“Sorry, your baby isn’t viable”: Exploring ectopic pregnancy through the discourse of psychotherapy.

by

Susan Kennedy

Submitted to the Quality and Qualifications Ireland (QQI) for the degree.

MA in Psychotherapy from Dublin Business School, School of Arts

Supervisor: Miriam Kavanagh

June 2025

Department of Psychotherapy

Dublin Business School

Table of Contents

Chapter 1: Introduction 6

1.1 Background and Context 6

1.2 Research to Date 7

1.3 Aims and Objectives 8

1.4 Clarification of Terms 8

Chapter 2: Literature Review 9

2.1 Introduction 9

2.2 Psychological and Emotional Impact of Ectopic Pregnancy 9

2.3 Loss, Identity and Psychotherapeutic Meaning-Making 13

2.4 Cultural Silence and Disenfranchisement 16

2.5 Psychotherapeutic Concepts and Clinical Approaches 18

2.6 Summary and Justification 21

Chapter 3: Methodology 23

3.1 Introduction 23

3.2 Research Design 23

3.3 Development of Research Questions 24

3.4 Sample and Recruitment 24

3.5 Data collection 25

3.6 Data Analytics 26

3.7 Ethical Considerations 29

3.8 Reflexivity 30

3.9 Summary 30

Chapter 4: Findings 32

4.1 Introduction 32

4.2 Theme 1: Carrying the Impact 32

4.2.1 Navigating Clinical Crisis and Medical Shock 32

4.2.2 Holding the Loss of the Imagined Baby 34

4.2.3 Recovery and Emotional Aftermath 36

4.3 Theme 2: Self in Rupture 38

4.3.1 The Body as a Betrayer 38

4.3.2 Internalised Blame and Shame 39

4.3.3 Avoidance and the Drive to Get Back to Normal 40

4.4 Theme 3: Cultural Silence 42

4.5 Theme 4: Psychotherapeutic Presence and Practice 43

4.5.1 Naming the Loss and Validating Grief 44
4.5.2 Relational Holding and Psychotherapeutic Attunement 45
4.5.3 Creativity When Words Fail 47
4.6 Summary - Across the Silence 48
Chapter 5: Discussion 49
5.1 Introduction 49
5.2 Carrying the Impact 49
5.3 Self in Rupture 52
5.4 Cultural Silence 56
5.5 Psychotherapeutic Presence and Practice 58
5.6 Limitations 60
5.7 Implications for psychotherapy 60
5.8 Suggestions for Future Research 61
5.9 Final Reflection 61
References 63
Appendices 71
Appendix 1: Research Poster 71
Appendix 2: Participant Information Sheet 72
Appendix 3: Consent Form 73
Appendix 4: Guide Questions 74
Appendix 5: Mapping of Themes 76
Figure 1 76
Figure 2 77
Figure 3 78
Figure 4 79

Abstract

This study explores how psychotherapists experience and conceptualise their work with clients who have experienced an ectopic pregnancy, a medically urgent yet often culturally overlooked form of reproductive loss. Semi-structured interviews were conducted with seven accredited psychotherapists, and thematic analysis was used to explore how they understand and work with the emotional, relational, and identity-based dimensions of this experience. Four key themes were identified: *Carrying the Impact*, *Self in Rupture*, *Cultural Silence*, and *Psychotherapeutic Presence and Practice*. Findings suggest that clients often feel isolated and struggle to give a name to their grief due to the absence of social and cultural recognition. Psychotherapy was experienced as a space where loss could be voiced, medical trauma integrated, and the self reconnected. The study highlights the importance of attuned, embodied, and creative psychotherapeutic approaches, and calls for increased recognition and integration of ectopic pregnancy within psychotherapeutic practice.

Acknowledgements

I would like to express my deep appreciation to the research participants, who provided not only their time but such rich experiences, their compassion is evident throughout.

I want to thank my supervisor, Miriam Kavanagh, for her calm support and guidance on this paper, which holds such significance to me.

My thanks to Stephen McCoy and my research peers for providing feedback along the way and always assisting to ensure the important message of this research was conveyed.

Lastly, I would like to thank my husband, friends, and family for their support throughout this process, always listening to my thoughts, ideas, and worries.

"*There are three needs of the griever: To find the words for the loss, to say the words aloud and to know that the words have been heard*." - Victoria Alexander

Chapter 1: Introduction

1.1 Background and Context

Experiencing the loss of a baby during pregnancy or shortly after birth, known as perinatal loss, is a profoundly traumatic event for expectant parents. What begins as hopeful anticipation for new life abruptly transforms into grief and loss, leaving an indelible mark (Cohen et al, 2019). It is widely recognised that perinatal loss can lead to profound and enduring grief, as well as a broad spectrum of psychological and social consequences. Research indicates that approximately 30% of individuals who have encountered pregnancy loss endure significant emotional responses, such as depressive disorders, anxiety, substance abuse, and posttraumatic stress disorder (Cohen et al., 2019).

Among the various forms of pregnancy loss, ectopic pregnancy holds a significant place. Ectopic derives from the Greek word, "ektopos" which means "out of place"; therefore, ectopic pregnancy refers to an out-of-place pregnancy (Rana et al., 2011). Ectopic pregnancy arises when a fertilised egg implants itself outside the uterus, commonly in the fallopian tube, though implantation can also occur in the ovary, abdomen, or cervix. The incidence of ectopic pregnancy has shown an upward trend over time, accounting for 14.8 per one hundred pregnancies in Ireland (Spillane et al., 2018). Whilst the rate of ectopic pregnancy has increased, the mortality rate has decreased, now accounting for 2.7% of all pregnancy-related deaths (Zamani et al., 2023).

A pregnancy of unknown location (PUL) describes a liminal and uncertain phase where a woman has a positive pregnancy test. Yet, no clear evidence of either an intrauterine or ectopic pregnancy is visible on ultrasound (Hendriks et al., 2020). Clinically, diagnosis relies on the monitoring of serial beta-hCG levels, repeat ultrasounds, and, in some cases, uterine

aspiration to determine viability of the pregnancy. This illustrates a period of pain and bleeding in some cases, and uncertainty in most (Farren et al., 2020).

Once an ectopic pregnancy is confirmed, treatment may involve medical management through methotrexate or surgical intervention or, in selected cases, a more conservative, expectant approach (Hendriks et al., 2020). Therefore, the loss experienced by way of ectopic pregnancy is not always immediate, and it can be a process in itself, through which there are a series of medical treatments or tests to monitor until a pregnancy test is negative (Verdaguer, 2017). Each route, while clinically necessary, carries psychological implications that may overlooked in medical discourse.

1.2 Research to Date

The medical focus on pregnancy primarily targets the physical aspects of the expectant mother, often neglecting her mental well-being. An implication of considering the biological aspects of the expecting mother is that when she experiences pregnancy loss, others struggle to appreciate the meaning of the loss to the parent (Markin, 2017). This occurs despite research illustrating that pregnant women develop mental representations and attach early on in pregnancy to their unborn child, miscarriage and ectopic pregnancy are often treated as non-events (Markin, 2017). This cultural tendency may explain the limited psychotherapy research and clinical recommendations on pregnancy loss and ectopic pregnancy, as it remains viewed as a medical matter rather than a psychological one.

Notably, there is a striking lack of data on ectopic pregnancy, which may speak to the predominant clinical emphasis on managing its acute, and often life-threatening, medical risks Farren et al., 2020). It may also reflect the relative rarity of ectopic pregnancy when compared to miscarriage. Yet this absence of data can mirror a broader silence around the psychological and emotional impact of ectopic pregnancy loss, both in research and in clinical discourse.

Therefore, there is a gap in the research to explore the impact of ectopic pregnancy from a psychotherapeutic perspective.

1.3 Aims and Objectives

Aim: To explore how psychotherapists experience and make sense of working with clients who have experienced an ectopic pregnancy, with attention to the emotional, relational, and discursive dimensions of the psychotherapeutic encounter.

Objectives

1. To explore how psychotherapists understand and work with the emotional and relational impacts of an ectopic pregnancy.
2. To consider how psychotherapists encounter and understand experiences of identity and self in the psychotherapeutic work following an ectopic pregnancy.
3. To explore the psychotherapeutic approaches and discourses psychotherapists draw on when supporting clients who have experienced an ectopic pregnancy.

1.4 Clarification of Terms

Whilst the primary focus of this research is on ectopic pregnancy, the literature and findings discussed will refer to some overlapping terms to describe experiences in the reproductive context, including pregnancy loss, perinatal loss and reproductive trauma. Pregnancy loss is used as an overarching term within this research, as it refers to any loss during pregnancy, including miscarriage, ectopic pregnancy and stillbirth (Markin, 2017). Perinatal loss is often used to refer to any loss after 20 weeks gestation through to the neonatal period (Kersting & Wagner, 2012). Reproductive trauma is used as a more encompassing and psychologically oriented term, which can refer to emotional, relational and identity-based disruptions. Such disruptions arise from infertility, miscarriage, stillbirth, abortion and ectopic pregnancy (Jaffe, 2017).

Chapter 2: Literature Review

2.1 Introduction

This literature review explores how ectopic pregnancy has been understood in psychological, cultural, and psychotherapeutic literature, with a specific focus on its relevance to psychotherapeutic practice.

Ectopic pregnancy, a potentially life-threatening condition, often receives less attention regarding the grief it causes compared to other types of pregnancy loss (Spillane et al., 2018). Prioritising concerns about future fertility and physical recovery tends to overshadow the emotional toll experienced by women and their partners in the aftermath of ectopic pregnancy. Existing research on ectopic pregnancy typically merges it with other early pregnancy losses, resulting in a dearth of dedicated investigation into ectopic pregnancy as an independent loss (Verdaguer, 2017). Consequently, there is a lack of research on the psychotherapeutic aspects of ectopic pregnancy, leaving its emotional impact and how it can be worked with psychotherapeutically inadequately explored.

To explore this further, the literature review is structured across several thematic domains: the psychological and emotional impact of ectopic pregnancy; its implications for identity and self in psychotherapy; the role of cultural silence and disenfranchised grief; and current psychotherapeutic frameworks relevant to this experience. As there is limited research specific to ectopic pregnancy, as a result adjacent fields are drawn upon such as miscarriage, infertility and reproductive trauma.

2.2 Psychological and Emotional Impact of Ectopic Pregnancy

Ectopic pregnancy, like other forms of pregnancy loss, initiates a complex emotional response. However, the literature suggests it also brings unique psychological challenges, due in part to its urgent medical nature and its marginalisation in social discourse. Due to the lack of research on ectopic pregnancy specifically, other forms of pregnancy loss, perinatal loss and

reproductive trauma literature will be drawn upon in setting out the impact that may be experienced.

Pregnancy loss can be experienced as both a psychologically and physically traumatic event. Women can feel surprised by the intensity of the physical pain, particularly in ectopic pregnancy, and the amount of blood and other distressing bodily sensations which are involved (Markin, 2024). As the physical symptoms can unfold gradually or quite suddenly, women are left feeling confused and a loss of control, at times fearing that they may be dying. In circumstances where surgical procedures are required, this can compound the feelings of distress and have been linked to the onset of post-traumatic-like symptoms. Such symptoms can include shame, guilt, dissociation, re-experiencing, avoidance and hyperarousal symptoms (Markin, 2024). Therefore, the experience of pregnancy loss alone is found to align with other forms of trauma, in which it is experienced as shocking, devastating and the sense of violation of one's basic sense of safety (Markin, 2024).

Pregnancy loss, no matter when it occurs, can be a profoundly destabilising experience, one that often leaves parents navigating a complex emotional terrain shaped by grief, anxiety, guilt, and depression (Erato et al., 2022). This is not simply the loss of a future imagined child, but of a felt relationship. Even after the pregnancy ends, a woman may continue to experience a strong connection to the child she carried, and a sense of herself as mother, regardless of how others define her maternal status (Erato et al., 2022). These bonds and identifications can be both enduring and invisible, making space for sensitive psychotherapeutic attention. In the absence of direct research on the imagined child within ectopic pregnancy discourse, this research intends to explore whether this concept arises within psychotherapeutic practice.

Early pregnancy loss studies have illustrated that women view their loss as a significant life event, despite this, the emotional suffering of women who have experienced miscarriage or

ectopic pregnancy, has been linked to a struggle in letting themselves grieve, or denying the depth of their pain (Spillane et al, 2018). Women have reported difficulties in coming to terms with their hopes of a successful pregnancy being dashed, resulting in a struggle to cope with shattered expectations, and in intense feelings of sadness and confusion around their grief (Spillane et al, 2018). Many women experience a wide range of emotions including depression, anxiety, and post-traumatic stress. Depressive symptoms are observed in grief responses, which include low self-esteem and increased suicidal thoughts (Markin, 2017). These responses are grounded in theoretical perspectives of complex grief, ambiguous and disenfranchised loss.

Emerging research draws links between these internal states and the intensity of grief, particularly in the perinatal context. Shame and self-blame are not just emotional responses but can anchor grief further, especially when held in silence. Notably, those with an avoidant attachment style may be particularly vulnerable, finding it more challenging to process loss in relational ways and carrying heightened grief into subsequent pregnancies (Caldwell et al., 2023). These findings highlight the importance of attending not just to the event of loss, but to the relational templates and internal narratives that shape how loss is carried.

Questions arise as to whether there is a difference between the experience of ectopic pregnancy from other pregnancy losses, particularly when much of the research amalgamates them. However, it is hypothesised that the significant medical management of ectopic pregnancy may result in an environment that fails to acknowledge the loss and the resulting emotional aftermath of the experience (Spillane et al, 2018).

Studies on ectopic pregnancy have highlighted the potential for ongoing significant social and emotional impacts (Lasker & Toedter, 2003). In one study, out of 160 participants who had undergone surgical treatment for ectopic pregnancy, six women had attempted suicide within a year following their surgery. This number represents a one hundred times higher suicide rate

when compared to a matched non-pregnant population. This study proposed some factors including damage to self-image due to pregnancy failure, trauma of surgery and the risk to fertility (Farhi et al, 1994). When comparing scores on the Perinatal Grief Scale, no significant difference was observed between groups who had experienced ectopic pregnancy than those who experienced stillbirths and neonatal deaths. As higher levels of grief are commonly associated with later losses, the lack of difference in scores between these groups highlights the potentially significant distress experienced for ectopic pregnancy (Lasker & Toedtre, 2003).

Lasker & Toedtre (2003) further explored the long-term impact of ectopic pregnancy on women. This research follow up was conducted 16 years after the ectopic pregnancy loss, and most respondents advised that they still think about it and spoke to how it impacted the kind of people they were today. Participants reflected that it was a traumatic experience that impacted their fertility, relationships and for some, led to a crisis of faith (Lasker & Toedtre, 2003).

Zamani et al. (2023) highlighted an increase in state anxiety in those who have experienced an ectopic pregnancy, and a month on from diagnosis, a higher rate of woman met the criteria for PTSD at a high level in comparison to those who experienced a miscarriage. This paper also hypothesised a coping response to pregnancy loss, was to state that the pregnancy was unwanted, to mitigate the loss of the baby (Zamani et al., 2023). This illustrates both the heightened emotional state of individuals and couples, and the potential defense mechanisms that are evoked in the distress.

These findings possibly suggest long lasting trauma responses following an ectopic pregnancy. What is observed in sensorimotor psychotherapeutic approaches to trauma is in the aftermath of traumatic events, people are left with incomplete memory records of the event and a host of easily reactivated responses (Fisher, 2011). Even long after the event has ended, individuals can continue to experience intensely, emotions such as shame, fear, anger and a

sense of numbing of feeling and bodily sensation. Painful negative self-beliefs can intensify the distressing bodily response and distressing emotions (Fisher, 2011).

These emotional experiences do not occur in isolation; they are intricately tied to how individuals perceive themselves and their sense of identity. The following section explores the intersection between pregnancy loss and the sense of self, especially in the psychotherapeutic context.

2.3 Loss, Identity and Psychotherapeutic Meaning-Making

Pregnancy loss can be a rupture not only of future expectations but of core aspects of identity. This section considers how ectopic pregnancy is situated within theories of selfhood and maternal identity, and the implications for psychotherapeutic work.

Those who have experienced pregnancy loss often speak to a complex landscape of emotion, marked by intense feelings of personal responsibility, guilt, shame, and a sense of having failed, alongside experiences of social isolation and disconnection (Caldwell et al., 2023). While guilt is often named explicitly, the internal experience many describe the sense of being fundamentally at fault or flawed, resonates more closely with shame. Shame and guilt, both of which are classed as self-conscious emotions, arise in response to how we imagine we are perceived by others. Touching on the vulnerability of the self in the eyes of the world (Caldwell et al., 2023). Shame involves a painful self-judgment, feeling defective, powerless, or unworthy, whereas guilt tends to be tied to specific behaviours or actions.

Parents who suffer a miscarriage or other form of reproductive trauma often experience profound shame, a sense of feeling defective and less-than (Diamond & Diamond, 2017). This can arise from comparison to others, evoking a narrative that they cannot do what everyone else appears to be able to do, viewing reproduction as a skill in which they are failing. Therefore, pregnancy loss not only can evoke a sense of loss for the baby, but also a loss of a

part of self, causing couples to question who they are and where they might fit in (Diamond & Diamond, 2017).

In exploring why couples feel there is a part of self is lost following pregnancy loss, Van den Broeck et al (2010) theorised that pregnancy begins psychologically in advance of it occurring physically. Then during pregnancy, a process of attachment to the child-to-be-born begins, leading to a movement along the continuum from the "imaginary child" to the "real child". However, individuals experiencing impaired fertility or pregnancy loss, are unable to progress along this continuum, striking a transition to non-parenthood. Psychologically, the wished-for-child remains present, but physically absent (Broeck et al., 2010). Therefore, women who have experienced pregnancy loss do not fall under a particular social category, they remain on a threshold between motherhood and non-motherhood, resulting in uncertainty around their identity (Verdaguer, 2017). Highlighting that not only are women and couples attempting to cope with the loss of their baby, but they are also processing a loss of identity as a parent (Erato et al., 2022).

This prioritisation of maternal identity is conceptualised as the importance of motherhood, referring to the extent in which becoming a parent is a highly valued and significant priority (McQuillan et al., 2008). Whilst gendered expectations have changed in recent years, parenthood remains a social norm in which women are expected to have children and childlessness raises questions (Erato et al., 2022). One factor potentially at play is that of a woman's sociocultural identity and position in the life course, but questions remain as to the process itself, of coming to value motherhood. Erato et al (2022) found that when comparing women who had and had not experienced pregnancy loss, there was a significant importance on motherhood for those who experienced pregnancy loss.

In addition, many women report feelings of guilt in response to miscarriage, in particular when aspects of societal blame and stigma are present (Omar et al, 2019). Responsibility surrounding fertility often falls to women, as it includes monitoring their bodies, taking care of reproductive health, and quantifying sexual activity in order to become pregnant (Verdaguer, 2017). It is not unexpected that experiences of guilt and shame surround women who experience early pregnancy loss, due to the perception that it is their responsibility to become and maintain pregnancy. This responsibility highlights that the concept of the "good mother" is present even when a person is seeking pregnancy (Verdaguer, 2017). Therefore, women report feeling that they are a failure in response to their ectopic pregnancy, that they failed to achieve an intrauterine pregnancy (Spillane et al, 2018).

When pregnancy does not conform to the norm, it can be viewed as an incomplete rite of passage in some cultures. When considered through this lens, women struggling to have children may experience stigmatisation or experience feelings of inferiority (Romney et al, 2021). Grief and guilt can create a new self-narrative for women who experience pregnancy loss, that their body cannot do what it is meant to. Resulting in a cognitive shift towards the belief that they are defective and broken (Romney et al, 2021).

Research refers to miscarriage as an unintended termination of pregnancy prior to 20 weeks and can give rise to a complex grief reaction (Kersting & Wagner, 2012). As ectopic pregnancy results in the ending of the pregnancy, by surgery or medication, it could be classed as an intended termination. Therefore, what response is evoked when the termination is intended, and what impact does this have on identity and sense of self. Some comparison can be made to studies on termination as a result of fetal abnormality, however, a difference for ectopic pregnancy is there is no choice, intervention is required for the woman's survival. This research will therefore explore how this is conceptualised and supported in the psychotherapeutic encounter.

It is apparent that identity is observed in pregnancy loss, therefore this paper will explore whether the experience of ectopic pregnancy has a similar impact, or does it differ and how do psychotherapists frame this for psychotherapeutic practice. These frameworks highlight the need to consider not only the grief for the lost child, but the psychosocial rupture and identity reorganisation that may follow. This leads us to consider how such internal shifts are acknowledged, or not, within the broader cultural landscape.

2.4 Cultural Silence and Disenfranchisement

Beyond the intrapsychic experience, the social context in which loss occurs shapes how grief is understood, expressed, and contained. This section explores how ectopic pregnancy is often rendered invisible through cultural silence and disenfranchised grief.

Pregnancy is widely understood as a profound physiological and embodied experience, one that shapes identity, initiates new roles, and often marks a significant life transition. In contrast, pregnancy loss is frequently positioned as a rupture to this expected trajectory, framed as an exceptional or abnormal event, rather than integrated into the broader social and psychological understanding of reproductive life (Verdaguer, 2019). This illustrates some confusion in the discourse surrounding pregnancy and reproductive trauma.

Perinatal deaths are observed as evoking strong grief reactions; however, many still perceive this form of loss to be minor, a jarring experience for couples to navigate (Doka, 2002, p. 11). Research suggests the reason being, that pregnancy loss is associated with the concept of disenfranchised grief (Markin, 2017). Disenfranchised grief speaks to a grief that a person incurs that is not openly acknowledged, publicly mourned or socially supported (Doka, 1989, p. 4). Disenfranchisement is more profound than pure unawareness, it is an active process in which a grief is denied or rejected (Corr, 2002, p. 40).

Widening the net of disenfranchisement, research proposes that there are grieving rules arising from social and cultural factors, wherein social and cultural communities may deny recognition and support of grief experienced in spoken and unspoken ways (Corr, 2002, p. 41). As there are no culturally defined mourning rituals in many cultures, couples are left unable to mourn following pregnancy loss as it is complicated by the concept that it is often not considered a legitimate loss, or the feelings of grief are minimised (Markin, 2017).

The term hyper-enfranchised grief has also been associated with perinatal loss, it refers to a grief so terrible that others do not want to venture too close to those experiencing it (Olivier & Monroe, 2021). The bereaved find themselves being avoided by friends and family, as their loss threatens natural order, illustrating a risk to emotional safety and security of consistency for others. Therefore, the individual and couple become isolated in their grief, as others cannot bear to witness it.

Whilst grief reactions can appear similar following miscarriage and ectopic pregnancy, there is an additional burden to ectopic pregnancy, being the possibility of reduced fertility (Sperry & Sperry, 2004). Infertility, a potential result of ectopic pregnancy, is also observed as an unrecognised loss, not only does it involve a loss of a dream, but it can also involve a loss of self-esteem and worth, potentially resulting in relationship difficulties (Doka, 2002, p. 12). As there are no culturally defined mourning rituals in many cultures, couples are left unable to mourn following pregnancy loss as it is complicated by the concept that it is often not considered a legitimate loss, or the feelings of grief are minimised. Research is limited in exploring the sense of disenfranchised grief in ectopic pregnancy, this paper intends to explore within this aligns and assess whether psychotherapy can assist in acknowledging and validating the feelings of ectopic grief (Markin, 2017).

As discussed, this paper questions the impact of the medicalisation of the ectopic pregnancy loss, and whether this aspect sets it apart from other pregnancy loss. Previous literature which examines medical trauma, puts forth the concept of disenfranchised trauma in response to illness and medical intervention (Hall & Hall, 2013). The sense of disenfranchised here arising from the socialised expectation that whatever is experienced in a medical setting should be coped with without much thought given to the psychological impact of the medical treatment or environment (Hall & Hall, 2013). Leaving the question, as to whether this concept is observed and worked with within psychotherapy and ectopic pregnancy.

This paper therefore intends to explore whether this concept is observed in the psychotherapeutic relationship with client's who have experienced an ectopic pregnancy, and the discourse in which psychotherapists draw upon to inform their psychotherapeutic approach. In the absence of public or communal mourning, psychotherapy may represent one of the few relational spaces in which this loss can be witnessed. This invites reflection on how psychotherapists attune to grief that is both personal and culturally silenced.

2.5 Psychotherapeutic Concepts and Clinical Approaches

Given the psychological, identity-related, and cultural complexities of ectopic pregnancy, psychotherapeutic engagement must therefore navigate multiple layers of meaning. This section considers existing psychotherapeutic concepts and interventions used in work with pregnancy loss and how they may, or may not, apply specifically to ectopic pregnancy. Whilst perinatal loss appears to be a prevalent loss for individuals and couples, it is an under researched area in terms of agreed upon approaches, this dearth is potentially attributed to the perception that they are medical events as opposed to losses (Olivier & Monroe, 2021).

Hollins Martin and Reid (2023) carried out a scoping exercise on the therapies used to treat psychological trauma following perinatal loss. Within this study some of the approaches listed included cognitive behaviour psychotherapy, grief-counselling, debriefing, EMDR,

expressing writing and compassion focused psychotherapy. Positive outcomes were observed in most of the approaches; however, many were small samples and therefore it is difficult to determine overall effectiveness. Much of the research to date in respect to psychotherapeutic frameworks utilised in the aftermath of pregnancy loss centre on the reduction of symptoms, focusing on aspects of the experience or aftermath rather than the person as a whole. Therefore, this research will focus on the grounding theories and therapeutic understandings that inform how practitioners conceptualise and respond to the experience of ectopic pregnancy.

Grief patterns following pregnancy loss have been observed to be more complicated than initially hypothesised. Studies show that some grief reactions following pregnancy loss do not follow the typical trajectory of high to low levels of grief, with some grief reactions becoming more severe over time (Lin & Lasker, 1996). Perinatal loss is often linked with the concept of complex or complicated grief. The differentiation between "normal" and complex grief is observed when the symptoms continue to be disruptive, and long-lasting. This may be evoked due to the minimisation that occurs surrounding perinatal loss, in place of seeing the grief of the couple as a healthy attachment, there is instead a lack of support, and their grief remains unprocessed and complicated (Markin, 2024).

In addition to disenfranchised loss, the concept of ambiguous loss is observed in perinatal loss. It is best described as a loss in which the physical absence and psychological presence of the deceased are in contradiction (Olivier & Monroe, 2021). In respect to perinatal loss, the four sources of ambiguity can surround the viability of the pregnancy, the physical process of the pregnancy ending, arrangements for the remains, and disclosing the loss to others. Research posits that creating rituals and preserving the memory of the bereaved as helpful within psychotherapy, however for parents that have experienced perinatal loss, they often do not have memories or mementos in which they can remember their baby (Olivier & Monroe, 2021). The representation must be supportive to the bereaved parents, as some representations such as baby

clothes can be triggering, as they do not represent what their baby had experienced, rather what their baby had not yet experienced (Olivier & Monroe, 2011).

As discussed, the concept of parenthood begins before pregnancy, in the anticipation of the wished-for-child. Once a woman becomes pregnant, the narrative becomes more personal and the development of an attachment to the baby begins as they begin to visualise the raising of their baby (Romney et al, 2021). This attachment to the baby during pregnancy highlights the reality of becoming a mother and commences shaping a woman's identity as a parent. As a result of pregnancy loss, in addition to the broken attachment, there may be an experience of loss of identity. One approach that has been employed in psychotherapy, is the use of a reproductive story framework, which explores the conscious and unconscious narratives surrounding the journey to parenthood (Jaffee, 2017). In addition, exploring attachment styles and their relationship with pregnancy loss and complex grief.

The concept of the reproductive story refers to the internal narrative individuals carry about parenthood, shaped by their own early experiences of being parented. This story exists across gender, sexual orientation, and parental status, even those who do not wish to have children hold a reproductive narrative (Jaffe, 2017). As a core element of adult identity, disruptions to this narrative, such as infertility or pregnancy loss, can deeply shake one's sense of self and evoke feelings of failure or incompleteness. In psychotherapeutic work, exploring the reproductive story can help clients make sense of their grief, recognise this identity thread as just one aspect of themselves, and begin to reauthor the narrative in more integrated and hopeful ways (Jaffe, 2017).

Pregnancy and parenthood for couples following pregnancy loss is perceived as a positive outcome, however for many couple's reproductive trauma and attachment issues remain in subsequent pregnancies and parenthood (Markin, 2017). A psychodynamic approach can

explore the wounds that reproductive losses inflict on a person's sense of self, and the feelings of shame and inadequacy which are evoked (Diamond & Diamond, 2017). It is proposed that if such wounds are not addressed, this can negatively impact growing attachment relationships with future children (Markin, 2017).

While psychotherapeutic approaches to pregnancy loss commonly centre around themes of grief, loss, and identity, this paper seeks to explore the specific dimensions of ectopic pregnancy that may set it apart from other forms of pregnancy loss. Much of the research to date centres around symptom reduction, whilst this is important, this paper intends to conduct a more in-depth exploration of the concepts held and the presence of the psychotherapeutic encounter. Rather than evaluating the efficacy of specific modalities, this study aims to explore the underlying therapeutic principles that guide psychotherapists in their work. In doing so, it hopes to offer a more integrated and human-centred understanding that may support clinicians in meeting the complex needs that can arise in the wake of ectopic pregnancy.

2.6 Summary and Justification

The medical focus on pregnancy primarily targets the physical aspects of the expectant mother, often neglecting her mental well-being. An implication of considering the biological aspects of the expecting mother is that when she experiences pregnancy loss, others struggle to appreciate the meaning of the loss to the parent (Markin, 2017). This occurs despite research illustrating that pregnant women develop mental representations and attach early on in pregnancy to their unborn child, miscarriage and ectopic pregnancy are often treated as non-events (Markin, 2017). This cultural tendency may explain the limited psychotherapy research and clinical recommendations on pregnancy loss and ectopic pregnancy, as it remains viewed as a medical matter rather than a psychological one.

This research considers whether distinct psychotherapeutic frameworks or adaptations are required in response to the complex clinical, emotional, and relational dynamics associated

with ectopic pregnancy. Although existing approaches offer valuable insights into reproductive loss more broadly, there remains a notable lack of literature that explicitly addresses the unique psychological and psychotherapeutic needs of individuals who experience ectopic pregnancy. This gap highlights the need for more nuanced and differentiated psychotherapeutic understandings of this form of reproductive trauma.

Chapter 3: Methodology

3.1 Introduction

This study aimed to explore psychotherapists' experiences of working with clients who have experienced an ectopic pregnancy. It sought to gain in-depth insight into how psychotherapists understand, navigate, and make meaning of this complex and often underexplored area of reproductive loss within the psychotherapeutic space. The aim of this chapter is to outline the methodological approach taken in this research project. It details the research design, development of research questions, sampling and recruitment process, and the method of data collection. The chapter also outlines the process of data analysis using thematic analysis and addresses key ethical considerations. Finally, it reflects on the role of the researcher through the lens of reflexivity and considers the limitations inherent within the study.

3.2 Research Design

Knox and Burkard (2009) assert that all research methods are grounded in philosophical assumptions about how data is acquired and interpreted, and these underlying beliefs shape the way qualitative researchers approach interviews with participants. The primary incentive of qualitative research is to explore, describe and analyse ways in which people create meaning in their lives (McLeod, 2014, p. 93). Qualitative research values subjective experiences, meaning-making processes, and the depth of meaning of participants (Leavy, 2022, p. 137). Qualitative research methods are based on a process of either collecting stories or observing the ways in which stories are constructed (McLeod, 2014, p. 95). Qualitative research comes from a discovery-oriented mindset; it does not set out to test a hypothesis, instead it seeks to explore the meaning of different experiences and to develop understanding (McLeod, 2014, p. 96). Therefore, qualitive research requires the researcher to be alert, flexible and to interact positively with the data, rather than a strict and procedures-based approach (Hilal & Alabri, 2013). This approach enables the researcher to gain a deeper understanding of a topic, exploring

the meaning attributed to activities, situations, people, and objects (Leavy, 2022, p. 137). A qualitative research approach was utilised by the researcher in order to gain a greater insight into the experiences of psychotherapists working with clients who have experienced an ectopic pregnancy.

3.3 Development of Research Questions

Before any interview can take place, consideration must be given to the interview questions being asked (Knox & Burkard, 2009). Drawing on the themes identified in the literature review carried out at the proposal stage, the research questions were first developed. As this initial data was analysed, it led to a refinement of the study's primary focus, and the interview schedule of questions was drafted (Knox & Burkard, 2009). The schedule of questions contained a variety of closed and open-ended questions, to ensure consistency and to gather adequate information for thematic analysis. There were twelve questions in total, each being developed from the research aim and objectives. These questions were then refined during the supervisory process, to avoid repetition and to manage any potential biases.

3.4 Sample and Recruitment

Qualitative research often requires purposeful sampling, in order to obtain information rich cases in order to most effectively address the research questions (Leavy, 2022, p. 162). Participants were therefore purposefully selected to comply with pre-selected research criteria. This pre-selection criteria set out that participants would be fully qualified and accredited members of a professional body, who have worked with clients who have experienced an ectopic pregnancy. The justification for this was to ensure that participants had adequate experience and exposure to the research topic to provide a significant insight.

Recruitment began by contacting the Irish Fertility Counsellor's Association (IFCA) requesting circulation of an invitation to their members. However, as initial uptake was limited,

recruitment extended to a similar organisation in the UK, the British Infertility Counselling Association. Responding to low uptake, the recruitment strategy was then expanded to include direct email contact with individual psychotherapists who were listed on the IFCA's membership page, and psychotherapists who listed fertility, pregnancy related issues and pregnancy loss as areas of specialisation on the Irish Association for Counselling and Psychotherapy (IACP) and The Irish Association of Humanistic & Integrative Psychotherapy (IAHIP) directories.

Each participant when contacted was provided with a brief description of the study (see Appendix 1). If they agreed to partake in the research, they were then provided with the information sheet and consent form (see Appendix 2 and 3), in which they were asked to sign and return to the researcher.

A total of seven participants took part in the study, all participants were female. Six were based in Ireland, providing a geographic spread across different counties and representing a range of psychotherapeutic contexts, including fertility clinics and private practice. One participant was based in the United Kingdom. The inclusion of a UK based psychotherapist was necessary due to the difficulty in securing a sufficient number of participants based in Ireland. This decision was justified on the grounds that the participant met all inclusion criteria, practised within a similar cultural and clinical context, and contributed valuable insights consistent with the aims of the study.

3.5 Data collection

Interview methods are employed within qualitative research to follow the natural tendency of people towards conversation. Interview methods vary in the levels of structure in place, from unstructured to highly structured depending on the research question (Leavy, 2022, p. 152). One form of interview that is widely used in qualitative research is that of semi-

structured interview. This method of interviewing is conducted conversationally with one participant at a time and uses a mix of closed and open-ended questions (Adams, 2015, p. 493). Semi-structured interviews can be beneficial when exploring unfamiliar ground where significant issues may emerge, and it is important for interviewees to have the freedom to notice and follow meaningful threads as they arise (Adams, 2015, p. 493). Semi-structured interviews were used in this study to allow greater space for participant responses, whilst ensuring consistency throughout the interview process.

In this study, semi-structured interviews were conducted remotely via Microsoft Teams. This approach helped mitigate potential limitations of online interviews compared to in-person ones, while offering the advantage of accessing a wider range of participants from across the country, which may not have been viable had the interviews been in person (Knox & Burkard, 2009). Each interview lasted between 35 and 45 minutes and the audio was recorded using a dictaphone device. Each interview was then transcribed verbatim by the researcher.

3.6 Data Analytics

Thematic analysis was utilised to analyse the data collected (Braun & Clarke, 2006). Thematic analysis is utilised in psychotherapy research to draw data from interviews, to explore experiences and views of groups of psychotherapists and clients (Carew, 2009). Thematic analysis can be both a method to reflect and to tease out the surface of reality. Like any theoretical framework, it is not free from assumptions surrounding the nature of the data, however good thematic analysis will be transparent (Braun & Clarke, 2006). Thematic analysis provides a framework for identifying, analysing, and presenting themes which arose during the study, enabling themes or patterns to emerge from the data itself. In order for themes to emerge from the data, it involves a process of analysis by the researcher, this is done by identifying themes, determining which are of interest and reporting (Taylor & Usher, 2001). The researcher followed Braun and Clarke’s (2006) framework for thematic analysis, this framework present

six steps for the analysis process, including: familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report.

As the interviews were conducted, a degree of familiarity with the data had already begun to form, along with some initial reflections and interpretations (Braun & Clarke, 2006). This process of familiarisation was further deepened through the act of transcribing, followed by repeated reading of the transcripts. Engaging with the transcripts was experienced as an active process, one that not only allowed for immersion in the participants' narratives but also initiated the early stages of meaning-making and the identification of potential patterns. During this phase, notes were taken and preliminary observations recorded ahead of the more formal coding process. The process of familiarising oneself with the data ensures that there is both a cognitive and emotional response to the data, which can ground the researcher's gut feelings on certain aspects of the data (McLeod, 2014, p. 155).

Once the researcher was familiar with the data, the second phase of Braun and Clarke's (2006) framework could begin, generating initial codes. As the qualitative data is text-based, the basis of analysis is in the coding process (Hilal & Alabri, 2013). Coding is taken from transcribed interviews notes directly, where each data item has been given equal attention, to ensure that a comprehensive and thorough coding process takes place. Codes identify certain features of the research data which appear interesting to the researcher, which can include both semantic and latent content (Braun & Clarke, 2006). Codes are linked to words, phrases or entire paragraphs in the transcripts, these then come together in order to determine any connection between them (Hilal & Alabri, 2013).

As per Braun and Clarke's (2006) recommendations, coding was done for as many themes as possible, extracts were coded inclusively to ensure that context was not lost, and extracts were coded into as many themes as they would fit into, to ensure all data was accounted for. The coding process involves organisation into significant clusters to form a map of the analysis (Braun & Clarke, 2006). The researcher utilised the qualitative analysis software, NVivo, to assist with the coding process (Hilal & Alabri, 2013). Whilst coding can be done manually, the researcher utilised NVivo to ensure that the data was worked with more attentively and methodically (Hilal & Alabri, 2013). Line-by-line coding was considered an effective way of subverting and challenging any pre-existing assumptions or early patterns that may have been perceived by the researcher. Through the discipline of micro-coding, close attention was directed not only to what was present in the data but, more importantly, to what else might be revealed (McLeod, 2014, p. 155).

Once all data has been coded and collated, the codes are then sorted into potential themes for identification (Braun & Clarke, 2006). This phase of the analysis examines the broader level of themes, by analysing the separate codes and considering how each code may be grouped to form a theme. Techniques such as tables, mind maps, or writing each code on separate pieces of paper and arranging them into theme-based groupings were commonly used (Braun & Clarke, 2006). In this research, tables were created, and each code was added initially in order of frequency in the data set, and then re-organised into clusters. During this phase, attention was directed toward exploring relationships between codes, between themes, and across distinct levels of thematic structure.

Once initial themes had been identified, they were then subject to review and refinement to ensure coherence throughout (Braun & Clarke, 2006). The coded data extracts were analysed to evaluate whether they formed coherent patterns, once this was established the entire data set was reviewed to ensure that that the thematic map accurately reflected the data set (Braun &

Clarke, 2006). A deeper analysis was then conducted of the thematic map, refining the specifics of each theme, and establishing descriptive names to capture the key concepts and responses within each theme (Braun & Clarke, 2006).

Finally, a selecting vivid and relevant data extracts to illustrate each theme and most accurately reflecting psychotherapists' experiences with clients who have experienced an ectopic pregnancy (Braun & Clarke, 2006).

3.7 Ethical Considerations

Ethical approval for this research was granted by the ethics board of Dublin Business School. All participants received an information sheet and consent from in advance of the interviews being conducted. The information sheet outlined the purpose, scope, and voluntary nature of the study (Appendix 2). The consent form was signed by each participant, confirming their participation in the study (Appendix 3). At the start of each interview, the researcher verbally ran through both forms to ensure that participants understood and gave space for any further questions.

Each participant was assured that in order to protect participants' privacy and the confidentiality of their clients, all identifying information was removed from transcripts and pseudonyms were used in all documentation. Audio recordings were stored securely on the researcher's password-protected computer, with access restricted to the researcher alone and deleted after transcription and analysis. These recordings, along with the transcriptions, were coded and securely stored in accordance with Dublin Business School's ethical guidelines. Pseudonyms were used to protect participants' identities. Participants were informed of their right to withdraw from the study at any stage.

3.8 Reflexivity

In qualitative research it is unavoidable that the researcher will exert some influence, this may appear in what participants share with one researcher over another, or in analysis, one research may be more sensitive to meanings which another researcher may not (McLeod, 2014, p. 97). Therefore, researcher reflexivity is a key component of qualitive research. Reflexivity refers to the researcher's capacity to reflect on and consider their own personal and subjective involvement in the research, not to be confused with bias (McLeod, 2014, p. 97).

There are areas within qualitative research in which the researcher's capacity to be reflexive is most relevant: choosing the research topic, relationships with research participants, emotional responses to any aspect of the research, data analysis and in selecting examples to highlight in the report (McLeod, 2014, p. 97). Effectively addressing researcher reflexivity in qualitative research involves integrating specific practices into the research process. A common approach, and one that was used by the researcher, was the use of a reflexive journal. The researcher documented their expectations, personal experiences and reflections, particularly moments when the research took on personal significance.

In addition to keeping a reflective journal, the researcher engaged in dialogue with their supervisor and research colleagues in order to obtain essential outside perspectives. These conversations often highlight personal aspects of the research that the researcher may not have noticed or may have avoided acknowledging (McLeod, 2014, p. 97).

3.9 Summary

In summary, this chapter has outlined the qualitative methodological framework that guided the study, with a focus on capturing the nuanced experiences of psychotherapists working with clients who have experienced ectopic pregnancy. A semi-structured interview format enabled rich, reflective narratives to emerge, while thematic analysis provided a structured yet flexible approach to identifying patterns of meaning within the data. Careful

attention was given to ethical considerations, participant selection, and the integrity of the analytic process. Reflexivity was integrated throughout to ensure awareness of the researcher's position and influence. The approach taken reflects the study's commitment to valuing lived experience and meaning making within a psychotherapeutic context.

Chapter 4: Findings

4.1 Introduction

This chapter explores the experiences of psychotherapists working with clients who have experienced an ectopic pregnancy. In some cases, ectopic pregnancy was the central reason clients entered psychotherapy; in others, it emerged later in the process, particularly in the context of fertility treatment.

This chapter attends to how grief, trauma, shame, and identity rupture are processed within the psychotherapeutic relationship, and how psychotherapists offer meaning-making, containment, and attunement in the absence of external validation. This will be highlighted through participant quotes, which speak to the awareness they hold of their client's process and the psychotherapist's own ways of working. The findings illuminate how psychotherapists conceptualise, hold, and support these experiences, often in the absence of adequate cultural or clinical frameworks.

4.2 Theme 1: Carrying the Impact

This theme explores how psychotherapists encounter the psychological and emotional weight clients carry after experiencing an ectopic pregnancy. Participants described working with shock, trauma, and loss, all of which often emerged belatedly or in fragmented forms. This theme illustrates the complex intersectionality of emotional responses to which psychotherapists must remain attuned.

4.2.1 Navigating Clinical Crisis and Medical Shock

Participants spoke of how clients arrived in psychotherapy deeply affected by the traumatic urgency of their medical experience. The psychotherapeutic task involved naming the trauma, offering containment, and helping clients begin to process what may have been emotionally bypassed during the crisis.

Participants described their understanding of the early stages of an ectopic pregnancy as characterised by emotional dissonance and uncertainty. Participants reflected that clients often entered the experience with hope of seeing the positive pregnancy test, especially those who had struggled with fertility and "*the pregnancy has been so hard fought for*". Only to be suddenly confronted with pain, vague symptoms, or inconclusive scans. The term ectopic was unfamiliar, and the reality of the situation often landed late, compounding the shock.

> *"Hadn't heard of it before, hadn't really been aware of it, and didn't think it was going to happen to them, because they had been in a place of celebration up until the point of being in pain."*

Some participants spoke of the diagnostic limbo, which causes further distress and worry for clients. It was noted that, during this time, clients speak to a sense of denial or shock, as they remained hopeful while awaiting scan results, unable to grasp the potential gravity of what was unfolding.

> *"It can be really, really devastating when somebody gets the news that, not only is it an ectopic pregnancy, potentially they're going to lose a tube. Potentially they're going to lose their lives…"*

Several participants described clients as being in fight or flight, unable to process the information, hypervigilant to the expressions of clinicians around them, rather than absorbing the words being said. This sudden escalation into a medical crisis left clients emotionally unprepared and psychologically overwhelmed.

> *"Not being able to absorb what it meant reading the faces of the medics around them, the sort of the panic, 'What are we going to do here?'*

Many participants echoed that medical care is inconsistent, and often **"***very fast, very clinical, very matter of fact***"** which contributed to the trauma of the experience, not just for the

loss of the pregnancy, but for the erasure of emotional meaning amid medical urgency. Where medical care was sensitive and compassionate, clients reported feeling somewhat held. However, this was not the norm.

Participants described a primal drive to hold on to the pregnancy, and "*not really wanting to accept that their life might be in danger either".* The intensity of this attachment made the reality of treatment even more distressing, not only were clients losing a much-wanted baby, but they were also facing the terrifying knowledge that their own lives were at risk. participants spoke to "*a horrible helplessness in it*" for clients, the responses to their experience were out of their control, they did not have choice.

> "A *realisation that the feeling of powerlessness, the feeling of, I couldn't argue with them. I couldn't, there was no other option here."*

Within this subtheme it is evident from participant responses that psychotherapists hold an awareness of the shock, trauma, disconnection and breach of autonomy in response to the diagnosis and treatment of ectopic pregnancy.

4.2.2 Holding the Loss of the Imagined Baby

Participants reflected on supporting clients to grieve not only the pregnancy, but the imagined child and future. Psychotherapeutic work focuses on validating grief that has no formal recognition and exploring symbolic and narrative ways to give meaning to the loss.

Participants described how grief following ectopic pregnancy was often complicated by the absence of recognition, both in the medical system and in wider society. Ectopic pregnancy loss is frequently minimised, viewed as biologically common or inevitable, and this can invalidate the depth of emotional meaning attached to the pregnancy by the client.

> "*Very dismissive of the experience for the woman that this was, this was a potential child.*"

Some participants spoke to the confusion and ambivalence clients feel around whether they had “really” been pregnant. Participants noted the ambiguity of ectopic pregnancy, situated uncomfortably between miscarriage, medical emergency, and, in some cases, treatment resembling termination. Participants advised that much of the work with clients is in supporting them to name their loss. As clients struggle to locate themselves in familiar grief narratives, feeling like mothers who had lost a child, while simultaneously doubting their right to claim that role.

“*I'm not pregnant with a viable pregnancy. I'm not going to have that due date. My imagined future has been taken*”

Participants reflected on the hidden nature of this loss, not because there was a lacking emotion, but rather there was no external framework to help them mourn. At the fore for participants is to facilitate this space, to remove any barriers to a client’s grief.

“*It's about a loss that is hidden, not consciously, but because of circumstances. It's a loss that is not known or given full space*”

Participants conceptualise that the grief extends beyond the immediate pregnancy to a broader sense of rupture, including a loss of bodily trust, reproductive identity, and imagined motherhood.

“*Not only am I now grieving the loss of a baby, or what this pregnancy represented to me, but now I'm grieving the loss of maybe a sense of my womanhood, or a part of my body, and additionally, potentially future fertility issues”*

These reflections reveal that grieving an ectopic pregnancy is often disenfranchised, not just by others, but sometimes by the clients themselves, who feel unsure of their right to feel what they feel.

4.2.3 Recovery and Emotional Aftermath

Participants described the anxiety, numbness, or disconnection, signs of unresolved trauma in client presentations following an ectopic pregnancy. Participants described how they held space for complex and delayed reactions and worked to help clients integrate what was held in the body, mind, and relational life. Participants held an awareness that the rupture experienced by clients, can leave a lasting imprint on the individual's relationship with their body, their sense of control, and their unfolding reproductive narrative.

Participants spoke to the complex, often non-linear recovery clients faced following ectopic pregnancy. For many, physical healing occurred far more quickly than emotional integration. participants reflected that clients frequently describe feeling unsure of what recovery was "meant" to look like, particularly in the absence of public narratives or cultural rituals. This uncertainty could evoke anxiety, depressive symptoms, or a lingering sense of disorientation.

> "*When you don't have a frame of reference, there's often an emotional toll on that as well. What if I never feel better? What if, this is how I feel from now on?*"

Participants highlighted a disconnection between mind and body in the aftermath, particularly when medical guidance suggested they were "ready" to try again, even if they did not feel emotionally safe. Participants reflected on the pressure some clients internalise, whether from clinicians, partners, or themselves, to move on, conceive again, or recover within a fixed timeframe.

> "*There is a pressure from being told by a doctor, you know, you're fine to start trying again now in three months. Or, you know, instead of going, oh, I have to be ready to do it at that point, even if I'm still very traumatized by it, even if I don't know if I want to."*

Even where subsequent pregnancies occurred, psychotherapists observed persistent anxiety. Some clients became hypervigilant, unable to experience joy or trust in their body. The fear of recurrence remained close to the surface, highlighting the significant trauma response and sense of it being out of their control.

"*You're somebody who has had that experience, and you're never going to look at your own substantive pregnancies, your friends, pregnancies, your sisters' pregnancies, your kids' pregnancies, without having that realization or that knowledge of this awful thing can happen.*"

Participants highlighted a strong trauma informed practice, noting how and where trauma often becomes embedded not just psychologically but somatically, or symbolised in certain objects.

"*That trauma resides in that building for them."*

"*That part of her body completely closed in fear*".

Several participants also highlighted that recovery was not only difficult for the woman who experienced the ectopic pregnancy, but for her partner as well. While often overlooked, partners sometimes witnessed the trauma firsthand, gave consent for medical procedures, or lost their own dreams of parenthood. In some cases, this unresolved distress impacted the couple's emotional and sexual intimacy.

"*He was terrified, in a way, that his partner would become pregnant, because he didn't want to lose her. He didn't want her to go through the same, he didn't want them both to go through the same trauma again*".

Within this theme and subtheme, it is prominent that the impact on the client is long lasting, often appearing as a disconnection between mind, body and their ectopic pregnancy experience and recovery.

4.3 Theme 2: Self in Rupture

This theme focuses on how psychotherapists encountered disruptions to clients' sense of self, body, identity, and relational belonging following ectopic pregnancy. Participants described how the psychotherapeutic relationship helped clients navigate internalised shame, loss of bodily trust, and the fragmentation of identity that followed ectopic pregnancy.

4.3.1 The Body as a Betrayer

Participants described how clients struggled with a sense that their bodies had failed them. Psychotherapy became a space where dissociation, fear, and the re-integration of the body could be gently explored over time.

Participants described how, for many clients, ectopic pregnancy triggered a profound rupture in their relationship with their body. Within dominant cultural narratives, pregnancy is often framed as a natural extension of womanhood, something the body is designed to do. When that function fails, clients were left not only grieving a pregnancy but grappling with the sense that their body had betrayed them.

> *"It drops quite heavily into a sense of shock, denial and sense of failure in their body. Their body has failed them."*

This experience was not purely physical, participants spoke of how clients began to see their bodies as untrustworthy, disconnecting from it in order to cope with the trauma. Some described a subtle dissociation, a splitting between self and body that offered a temporary sense of control or psychological safety. This disconnection was both protective and painful. One participant reflected that for some clients, the part of their body that housed the pregnancy, the

womb, the fallopian tube, became a site of fear or shame. This can be experienced psychosomatically, feeling pain where there is no physical cause. Avoiding physical connection or embodiment was not a lack of grief, but rather a signal of emotional overwhelm.

> *"Slightly dissociated from their body because their body has done something that they weren't expecting".*

Participants reflected that this bodily rupture often led to deeper identity questions, particularly around gender, fertility, and worth. The failure of the body to sustain a pregnancy was not experienced in isolation, it cut across societal ideals of womanhood and maternal capability. Clients struggled with internalised shame and self-doubt: if they could not carry a pregnancy, what did that mean about who they were?

> *"I'm not a real woman, because my body let me down."*

The impact of ectopic pregnancy, then, was not simply a reproductive loss, it was an existential blow to self. The woman's sense of wholeness, identity, and belonging become fractured.

4.3.2 Internalised Blame and Shame

Following on from the subtheme of the perceived bodily failings, many participants described clients who blamed themselves for the loss, despite the random nature of ectopic pregnancy. Psychotherapeutic work involved unpacking shame, challenging internalised narratives of failure, and restoring a sense of self-compassion and perspective.

In the aftermath of ectopic pregnancy, participants described how many clients struggled to make sense of what had happened, and in that struggle, blame needed somewhere to land. Sometimes this blame was projected outward, onto medical professionals, particularly if there had been a delay in diagnosis or a perceived lack of care. However, more often, participants

observed that blame turned inward, towards the self, the body, and even the client's sense of identity.

"But that sense of, what did I do wrong? What could I have done differently? Is this somehow my fault? Is there something that I could have done or should have done?"

This internalised blame deepened clients' feelings of failure, reinforcing the idea that their body had let them down, not only failing to sustain the pregnancy, but also failing to protect the baby. The sense of being "broken" emerged as a powerful, repeated image. The desire to locate a cause, to restore meaning and order, often led to self-blame. Grief became entangled with guilt and a profound sense of personal inadequacy.

"Somehow my body failed, I'm broken. There was a lot of this kind of sense of being broken, right, as a woman, as a mother, I couldn't protect my baby".

Participants noted that these feelings of failure were magnified by the social context in which pregnancy is frequently portrayed as natural, successful, and joyful. In contrast, clients who had experienced loss found themselves surrounded by images and stories of successful motherhood and saw no reflection of their own experience.

"You know, when you're looking around and see or perceive every woman, every other woman, to be able to do this".

In this way, shame appeared unavoidable, as not only had the client suffered a traumatic loss, but that loss was culturally invisible.

4.3.3 Avoidance and the Drive to Get Back to Normal

Participants reflected on how clients often rushed toward recovery, emotional shutdown, or new pregnancy to bypass grief. Psychotherapy offered a pause, a chance to reconnect with emotional and somatic experience that had been pushed aside.

Participants described how many clients attempted to return to their previous lives as quickly as possible following ectopic pregnancy. In the absence of cultural reference points or emotional scripts, recovery was often measured against a personal baseline, how they felt before the trauma, rather than understanding what it means to heal. For some, this created unrealistic expectations and internal pressure to "be normal" again.

"a clinic will say to a woman, okay, you're discharged. Now you're fine. It can sometimes amplify their experience of loneliness in the emotional and psychological healing."

This urgency often masked a deeper avoidance of the emotional and somatic impact. Participants reported that clients disconnected from their grief, their body, or both, sometimes unaware that the trauma still resided within them. Participants noted that when recovery focused solely on physical healing, the psychological wound remained unattended, often resurfacing later. The disconnect between body and mind made it difficult for clients to trust either. For some, the body had become a source of fear or betrayal; for others, their own emotional responses were experienced as unreliable or overwhelming.

"I was physically recovered in February, but in my body, I continue to feel that there's something wrong again. It's just coming back to that feeling of failure, doubt, fear".

Participants also reflected on a rush to conceive again, driven by many factors: the hope of redemption, avoidance of grief, or to ease the distress of others. In some cases, the pressure came from within, in others, from a perceived social gaze. Rather than being supported, clients often felt watched, as if they were expected to demonstrate resilience, or to reassure those around them by "moving on." For some, trying to conceive again became a way of soothing the discomfort of others, repairing a perceived rupture in how they were viewed as women, friends, or potential mothers. If she could become pregnant again quickly, perhaps she could restore a sense of normality, not just for herself, but for others too.

"There is a kind of a sense of everyone's watching them to see, when do we get pregnant again? So *that it can be okay, so that they find out that it all worked out okay for her in the end."*

This pressure was not always explicit, but it lived in the social field, in the well-meaning comments, but invalidating their loss and experience. For clients, this created a painful dissonance, while others celebrated their pregnancies, the woman grieving an ectopic loss often felt out of place and left behind.

4.4 Theme 3: Cultural Silence

This theme explores how psychotherapists understood the wider cultural, relational, and medical silences surrounding ectopic pregnancy. Psychotherapy became one of the few spaces where the experience could be named, legitimised, and emotionally processed. The findings highlight how psychotherapists not only supported clients individually but also worked within, and against, systemic silences.

Ectopic pregnancy, as described by participants, is marked not only by physical and emotional trauma but by a profound absence of language, cultural narrative, and public recognition. Clients experiencing ectopic pregnancy often do so in isolation, not because they are emotionally closed, but because there is no shared script for how to talk about it, or even to expect it. This silence is not incidental, but embedded within the social, gendered, and medical narratives that frame pregnancy and womanhood.

"Some clients have never heard of an ectopic pregnancy until they have one themselves".

The assumption that pregnancy is inherently joyful and successful contributes to this erasure. There is no mainstream education around the risk of early pregnancy, let alone the life-threatening potential of ectopic pregnancies. When such a rupture occurs, it feels not only devastating, but unintelligible, both for the client and those around her.

"It's a very serious condition, but it doesn't feature in society."

Participants reflected on how this silence intersects with cultural norms around not disclosing pregnancy before 12 weeks, a rule framed as protective, but which functions to shield society from the discomfort of loss. When early pregnancy ends, especially in such a traumatic way, couples are left to carry that grief alone. If they have told no one, the wound is hidden. If they have told others, it becomes a public wound, subject to discomfort, minimisation, or awkward silence.

"What we're doing in that situation is we are taking a burden of grief, and we are saying the community does not want to bear this, so women must bear it alone".

The silence surrounding ectopic pregnancy is not just personal, it is systemic. It is reinforced through medical discourse, reproductive norms, social rituals, and emotional avoidance. Even in spaces intended for support, such as miscarriage communities or pregnancy loss groups, women who have experienced an ectopic pregnancy can find themselves emotionally out of place.

"*I'm quite alone in this, and even in the community of miscarriage, I'm quite alone. I don't fit into the normal "miscarriage*".

This underscores the unique emotional displacement caused by ectopic pregnancy. It is not only medically "ectopic", out of place, but symbolically and socially out of place as well. There is no clear narrative for it, no shared language to speak it, and few relational spaces in which it is recognised as a legitimate loss.

4.5 Theme 4: Psychotherapeutic Presence and Practice

This theme examines the psychotherapeutic practices, relational stances, and clinical frameworks psychotherapists used to support clients through and beyond ectopic pregnancy.

participants described their roles not as solution-givers but as emotional witnesses, creative co-holders, and grief-informed practitioners working in the absence of broader societal support.

4.5.1 Naming the Loss and Validating Grief

Participants described how a core task in the psychotherapeutic relationship was to help clients name what had happened as a real and grievable loss. In a context where the experience is often silenced or dismissed, psychotherapy offered validation, emotional legitimacy, and language for mourning.

Beginning each interview, each participant was asked whether the ectopic pregnancy experience was the primary or secondary focus of psychotherapy, to which there was a mixture of respondents. One participant reflected that in their practice they ask about the experience of pregnancy early in the psychotherapeutic encounter, to facilitate naming not only grief, but their reproductive story.

> "*I generally ask women if they've had any pregnancies in their lives, because that allows for a woman to be able to say they've had a miscarriage, they've had a termination, they've placed a baby for adoption, they've had Sudden Infant Death, or they don't want to have children, or they have fertility problems*."

Participants consistently emphasised that one of the most crucial aspects of the work was validating the reality of the loss. In a cultural and medical context where ectopic pregnancy is often minimised or misunderstood, many clients, and their partners, arrived in psychotherapy uncertain whether they were even "allowed" to grieve. The work, then, began by helping clients name the experience as a loss, and ground it in emotional truth.

> *"This baby existed for a brief time in your world, but they did exist, and they were real to you, and their potential was absolutely real.*"

Clients often questioned whether they had a right to call themselves parents, even for a brief time. Participants reflected on the emotional liminality of this experience, clients were on the other side of parenthood, but had no cultural role, identity, or title to anchor it. In helping clients make sense of their emotional responses, participants found it helpful to draw on grief models, particularly the dual process model, which allowed clients to understand that oscillating between sadness, numbness, distraction, or even future-planning was still part of grieving.

"Dual process model of grief... to understand that everything they're doing is grieving, whether it is restoration or whether it is loss, or whether there is the oscillation between the two, it's still grieving".

For couples, participants noted that grief was often felt and expressed differently between partners, and that this mismatch could lead to miscommunication or emotional disconnection. Psychoeducation was key in helping clients understand that divergent grieving styles did not indicate a lack of care or love but reflected different internal timelines and coping strategies.

"Within the relationship, you might not be grieving in the same way or at the same pace as your partner, but that's okay too."

Participants described moments where one partner assumed the role of emotional minder, while the other was seen as needing care, roles that could reverse or shift over time. Without open dialogue, these dynamics sometimes led to resentment, avoidance, or fear of burdening one another. Psychotherapy provided space for couples to re-learn how to speak to each other, not just about the event, but about the meaning it held for each of them individually.

4.5.2 Relational Holding and Psychotherapeutic Attunement

Participants spoke of the importance of being emotionally and relationally present for clients, holding the trauma when the client could not. The psychotherapeutic stance was

grounded in trauma-informed care, offering safety and containment to allow integration over time.

Across interviews, participants spoke to the importance of meeting each client as they are, without assumptions, and without imposing a pre-written narrative. While understanding the medical and emotional dimensions of ectopic pregnancy was seen as essential, participants were careful not to presume what the experience meant for any individual.

> *"Only the person who has the ectopic and is being operated, only that woman probably knows a little bit more what it means to have a pregnancy outside."*

Given the silence and isolation that often surrounds ectopic pregnancy, participants emphasised the need to offer a holding environment where all aspects of the experience, physical, emotional, existential, could be given space. Holding did not mean solving, or interpreting prematurely, but staying present with whatever arose, including silence, confusion, or fear.

> *"Really hearing their experience, hearing it, letting them feel into it, letting them begin to notice where it's landing in their emotional body, the distress, the physical stress, the emotional stress that turns up"*.

This attunement was rooted in trauma-informed practice, with participants highlighting the importance of recognising the diverse ways trauma may manifest through shutdown, dissociation, hypervigilance, or overwhelm. Where the client could not yet bear to hold the trauma herself, the psychotherapist's task became one of containing it, until safety, trust, and emotional readiness allowed for shared meaning-making.

> *"You absolutely need to work from a trauma informed perspective in order to really be able to understand the different responses that somebody can have in terms of their reaction and response to trauma."*

Participants also reflected on the importance of working with the whole person, holding not only the trauma, but also the client's autonomy, agency, and potential. It means tracking what the client needs moment to moment, sometimes stepping forward, sometimes standing back, always with deep respect for the client's pace and internal world.

> *"Trying to just see the whole person, but also to very much work with their autonomy in mind, and where do they want to go."*

It was evident throughout participant reflections that it is key to attune to the client and their pacing, ensuring containment so that they do not become retraumatised or shutdown.

4.5.3 Creativity When Words Fail

Given the limitations of language around ectopic pregnancy, participants described the value of creative and somatic methods, from art and sand tray work to sensorimotor awareness. These approaches allowed clients to access and express their experience symbolically, often bypassing the silence surrounding the loss.

Participants described using a wide range of creative and embodied approaches to support clients to explore and express their experiences, particularly when language was unavailable or insufficient. For many clients, the trauma of ectopic pregnancy existed beyond words, shaped as much by bodily sensation and emotional overwhelm as by narrative. Given the absence of cultural discourse, and the emotional silencing described elsewhere, creative tools became alternative forms of communication, ways to speak without speaking.

> *"I found art psychotherapy to be really helpful, because sometimes it's hard to put into words, what you're going through, what you're dealing with, there's such complex layers to it all."*

Sensorimotor approaches were used to ground the client in her body and explore where trauma responses might be locked somatically. Participants spoke to the importance of symbols,

ceremony, and rituals in expressing their grief. Whilst other clients engaged in artmaking, sand tray work or journalling, which provided symbolic containers for pain that was still raw, fragmented, or ambiguous.

> *"Really hearing their experience, hearing it, letting them feel into it, letting them begin to notice where it is landing in their emotional body, the distress, the physical stress, the emotional stress that turns up".*

Creative practice was also extended beyond the one-to-one space. One participant reflected on the use of psychotherapeutic groups, which offered clients the opportunity to witness and be witnessed by others who had experienced reproductive loss. In contrast to the silencing nature of broader society, these groups became micro-communities of understanding, where grief was spoken, or drawn or symbolised, and held without judgement.

> *"That was a big thing in my group that we would talk about was, like, the need to ritualize these losses and kind of make them more concrete, because they can feel really like ambiguous and abstract".*

Whether in individual or group work, creativity and ritual became a way to externalise what was held inside, to honour the loss, and to begin the process of integration.

4.6 Summary - Across the Silence

These findings contribute not only to a deeper understanding of client experiences of ectopic pregnancy, but to psychotherapeutic practice itself. They highlight the need for training in reproductive trauma, a broader use of creative and embodied approaches, and the importance of grief literacy among clinicians. In offering a space for what cannot be spoken, psychotherapists help clients rebuild meaning, identity, and relational safety, even when the world around them remains silent. The following discussion will explore these findings in dialogue with existing literature.

Chapter 5: Discussion

5.1 Introduction

The findings of this study suggest that ectopic pregnancy exists at the margins of both medical and cultural discourse, rarely named, poorly understood, and often rendered emotionally invisible. Despite its significant psychological impact, clients may arrive in psychotherapy unable to articulate their experience, and psychotherapists themselves may lack a framework for understanding it.

As discussed in Chapter 4, Thematic Analysis was selected as the method of data analysis and four main themes were identified during this process. The findings provided rich insights in psychotherapy practice following ectopic pregnancy, however this discussion chapter will further explore some of the key the themes identified, Carrying the Impact, Self in Rupture, Cultural Silence, and Psychotherapeutic Presence and Practice, align with and extend current literature as outlined in Chapter 1.

This chapter draws together the key findings in relation to the research aim and objectives: to understand the emotional and relational impacts of ectopic pregnancy in psychotherapy; to explore how experiences of identity and self are navigated in psychotherapeutic work; and to consider the discourses and therapeutic approaches psychotherapists engage with in this work.

5.2 Carrying the Impact

This theme explored how psychotherapists understand and work with the emotional and relational impacts of an ectopic pregnancy, prominent findings were that of trauma and loss.

From the findings, it was evident that the loss experienced from ectopic pregnancy is conceptualised as a loss which is not socially supported or mourned, aligning with the concept of disenfranchised loss (Doka, 1989, p. 4). Participants spoke about well-meaning friends and family in trying to put a positive spin on the experience, in turn minimising the loss, and

creating a barrier for the expression of grief (Markin, 2017). Therefore, it is apparent that psychotherapy facilitates the parents' grief, staying with the difficult emotions of loss, not minimising, or invalidating their loss following an ectopic pregnancy.

Developing this further, participants reflected on client's experience of loss and grief to varying degrees, and some adapted their intake questions to ensure that any loss or reproductive trauma is invited in by asking if there have been any pregnancies. Opening a dialogue in which a client can speak to any previous losses in which they did not feel was a "loss", which aligns with literature on reproductive trauma, in that everyone has a reproductive story (Jaffe, 2017). Participants primarily spoke to acknowledging and validating their emotions, in particular grief and loss. As well as processing the loss of the ectopic pregnancy, participants held the awareness that such an experience can evoke previous experiences of loss, in which each bereavement will need to be worked through, which aligns with previous literature on ectopic pregnancy (Schaper et al.., 1996).

As discussed, a process of attachment to the child-to-be-born begins during pregnancy, leading to a movement along the continuum from the "imaginary child" to the "real child" (Broeck et al., 2010). It is then suggested that ectopic pregnancy disrupts this process, leaving couples suspended in a space of non-parenthood. However, the wished-for-child remains present, but physically absent (Broeck et al., 2010). This is evident in the findings, there is a strong sense of the wished for child, therefore psychotherapists must hold this awareness in approaching the identity questions this raises and the loss it evokes. As well as the wished for child, there could be the concept of the wished for fertility, in which clients hold this view that it should be without complications and therefore causing a rupture between what they wish for, and what is in the present.

Aligning with the concept of ambiguous loss, participants spoke to the importance of symbolism and rituals in supporting clients' processing of grief. It is observed that in the absence of tangible evidence of their loss, acts as a barrier to grief expression (Schaper et al., 1996). Therefore, in direct conflict with the silent discourse surrounding ectopic pregnancy, psychotherapy assists in grounding the loss, removing this barrier to grief, enabling parents to express their loss in ways that are meaningful to them. Psychotherapy supports the loss to become less ambiguous.

The trauma of ectopic pregnancy can be understood as twofold: firstly, in terms of its immediate and lasting impact on the woman and, where relevant, the couple, manifesting in both physical symptoms and enduring emotional responses; and secondly, in its deeper disruption to the sense of self, which will be explored further in the following section *Self in Rupture*. Conceptually, it is held that traumatic experiences can persist in embodied emotions and sensations, beneath language and often through images, such as dreams, memories or reminders in the world (McMorrow, 2024). Creative and embodied practices discussed in the findings align with trauma literature, as it supports ways to express and discharge the trauma which have been long held in since their ectopic pregnancy experience (Fisher, 2011).

Research illustrates the trauma responses that are evoked due to medical diagnosis and treatment, as well as the environment. Reduced personal agency, volition and personal symbolism can all influence a person's experience and contribute to the stress response. Therefore, psychotherapists should hold this medical trauma informed awareness in supporting clients to process each aspect, and integrate into their awareness (Hall & Hall, 2013). This was observed in participant responses in supporting clients in sharing their medical experiences, integrating the physical, emotions and spiritual aspect of the ectopic pregnancy experience.

One participant spoke movingly to the significant impact that multiple ectopic pregnancies can have on the woman and within the couple. Research suggests that recurrent ectopic pregnancies double the psychological impact, triggering or reactivating the grief and trauma response at a heightened level (Ren et al., 2024). Often when clients present following an ectopic pregnancy, there are concerns for their ongoing fertility, or their presentation is a part of fertility treatment. Therefore, when psychotherapists are working with the concept of reproductive trauma, there must be an understanding that such individuals and couple can be continuously experiencing multiple traumas in waves (Brigance & Brigance, 2023). Particularly as they navigate fertility treatment such as IVF, the wave of emotions as they move through hope, helplessness, loss. As discussed, as a form of trauma, infertility can be conceptualised as a form of ambiguous loss, which in turn can evoke shame, hopelessness, fear, grief, depression, post-traumatic stress for both women and men (Brigance & Brigance, 2023). Therefore, the resulting infertility, from ectopic pregnancy continues the cycle and intensity of the ectopic pregnancy loss and trauma (Schaper et al., 1996).

5.3 Self in Rupture

This theme considers how psychotherapists encounter and understand experiences of identity and self in the psychotherapeutic work following an ectopic pregnancy.

Within the findings, it was agreed that being trauma informed is necessary when working with ectopic pregnancy experiences, in particular as a result of the speed and urgency of the medical response and treatment. This is in line with research which illustrates that trauma experienced as a result of medical treatment can develop into clinically significant reactions, and psychotherapy is central in the processing of the medical trauma and the aftereffects (Hall & Hall, 2013). Clients may disclose difficulty assimilating information, identifying memorable events of the process, following ectopic pregnancy. Therefore, psychotherapy assists to anchor the experience, process the serious ramifications of the experience, in addition to promoting

grief process (Schaper et al., 1996). In line with previous research, as clients begin to come to terms in the aftermath, they must then navigate a complex landscape of emotion, marked by intense feelings of personal responsibility, guilt, shame, and a sense of having failed, alongside experiences of social isolation and disconnection and the impact it as on their sense of self (Caldwell et al., 2023).

Where ectopic pregnancy appears to sit in a difficult place is the sense that it is between a termination and miscarriage, as the location of the pregnancy warrants termination to save the woman's life. Research advises that a complex grief reaction is observed when there is an unintended termination, therefore where does ectopic pregnancy lie in respect to complex grief and how can psychotherapy support the processing of this grey area. Sharing some similarity with research on pregnancy termination for fetal anomaly, it is essential that psychotherapists are aware of the weight of the termination aspect of an ectopic pregnancy (Leon, 2017). Whilst this can be a complex issue to navigate for any client, it can be particularly rupturing for a client whose religion or culture have a set view on any form of termination (Condic & Harrison, 2018). The findings and literature highlight that the role of psychotherapy is to reveal links that lead to positive and negative mental health outcomes for each client, exploring the client's values and meaning they have attached to such experiences, which will assist in processing trauma and loss (Rubin & Russo, 2014).

When compared to abortion, there is choice in termination, therefore the question of autonomy is raised in regard to the sense of autonomy in terminating an ectopic pregnancy. For many, ectopic pregnancy arises during fertility treatment, for those who worked "very hard to get pregnant", and to be faced with a termination can be jarring. Psychotherapy involves unpacking the values and meaning the client attaches to the process of termination, in order to process any shame or guilt that may be evoked. It is evident from the literature and the findings that women and partners experience limited acknowledgment and support, whilst potentially

encountering complicated concerns related to the intersection of perinatal loss, culture, religion and spiritual issues, therefore psychotherapists must address the complex cultural considerations (Crockett et al., 2021).

A prevalent observation made my participants was the sense of urgency from clients to recover, to get back to normal. There is a myriad of reasons for this, which can speak to different psychotherapeutic concepts, such a defense mechanism, attachment style or previous traumatic experiences. However, the result of which can often result in a complicated grief response, as literature sets out as a long-lasting and disruptive grief, suspending clients in uncertainty of their experiences and identity (Markin, 2024).

Some participants reflected on a pressure within some cultures for women to conceive and have successful pregnancies, as the perceived honour of the family can be tangled up in these expectations. As a result of such stigmatisation, women are driven to prove that they and their bodies are not failures, they can maintain the honour, in an urgency to right the image for fear of being cast out. This highlights a rupture in the sense of self, which is observed in precious literature. Clients are navigating between one side, the good wife/daughter who must create a family, and the self who is struggling following loss and uncertainty for future conception (Toluk et al., 2025).

Potentially there is another image to be preserved, the image of the "ideal worker" as set out by Gilbert et al. (2023). Research highlights that pregnancy loss is considered taboo within the workplace, and it was reflected in participants reflections that clients felt isolated in the workplace where there was little understanding that the impact of ectopic pregnancy could be experience months after the event. In addition to the rupture to the sense of self which is caused by the loss and trauma within the ectopic pregnancy experience, it is evident that psychotherapy must work with all aspects of self and identity to support re-integration after an ectopic pregnancy.

Clients often attend psychotherapy during the fertility process, therefore questions of identity are present throughout this process as outlined in and as discussed, impacted on by the ectopic pregnancy experience. Some of the responses following an ectopic pregnancy, particularly if it happened during fertility treatment, is the urgency to fall pregnant again, or for some the trauma and loss may be too powerful and they put parenthood on hold or stop completely. Attending to the impact on identity is critical as clients explore their next steps. As discussed, there can be a profound anxiety in pregnancy following an ectopic pregnancy. There can also be an impact on the child that is born following this experience, if the parent has not processed wounds to identity and sense of self (Diamond & Diamond, 2017). This examination looks at what the parents are, exploring the impact of ectopic pregnancy on the client's identity and sense of self therefore can have the most profound impact and lasting effect for clients.

Participants primarily spoke about client's undergoing surgery as the medical intervention for their ectopic pregnancy, and the resulting loss of fallopian tube or ovary. Surgical intervention in the literature is observed as having a greater impact from a psychological point of view, proposing that surgery amplifies psychological trauma, along with the emotional shock experienced by women when receiving the diagnosis that the desired pregnancy is no longer viable (Tetea et al., 2021). In addition to this physical trauma, and the overwhelming feeling that their body has failed them, it is evident that psychotherapy must attend to the symbolic loss of "womanhood", and what it means for clients following an ectopic pregnancy.

As observed in the literature and it was represented in the findings, clients who experience an ectopic pregnancy, a form reproductive experience profound shame, a sense of feeling broken (Diamond & Diamond, 2017). When attempting to compare to others, in which there appears to be none, it evokes a narrative that they cannot do what everyone else appears to be able to do, viewing reproduction as a skill they have failed to master. Therefore, evident in the

findings, an ectopic pregnancy not only evokes a sense of loss for the baby, but also a loss of a part of self, causing women and couples to question who they are and where they might fit in (Diamond & Diamond, 2017).

The inconsistency in care provided by those experiencing an ectopic pregnancy was prevalent in participant interviews, whilst the focus speaks more to the medical aspect of the experience, psychotherapists are working with the impact of such inconsistencies, and this awareness is important. This is supported by research into women's experiences of ectopic pregnancy, those who experienced good communication and empathetic care in hospital, where at a reduced risk of psychological distress (Michaud et al., 2022). Why this is relevant is to ground further the isolation in the ectopic pregnancy experience, when a woman is held emotionally when in that initial stage of shock and trauma, the impact is reduced. In addition, the evoking of defenses may arise in this, as some participants advised that positive and negative projections were sometimes put onto medical experiences, to externalise the blame and guilt, therefore teasing out the medical experience is essential when working with ectopic pregnancy in psychotherapy.

5.4 Cultural Silence

A strong element throughout the findings was the sense that the psychotherapist's role in a counter-cultural witness, in what appears to be a silent system. Psychotherapy facilities finding the words, which is particularly empowering when the psychotherapist is informed. Whilst much of the work of psychotherapy is in the relationship, awareness of reproductive trauma appears to be particularly beneficial in respect to working with ectopic pregnancy, given the lack of discourse around it.

A finding throughout participants was the providing of psychoeducation, or even medical information to support the processing and integration of the ectopic pregnancy experience. Psychotherapy is trying to catch up with the lack of prevention in the discourse, to what can be

labelled as disenfranchised trauma (Hall & Hall, 2013). Participants spoke to the empowerment of clients, supporting them to understand what happened to them, and the ongoing impact. Reestablishing a client's power, as observed in medical environments there is a sense of follow what is being advised. In this, all the information can remain with the medical professionals, therefore psychotherapy can facilitate power becoming more balanced, by providing the resources which are lacking in the cultural and medical discourse.

The findings of this paper heavily support the theory of disenfranchised grief in the response to ectopic pregnancy. Through medical and cultural discourse, woman and couples are conflicted between feeling their loss and trauma, and the narrative that it was a medical procedure, and other minimalising sentiments to shut down the experience of loss. Therefore, it is evident of psychotherapists role in hearing the details of the loss, validation and mirroring of the client's experience stabilises a sense of self, making speakable the unspeakable (Diamond & Diamond, 2017).

Previous research and the findings discussed illustrate significant impact on women and couples who have experienced an ectopic pregnancy; however, many are not seeking psychotherapeutic support (Tetea et al., 2021). Despite the frequency and prevalence of pregnancy loss, there is a relenting cultural silence surrounding it (McMorrow, 2024). One participant reflected on the lack of community, and the development of groups to provide that sense of community to counteract the silence. The sense of shock that surrounds ectopic pregnancy is accompanied by the confusion of not knowing this could happen or examples within their social context. However, what is observed is that once a woman experiences it, other women often share their experiences also. When this occurs, it is found to be a strong support (McMorrow, 2024). This supports the findings of the benefit and vital need for group psychotherapy following ectopic pregnancy, to franchise the grief in a created community which accepts the client's loss and experience, directly challenging the lack of discourse.

5.5 Psychotherapeutic Presence and Practice

Therapeutic practice has been addressed throughout the discussion; this section will therefore discuss specific elements of psychotherapeutic approaches and discourses psychotherapists draw on when supporting clients who have experienced an ectopic pregnancy.

As noted from the approaches discussed in the findings, due to the complexity of loss and trauma for clients who have experienced an ectopic pregnancy, aligning with literature, a holistic approach is critical to support clients in reestablishing healthy relationships with their bodies, themselves and others (Hall & Hall, 2013). A holistic approach is necessary, particularly due to the disenfranchised nature of both the loss and trauma in ectopic pregnancy, as observed in the findings, psychotherapists do this by incorporating creative, narrative and psychosomatic approaches to for re-integration.

Literature by Sperry and Sperry (2004) highlight that psychosomatic can experienced at milestones, such as the due date or anniversary of the ectopic pregnancy, as a result of the grief had not yet been expressed, as all focus had been on surviving the medical emergency (Sperry & Sperry, 2004). Once the grief had been expressed, through naming the unborn child, and acknowledging that part of her, the symptoms disappeared. This is reflected in the findings which reflected on the psychosomatic symptoms following ectopic pregnancy, holding a similarity to birth trauma, where the trauma is held until it can be processed.

Findings within this research proposed that it is important that psychotherapists hold an awareness of all aspects of the ectopic pregnancy experience, to ensure that a clint does not feel invalidated or minimised in the psychotherapeutic encounter. If a psychotherapist isn’t focused on attunement when working with ectopic pregnancy, literature would suggest it can lead to rupture within the psychotherapeutic relationship, due to invalidation of the experience, and resulting in damaged self-esteem, and potential reenactment of historical adverse attachment experiences (Markin & McCarthy, 2024).

Most of the participants spoke to working in the field of fertility; therefore, it is evident that they hold an awareness of the nuances of infertility and pregnancy loss. What research presents is that psychotherapists can also be internalise the social invalidation of pregnancy loss, and with that ectopic pregnancy (Markin & McCarthy, 2024). Therefore, attunement is key to the psychotherapeutic encounter, due to the profound feelings of shame and inadequacy that is evoked following an ectopic pregnancy, clients may be more sensitive to misunderstandings in the psychotherapeutic relationship. As highlighted in the findings, the participants spoke often in following where the client is, a practice grounded in the core conditions and compassion, the psychotherapeutic relationship is at the centre. Whilst a reproductive story was not specified, from the participant responses, it is evident that aspects this framework are utilised in their work, in facilitating grief, resolving feelings of guilt and conflict resolution within the couple (Jaffe, 2017).

Traditional talking therapies can be effective in addressing emotional, relational and cognitive symptoms of the trauma-response; however, there may be a lack of attention paid to the autonomic and somatic effects of ectopic pregnancy (Fisher, 2011). Observed in the findings is the disconnect between a woman and her body during the ectopic pregnancy experience and in recovery. What many participants spoke to was a sense that clients are not engaging with what their bodies need; therefore, sensorimotor psychotherapy may bridge the gap in this disconnect. Whilst few participants directly to using a sensorimotor approach, it is evident in their practice that they are framing the experience with clients through emotional reconnection with the body. The concept of a client revisiting their experience and observing their emotional and bodily responses to explore how these have been encoded was evident, allowing the client to return to their body and experience while providing psychotherapeutic holding (Fisher, 2011).

This further strengthens the proposal of the use of embodied and a whole person approach when working with clients who have experienced an ectopic pregnancy.

5.6 Limitations

The small sample of seven female participants, most of whom were based in Ireland, limits the generalisability of this study. Whilst this research sought depth, this homogeneity may mean that more diverse clinical, cultural, or gendered perspectives are underrepresented.

Most participants specialised in fertility or perinatal health, whilst this added a richness to the data, it may also mean that the level of awareness and training reported is not reflective of the broader psychotherapeutic field, where ectopic pregnancy may be less visible.

5.7 Implications for psychotherapy

The findings of this study highlight the importance of increasing reproductive trauma literacy within psychotherapeutic training and practice. psychotherapists must be aware not only of the clinical and emotional complexities of ectopic pregnancy, but also of the cultural narratives and silences that shape how clients, and psychotherapists themselves, make sense of the experience.

The findings suggest that psychotherapy offers a unique space to reframe ectopic pregnancy as a significant loss and identity rupture, rather than solely a medical emergency. Trauma-informed, relational, and body-oriented approaches were found to be particularly beneficial in supporting clients through grief, disconnection, and re-integration. In addition, creative approaches, such as artmaking, ritual, and symbolic exploration, were highlighted as valuable tools when language alone felt insufficient.

This research may also contribute to the development of a more consistent psychotherapeutic framework for working with ectopic pregnancy, offering guidance on how to hold space for disenfranchised grief, facilitate emotional and somatic integration, and respond to the complex dynamics in both verbal and non-verbal ways.

5.8 Suggestions for Future Research

It was apparent from participant reflections that partners are often overlooked in both clinical and social contexts following an ectopic pregnancy. Despite witnessing trauma and experiencing loss, psychotherapists noted that partners felt they did not hold a legitimate claim as it did not happen to them directly. Although partner experiences were not a central focus of this research, their presence at the margin points to a critical area for future inquiry. Further research into how partners are impacted by ectopic pregnancy, and how they can be supported within psychotherapeutic spaces, would be valuable, particularly in bridging emotional divides within couples and in expanding psychotherapeutic understanding of relational grief and trauma.

This research primarily focused on the impact of and aftermath of an ectopic pregnancy for clients and the resulting psychotherapeutic encounter. However, whilst research provides insight to the ongoing impact reproductive trauma can have on resulting pregnancies, and children, it was not discussed in this paper. Therefore, additional research exploring the longer-term impact of ectopic pregnancy on parenthood warrants further exploration.

Some participants spoke about the different responses to an ectopic pregnancy depending on whether the pregnancy was planned or unplanned. However, this paper did not explore this at depth, only noting that there was a noted a difference between, additional research in exploring the differences between would benefit psychotherapeutic practice.

5.9 Final Reflection

Ectopic pregnancy is not only a medical event but an experience that can rupture identity, relationships, and one's connection to the body. A recurring thread in participants' reflections was the isolation that surrounds this experience, a silence that leaves women and couples without language or cultural holding. Psychotherapists, often in the absence of wider societal frameworks, become the ones who witness, contain, and help give shape to these complex and

painful narratives. Through attunement, presence, and theoretical grounding, therapists offer a space where grief, loss, and trauma can be expressed, held, and slowly integrated. In doing so, they support not only emotional healing, but also the reconstruction of meaning and self.

References

Adams, W.C. (2015) Conducting Semi-Structured Interviews. In: Wholey, J.S., Harty, H.P. and Newcomer, K.E., Eds., *Handbook of Practical Program Evaluation* (pp 492-505) Jossey-Bass, San Francisco. https://doi.org/10.1002/9781119171386.ch19

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brigance, C. A., & Brigance, M. L. (2023). A qualitative study of a couple experiencing reproductive trauma: an attachment perspective through a duoethnography. *Journal of Couple & relationship psychotherapy*, *22*(2), 105-129. https://doi.org/10.1080/15332691.2022.2142716

Carew, L. (2009). Does theoretical background influence psychotherapists' attitudes to psychotherapist self-disclosure? A qualitative study. *Counselling and Psychotherapy Research*, *9*(4), 266-272. https://doi.org/10.1080/14733140902978724

Caldwell, J. M., Meredith, P. J., Whittingham, K., Ziviani, J., & Wilson, T. (2023). Women pregnant after previous perinatal loss: relationships between adult attachment, shame, and prenatal psychological outcomes. *Journal of reproductive and infant psychology*, 1–15. Advance online publication. https://doi.org/10.1080/02646838.2023.2180142

Cohen, K., Leibovich, L., Markin, R., & Zilcha-Mano, S. (2019). The process of change in psychotherapy with a pregnant patient following perinatal losses: An analysis of a case study. *Journal of Clinical Psychology*, *75*(5), 874-885. https://doi.org/10.1002/jclp.22763

Condic, M. L., & Harrison, D. (2018). Treatment of an Ectopic Pregnancy: An Ethical Reanalysis. *The Linacre Quarterly*, *85*(3), 241-251. https://doi.org/10.1177/00243639187824

Corr, C. A. (2002). Rethinking the concept of disenfranchised grief. In K. J. Doka (Ed.), *Disenfranchised grief: New directions, challenges, and strategies for practice* (pp. 39–60). Research Press.

Cousineau, T. M., & Domar, A. D. (2007). Psychological impact of infertility. *Best practice & research Clinical obstetrics & gynaecology*, *21*(2), 293-308. https://doi.org/10.1016/j.bpobgyn.2006.12.003

Diamond, D., & Diamond, M. (2017). Parenthood after Reproductive Loss: How Psychotherapy Can Help with Post-Partum Adjustment and Parent-Infant Attachment. *Psychotherapy, 54,373–379*. https://doi.org/10.1037/pst0000127

Doka, K. J. (1989). *Disenfranchised loss*. In K. J. Doka (Ed.), Disenfranchised grief: Recognizing hidden sorrow. Lexington, MA: Lexington Books D. C. Health & Co.

Doka, K. J. (2002). *Disenfranchised grief: new directions, challenges, and strategies for practice.* Champaign, Ill.: Research Press.

Erato, G., Ciciolla, L., Shreffler, K. M., & Greil, A. L. (2022). Changes in importance of motherhood following pregnancy loss. *Journal of Family Issues*, *43*(3), 741-751. https://doi.org/10.1177/0192513X21994138

Farhi, J., Ben-Rafael, Z., & Dicker, D. (1994). Suicide after ectopic pregnancy. *The New England journal of medicine*, *330*(10), 714. https://doi.org/10.1056/NEJM199403103301013

Farren, J., Jalmbrant, M., Falconieri, N., Mitchell-Jones, N., Bobdiwala, S., Al-Memar, M., ... & Bourne, T. (2020). Posttraumatic stress, anxiety and depression following miscarriage and ectopic pregnancy: a multicenter, prospective, cohort study. *American*

journal of obstetrics and gynecology, *222*(4), 367-e1. https://doi.org/10.1016/j.ajog.2019.10.102

Fisher, J. (2011). Sensorimotor approaches to trauma treatment. *Advances in psychiatric treatment*, *17*(3), 171-177. https://doi.org/10.1192/apt.bp.109.007054

Gilbert, S. L., Dimoff, J. K., Brady, J. M., Macleod, R., & McPhee, T. (2023). Pregnancy loss: A qualitative exploration of an experience stigmatized in the workplace. *Journal of Vocational Behavior*, *142*, 103848. https://doi.org/10.1016/j.jvb.2023.103848

Hall, M. F., & Hall, S. E. (2013). When treatment becomes trauma: Defining, preventing, and transforming medical trauma. *VISTAS Online*, *73*(1), 1-15.

Harper, D., & Thompson, A. R. (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. John Wiley & Sons. https://doi.org/10.1002/9781119973249

Hendriks, E., Rosenberg, R., & Prine, L. (2020). Ectopic Pregnancy: Diagnosis and Management. *American family physician*, *101*(10), 599–606.

Hollins Martin, C. J., & Reid, K. (2023). A scoping review of therapies used to treat psychological trauma post perinatal bereavement. *Journal of reproductive and infant psychology*, *41*(5), 582-598. https://doi.org/10.1080/02646838.2021.2021477

Hilal, A. H., & Alabri, S. S. (2013). Using NVivo for data analysis in qualitative research. *International interdisciplinary journal of education*, *2*(2), 181-186. https://doi.org/10.12816/0002914

Jaffe, J. (2017). Reproductive trauma: Psychotherapy for pregnancy loss and infertility clients from a reproductive story perspective. *Psychotherapy*, *54(4)*, 380–385. https://doi.org/10.1037/pst0000125

Kersting, A., & Wagner, B. (2012). Complicated grief after perinatal loss. *Dialogues in Clinical Neuroscience*, *14*(2), 187–194. https://doi.org/10.31887/dcns.2012.14.2/akersting

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566–575. https://doi.org/10.1080/10503300802702105

Lasker, J. N., & Toedter, L. J. (2003). The impact of ectopic pregnancy: a 16-year follow-up study. *Health care for women international*, *24*(3), 209–220. https://doi.org/10.1080/07399330390178486

Leavy, P. (2022). *Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches*. Guilford Publications.

Leon, I. G. (2017). Empathic psychotherapy for pregnancy termination for fetal anomaly. *Psychotherapy*, *54*(4), 394. https://doi.org/10.1037/pst0000124

Linehan, L., Hennessy, M., & O'Donoghue, K. (2023). Recurrent miscarriage and infertility: a national service evaluation. *Journal of Obstetrics and Gynaecology*, *43*(2), 2241916. https://doi.org/10.1080/01443615.2023.2241916

Markin, R. D. (2017). An introduction to the special section on psychotherapy for pregnancy loss: Review of issues, clinical applications, and future research direction. *Psychotherapy, 54 (4), 367–372*. https://doi.org/10.1037/pst0000134

Markin, R. D., & McCarthy, K. S. (2020). The process and outcome of psychodynamic psychotherapy for pregnancy after loss: A case study analysis. *Psychotherapy*, *57*(2), 273. https://doi.org/10.1037/pst0000249

Markin, R. D., & McCarthy, K. S. (2024). Psychotherapist contribution, client reflective functioning, and alliance rupture–repair: A microprocess case study of psychodynamic psychotherapy for pregnancy after loss. *Psychotherapy*. https://doi.org/10.1037/pst0000520

Maxwell, J. A., & Levitt, H. M. (2023). How qualitative methods advance the study of causation in psychotherapy research. *Psychotherapy Research*, *33*(8), 1019–1030. https://doi.org/10.1080/10503307.2023.2181112

McLeod, J. (2014). *Doing Research in Counselling and Psychotherapy*. SAGE.

McMorrow, D. J. (2024). Entering the womb house: Bringing visibility to women's lived experience of pregnancy loss through an imaginal-hermeneutic method of research. *Qualitative Psychology*, *11*(1), 165. https://doi.org/10.1037/qup0000278

McQuillan J., Greil A. L., Scheffler K. M., Tichenor V. (2008). The importance of motherhood among women in the contemporary United States. *Gender & Society*. https://doi.org/10.1177/0891243208319359

Michaud, S. J., Clausen, H. V., & Amirian, I. (2022). Mental health after ectopic pregnancy. *Ugeskrift for Laeger*, *184*(17), V11210890-V11210890.

Olivier, H., & Monroe, B. (2021). Relational-cultural theory as a psychotherapeutic approach to perinatal loss. *Journal of Prenatal & Perinatal Psychology & Health*, *35*(1), 77-88.

Omar, N., Major, S., Mohsen, M., Al Tamimi, H., El Taher, F., & Kilshaw, S. (2019). Culpability, blame, and stigma after pregnancy loss in Qatar. *BMC Pregnancy and Childbirth*, *19*, 1-8. https://doi.org/10.1186/s12884-019-2354-z

Patel, A., Dinesh, N., Sharma, P. S. V. N., Kumar, P., & Binu, V. S. (2018). Outcomes of structured psychotherapy for emotional adjustment in a childless couple diagnosed with recurrent pregnancy loss: A unique investigation. *Journal of human reproductive sciences*, *11*(2), 202-207. https://doi.org/10.4103/jhrs.jhrs_127_17

Rana, P., Kazmi, I., Singh, R., Afzal, M., Al-Abbasi, F. A., Aseeri, A., ... & Anwar, F. (2013). Ectopic pregnancy: a review. *Archives of gynecology and obstetrics*, *288*, 747-757. https://doi.org/10.1007/s00404-013-2929-2

Ren, N. N., De Ala, M. B., Chang, L., Gao, Y., Li, M. X., & Li, K. L. (2024). Psychological Distress in Patients With Recurrent Ectopic Pregnancies: A Cross-Sectional Study. *Nursing Open*, *11*(11), e70069. https://doi.org/10.1002/nop2.70069

Romney, J., Fife, S. T., Sanders, D., & Behrens, S. (2021). Treatment of Couples Experiencing Pregnancy Loss: Reauthoring Loss from a Narrative Perspective. *International Journal of Systemic psychotherapy*, 32(2), 134–152. https://doi.org/10.1080/2692398x.2020.1855621

Rubin, L., & Russo, N. F. (2014). Abortion and mental health: What psychotherapists need to know. In *From Menarche to Menopause* (pp. 69-90). Routledge**.**

Schaper, A. M., Hellwig, M. S., Murphy, P., & Gensch, B. K. (1996). Ectopic pregnancy loss during fertility management. *Western Journal of Nursing Research*, *18*(5), 503-517. https://doi.org/10.1177/019394599601800503

Sperry, P., & Sperry, L. (2004). The family experience of loss associated with miscarriage and ectopic pregnancy. *The Family Journal*, *12*(4), 401-404. https://doi.org/10.1177/1066480704267547

Spillane, N., Meaney, S., & O'Donoghue, K. (2018). Irish women's experience of Ectopic pregnancy. *Sexual & Reproductive Healthcare*, 16, 154-159. https://doi.org/10.1016/j.srhc.2018.04.002

Taylor, G.W. and Ussher, J.M. (2001) Making sense of S&M: a discourse analytic account. *Sexualities, 4*, 293 - 314. https://doi.org/10.1177/136346001004003002

Tetea, A. A., Sima, R. M., Pomană, C. D., Bobei, T. I., Bălăşoiu, A. M., & Pleș, L. (2021). Impactul psihoemoţional al sarcinii ectopice–experienţa clinicii noastre. *Ginecologia. ro*. https://doi.org/10.26416/gine.31.1.2021.4330

Thoma, M., Fledderjohann, J., Cox, C., & Kantum Adageba, R. (2021). Biological and Social Aspects of Human Infertility: A Global Perspective. Oxford Research Encyclopedia of Global Public Health. https://doi.org/10.1093/acrefore/9780190632366.013.184

Toluk, G., Kirca, N., & Ozekinci, M. (2025). The Socio-Cultural Dimension of Infertility and Stigmatization. *International Journal of Caring Sciences*, *18*(1), 588.

Van den Broeck, U., Emery, M., Wischmann, T., & Thorn, P. (2010). Counselling in infertility: individual, couple and group interventions. *Patient education and counseling*, *81*(3), 422– 428. https://doi.org/10.1016/j.pec.2010.10.009

Zamani, M., Hasan Zadeh, A., Rajabi, N., Alimi, R., & Azmoude, E. (2023). Psychological Consequences of Miscarriage, Ectopic Pregnancy, and Ongoing Normal Pregnancy:

The Results of a Pilot Study. *Journal of Midwifery and Reproductive Health*, *11*(2), 3751-3758. https://doi.org/10.22038/JMRH.2022.63485.1841

Zhou, R., Cao, Y. M., Liu, D., & Xiao, J. S. (2021). Pregnancy or psychological outcomes of psychotherapy interventions for infertility: a meta-analysis. *Frontiers in Psychology*, *12*, https://doi.org/10.3389/fpsyg.2021.643395

Appendices

Appendix 1: Research Poster

Are you a psychotherapist who has worked with a client who has experienced an ectopic pregnancy?

As part of the MA in Psychotherapy in Dublin Business School, I am conducting research exploring ectopic pregnancy through the discourse of psychotherapy, and seeking psychotherapists who have worked with individuals affected by ectopic pregnancy to share their insights.

What will I be asked to do?

You will be invited to take part in a 30 - 60 minute online interview.

Who can take part?

If you are a fully qualified and accredited member of a professional body, who has worked with a client who has experienced an ectopic pregnancy.

If you are interested in taking part or want more information, please contact Susan Kennedy; email: 10507029@mydbs.ie, mobile: +353 (0)861796002.

Appendix 2: Participant Information Sheet

INFORMATION FORM

My name is Susan Kennedy, and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which aims to explore ectopic pregnancy through the discourse of psychotherapy. I will be exploring the views of people like yourself who work with clients who have experienced an ectopic pregnancy.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a fully qualified and accredited member of a professional body who has worked with clients who have experienced an ectopic pregnancy. If you agree to participate in this research, you will be invited to attend an interview with myself remotely, or in a setting of your convenience, which should take between 30 to 60 minutes to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in an encrypted file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in an encrypted file. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION
I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.
I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) ________________________________

Signature____

Date / /

If you have questions regarding your rights as a participant in this research, please contact Dr. Gráinne Donohue, Research Co-ordinator, Dept. of Psychotherapy, School of Arts, Dublin Business School grainne.donohue@dbs.ie

Appendix 3: Consent Form

CONSENT FORM

Title: **An exploration of ectopic pregnancy through the discourse of psychotherapy**

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.
☐**Yes** ☐ **No**

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.
☐**Yes** ☐ **No**

I understand that my identity will remain confidential at all times. ☐**Yes** ☐ **No**

I am aware of the potential risks of this research study. ☐**Yes** ☐ **No**

I am aware that audio recordings will be made of sessions ☐**Yes** ☐ **No**

I have been given a copy of the Information Leaflet and this Consent form for my records.
☐**Yes** ☐ **No**

Participant ____________________ ________________________
Signature and dated Name in block capitals

To be completed by the Principal Investigator or his nominee.
I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them. In line with GDPR regulations, data will be retained for no longer than is necessary. All records where you can be identified (e.g. recordings, etc) will be destroyed after all phases of data collection are complete and the data have been fully anonymised. At this point, your data can no longer be withdrawn from the study as it is no longer identifiable.

______________ ____________________ _______
Signature **Name in Block Capitals** **Date**

Appendix 4: Guide Questions

1. Was your client's ectopic pregnancy the primary or secondary focus of therapy?

   ----

2. How do clients describe the moment they learned about their ectopic pregnancy, and in what ways, if any, does this affect their emotional response?

   ----

3. How was your client's ectopic pregnancy managed, and what, if any, was the emotional and psychological impact of this?

   ----

4. What specific emotions or emotional patterns have you observed in clients processing ectopic pregnancy experiences?

   ----

5. What themes or patterns, if any, have you observed in how ectopic pregnancy impacts your clients' psychological well-being?

   ----

6. How do clients describe their experiences with physical recovery, and what role, if any, does it play in their emotional and psychological healing?

   ----

7. Can you share any insights into how clients navigate their relationships following an ectopic pregnancy?

   ----

8. In your experience, do cultural or societal expectations have an impact on clients' experiences or recovery from ectopic pregnancy? If so, how?

   ----

9. In your experience, do discussions about identity and self-concept typically emerge during therapy sessions with these clients?

    a. In your experience, how do clients describe the effect of ectopic pregnancy on their identity or sense of self?

    ----

10. What approaches do you use to help clients reflect on and integrate their experiences following an ectopic pregnancy?

    ----

11. What therapeutic frameworks do you use to support your clients who have experienced ectopic pregnancy?

    ----

12. What insights, if any, have you gained from working with clients who have experienced ectopic pregnancy, and how have these influenced your approach to therapy?

Appendix 5: Mapping of Themes

Figure 1

Carrying the Impact

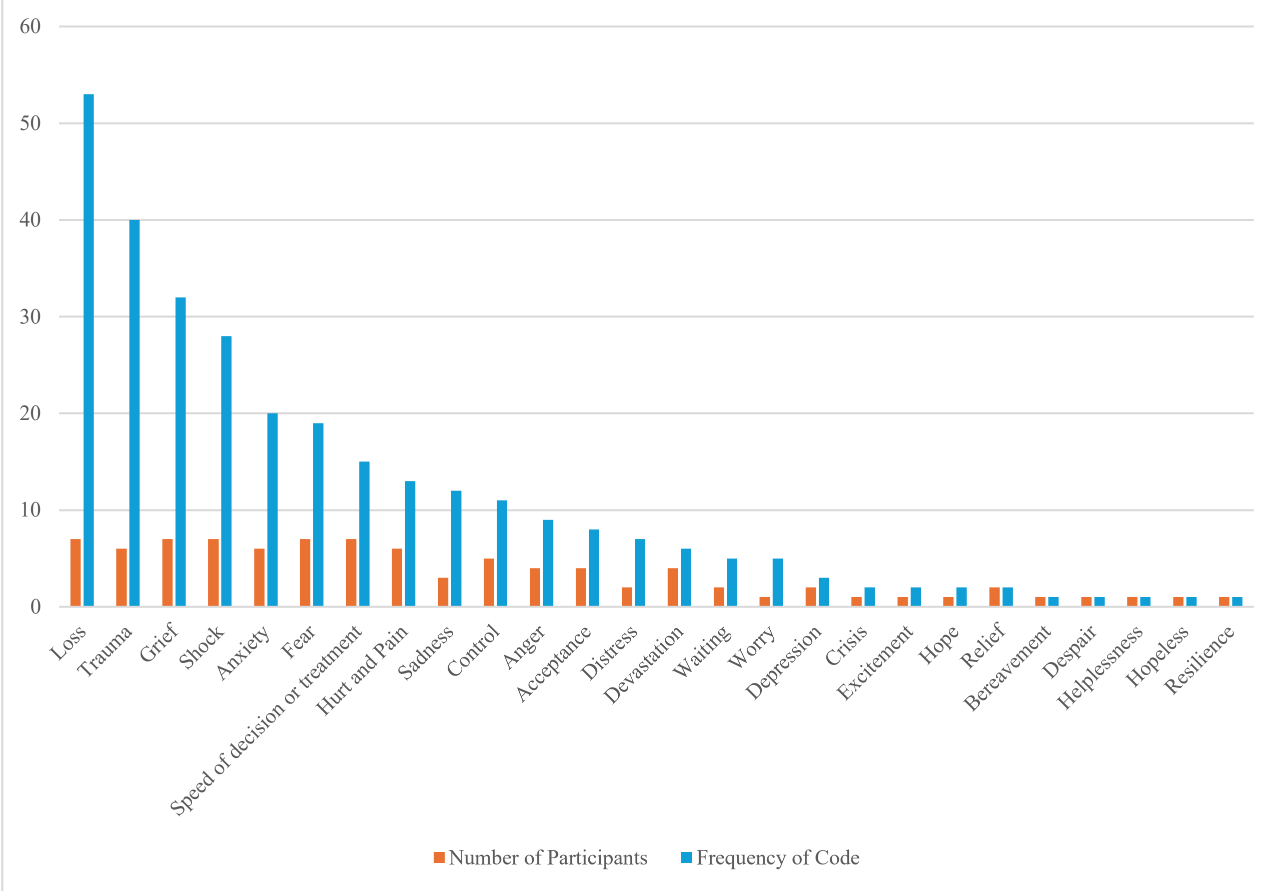

Figure 2

Self in Rupture

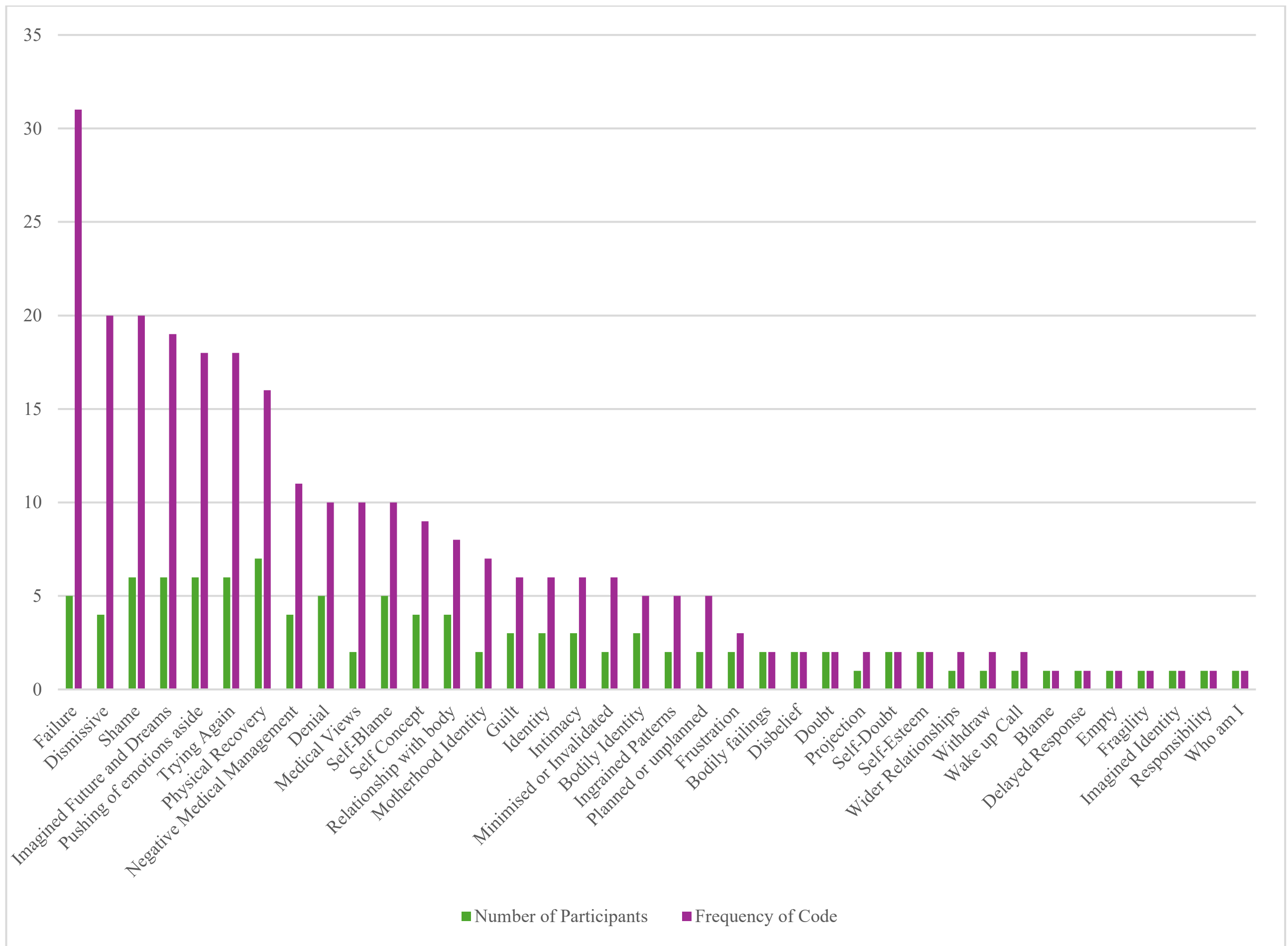

Figure 3

Cultural Silence

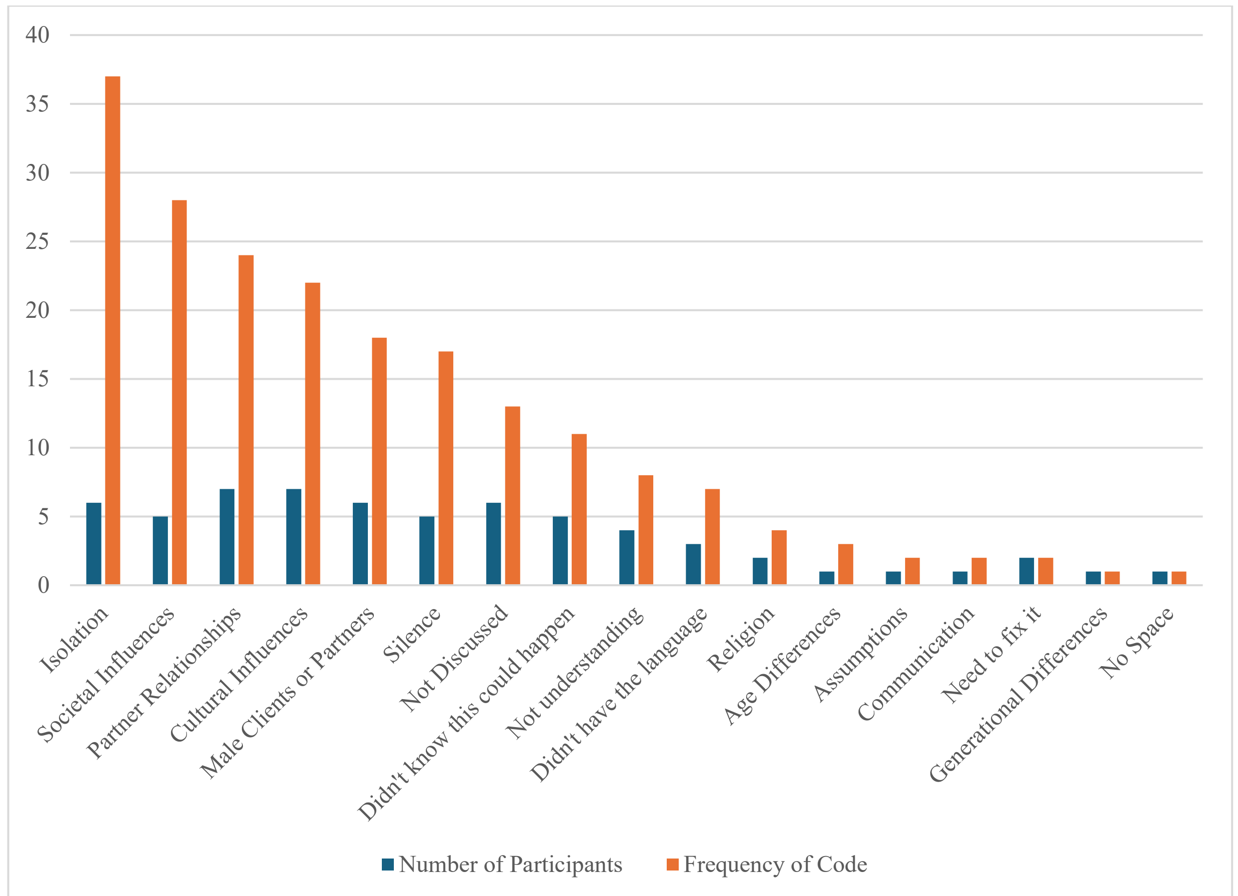

Figure 4

Psychotherapeutic Presence and Practice