases that I saw for the Family Court. They explore real themes and dilemmas, but names, identities, numbers of children and geography will be fictionalised. Against the background of these forward chronologies, I will include reminiscences and memories from medical school and clinical material from earlier in my career. The three strands of memoir relate to one another by revealing frictions and troubling ethical interfaces. The master strand is the story of the 'successful' pregnancy.

The existing memoirs about miscarriage are almost all stories that sociologist Arthur Frank (1997) described as ‘quest narratives' in his study of illness narrative, The Wounded Storyteller. Frank described the quest illness narrative as when ‘the ill person meets suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest.’ They focus on describing the pain of loss and through grief, writers claim insights or a wiser state. Emma Mellon’s Still Life: A Parent’s Memoir, about her experience of stillbirth and the aftermath is typical of the genre, as is I Never Held You, by Ellen Du Bois. An exception is Saying Goodbye, in which Zoe Clarke Coates combines her personal story of recurrent miscarriage with ninety days of guided self-help.

My proposed memoir will be different from these miscarriage memoirs for several reasons. Firstly, it will be, to use Frank's terminology, a ‘restitution narrative’, about my body returning to a former image of itself, as a fertile and productive body, through a relationship with modern medicine. Secondly, it closely examines the personal-professional interface, giving professional perspectives on the questions above, as well as on imperfect healthcare systems, as junior doctor Rachel Clarke does in Your Life in my Hands. The memoir will have similarities with other doctor memoirs, for example psychiatrist Lynne Jones’ Memoir of War, Disaster and Humanitarian Psychiatry and neurologist Suzanne O’ Sullivan’s It’s All in Your Head.

My critical component will examine metaphors, similarities and differences in the language of foetal death, by investigating the language used in the recent British medical literature and in the writing of women to describe foetal death, with a particular focus on deaths in early pregnancy, medically known as miscarriages.

I will pay close attention to the significance of class, education, culture, community, ethnicity, religion, disability and sexuality in mediating this discourse. The work will be making an original contribution to an ongoing literature about medical metaphors from Susan Sontag's Illness as Metaphor (1978) and AIDS and its Metaphors (1989) to contemporary scholars like Deborah Lupton’s work on conceptualising and configuring the unborn human (2013). Sontag, who wrote her essay, Illness as Metaphor as an argument against the myths of psychological and moral causes of disease, interrogated and challenged the myth of illness metaphor, especially ‘invasion’

for cancer and ‘plague’ for AIDS. Sontag used this challenge to unsettle readers about their own moral and value judgements of those affected by these illnesses. Lupton has argued, ‘human embryos and foetuses have become entities that traverse many social words, spatial locations and temporal zones, their meanings often changing’. The critical essay will examine the language used in those changing meanings.

Textual material will be derived from wide reading of contemporary British medical literature to identify the military metaphors and also establish their origins. I will also identify what the range of miscarriage metaphors are in the medical literature of the last twenty years. I will then look at whether similar metaphors are to be found in the writing of women who describe miscarriages, in memoirs and in fiction.

Supervision
At UEA I am fortunate to have interdisciplinary supervisors, from creative writing and the medical school, whose expertise matches my interests.

From the School of Literature, Drama and Creative Writing, Professor Rebecca Stott, Costa-winning memoirist, historian, and bestselling historical novelist, will supervise the creative component. Stott’s memoir, In the Days of Rain, explores her childhood in the Exclusive Brethren and its pervasive aftermath.

Award-winning poet, Professor Tiffany Atkinson, will supervise the critical essay. Atkinson has strong research interests in representations of the body. Atkinson won the Medicine Unboxed Creative Prize in 2014 for Dolorimeter - 19 Readings, exploring pain, language and healing.

Providing specialist medical supervision to both components, Professor Amanda Howe OBE is a practising GP, an academic clinician, and immediate past president of the World Organisation of Family Medicine. Part of the founding team for Norwich Medical School, Howe’s diverse research interests include the contributions patients can make to health care.

This Medical Humanities PhD presents an opportunity to forge a new collaboration between Creative Writing and the Medical School at UEA, building on previous Medical Humanities PhD projects supervised by Stott and Atkinson.

Plan of research including brief timetable and milestones

I propose to work on both components simultaneously, according to the following schedule:

Year 1
Research and write detailed, structured plan for critical component, including finalised methodology and identification of texts.
Write first trimester chapters for memoir component.
Complete literature review of texts for critical component.
Year 2
Analyse texts for critical component.
Write second and third trimester chapters for creative component.
Write detailed plan for post-partum memoir section.
Year 3
Edit and complete critical component
Write post-partum section of creative component.
Edit and complete creative component

Relevance of the project to scholarship, policy and/or practice

This project is relevant to the policies, scholarship and practice of professionals caring for women before and after childbirth, including general practitioners, midwives, health visitors, obstetricians, psychiatrists and therapists. These groups have individually sought to understand diverse precipitating and perpetuating factors of maternal mental ill health and suicide. This PhD represents the first interdisciplinary, medical humanities, approach.

My research will make an important contribution to an ongoing literature about medical metaphors including, most famously, Susan Sontag's Illness as Metaphor (1978) and AIDS and its Metaphors (1989). Recourse to military phrases like “attack” and “defence”, when applied to a woman’s body, may evoke a sense of blame, exclusion, and stigma. Any conflicts between the ways doctors and women describe and imagine foetal death are likely to affect medical explanations and understanding of maternal grief and perinatal mental health. I am committed to understanding this and to challenging unhelpful metaphors in British medicine and to publicly advocating approaches that privilege women's metaphors.