“Take the hope away from me… take away that horrible turmoil” Beyond Disappointment: Conceptualising Maternal Disenfranchised Limerence Through Mothers' Lived Experiences

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Abstract

Background: 'Gender disappointment' ('GD') is an emerging maternal mental health phenomenon (Groenewald, 2016; Hendl and Browne, 2019; Saccio, 2025; Young et al., 2021). It is thought to be experienced by parents who have a child or children of one sex, but long for a child of the opposite sex (McMillan, 2012). It has been argued that 'GD' arises from embedded gender essentialist views and notions of the 'good' mother in the Global North (Groenewald, 2016; Hendl and Browne, 2019). Mothers who suffer from maternal 'GD' have been said to experience emotions ranging from a simple 'disappointment' to intense maternal anguish, including loss, guilt, and shame (Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021). It is notable that some of the most research into 'GD' is not informed by the voice of women with the experience, and this drove the study design (Hendl and Browne, 2019; Winter, 2021).

Aims and objectives: This study aimed to develop a more informed conceptual understanding of the phenomenon known as 'GD' from the perspective of mothers. This was achieved by exploring the impact of maternal 'GD' on women's emotions, well-being and help-seeking behaviours.

Method: The author has lived experience of 'GD' and it was the loneliness, confusion, and pain of this experience that led to the design of a study that collected data from women who had experienced 'GD'. Although not a prerequisite but of analytical significance, all the mothers who contacted the author to enquire about taking part in the study were mothers to only sons. Data was primarily collected via walking interviews at a location chosen by the women. A semi-structured interview schedule guided how the women were invited to share their journeys of maternal 'GD'. The interviews were analysed by adapting the listening guide (LG) to include structured reflexive thematic analysis. The LG generated a case study for each woman, which included the mother's journey in her own words, an I Poem, and the identification of two contrapuntal voices. This allowed for a nuanced exploration of the multiple and sometimes contradictory voices within each mother's account. Following the case study, there was an amalgamation of the LG with reflexive thematic analysis, which enabled systematic thematic coding of the data set and the identification of shared patterns and themes.

Findings: Analysis of the findings identified two overarching themes: i) hope, and ii) broken. Before the women became mothers, they had imagined themselves as mothers to a daughter and longed for a maternal relational experience they believed was only possible with a girl. This is understood through the lens of limerence, which is conceptualised as a state of obsession, idealisation and longing, thus allowing for deeper understanding of the mothers' imagined daughters, which were the idealised figures of their longing and focus of their obsessive rumination. Consequently, this state of maternal limerence shaped the women's investment in their long hoped-for daughter. The mother's hope was what propelled them to seek out multiple pathways to attempt the conception of a female child. However, with the conception of each son, their distress at not having a daughter intensified, and the mothers' hope became maladaptive, creating further complex layers of distress. The mothers' imagined daughter was idealised and led to obsessive rumination, and as the daughter remained elusive, the mother's assumed future was ruptured, adding another layer of complexity to her experience. In contrast to the term "disappointment", the women in this study experienced enduring grief and distress for their imagined daughter. This shaped their friendships, partner relationships, and decision-making processes; thus, "disappointment" fails to capture the depth of mothers' experience. In moving towards acceptance, the women experienced a phase of action crisis; goal disengagement and finding new meaning in a different maternal path from the one they had expected. Significantly, the entirety of the mothers' 'GD' experience was shrouded in disenfranchisement. These findings lead to the modelling of the journey as a negatively compounding and repeating cycle that was forward-moving, non-linear, and layered, comprising of seven dimensions: i) the imagined and hoped-for maternal experience, ii) preoccupation, iii) finding out the sex of the foetus, iv) loss, v) distress, vi) birth of child, vii) reaching "the line" and moving towards acceptance. The term 'GD' is therefore multidimensionally problematic, while the new term proposed here, maternal disenfranchised limerence ('MDL'), more accurately reflects the complex and nuanced layers of distress experienced by the population in this study. This term and the accompanying conceptual model are provisional and positioned as a springboard for further exploration, offering a starting point for future research to refine and extend our understanding of this maternal phenomenon.

Conclusion: This study asserts that 'MDL' is a maternal experience shrouded in disenfranchisement and characterised by complex layered distress driven by the paradox of hope. It contributes new insights to how 'MDL' is theorised by identifying the key roles played by hope, limerence, grief, and biographical disruption as central to this experience. A novel

terminology and model are proposed as a springboard for better understanding of the 'MDL' experience, while illustrating the forward-moving but non-linear dimensions of the distress experienced by the mothers in this study. These findings have implications for the terminology being used, timing, and type of support offered to mothers', as well as supporting the wider recognition of the phenomenon as a complex, valid, and multidimensionally distressing maternal experience.

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Dedication and Acknowledgements

Dedication:

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I was 16 and saw a book on a bookcase that looked different to the rest, and when I asked what it was, I was told it was the PhD thesis of Dr. Robert Young. I'd never heard of a PhD, I was in awe when I was told that it contained new knowledge, which, until the point of that PhD, had never been known in the world before. I dreamt, from that moment, that one day I may have the privilege of undertaking a PhD. Bob became my father-in-law for almost two decades, and twenty-five years after having met him, he did not know of this story, until today that is. Bob, in that tiny moment you set a spark in me, and today I am almost there. Thank you, and thank you for being the father figure in my life for so long.

Chapter 1: Introduction

1.1 Locating Myself

I approach this study as a mum to four children, three sons first and then a daughter. I have had a career as a primary school teacher and now as a coach working with mothers' who experience maternal 'GD' and individuals navigating other life transitions. It was my own maternal experience and journey with 'GD' that motivated me to undertake an MSc in Applied Developmental Psychology, with my empirical research project leading to publication (Young et al., 2021). This study builds on this previous research that was published under my previous surname of Young, now Francis.

I grew up as the eldest of three siblings: myself, my sister, and my brother. From the age of 10 I attended an all-girls Convent school and hoped to become a midwife. I've had varied experiences of men in my life: at age 10, when on holiday with my family, I was attacked by a man; it was terrifying. For as long as I can remember, I had a troubled relationship with my father. He was a functioning alcoholic who was verbally and emotionally abusive and just stopped short of anything physical. However, I had the most wonderful male role model in my life, my grandfather, whom we called Popar. He was my ultimate cheerleader; he was so kind and thoughtful, and I loved him beyond words. When I was just 16, I met who would become my partner and husband for over twenty years.

Being a mum was something that I always wanted; it was what I saw as my purpose, and it was a fundamental part of what I thought made me, me. However, I had given no conscious thought to the sex of my children. I fell pregnant at 23 years old and was very excited, but I was surprised to find out that Fin was a boy, and this confusion surprised me. Yet I thought nothing more of it, and just under three years later I fell pregnant again, and I was very excited. We did not find out the sex of Fraser, but I do remember indulging in the girl's section of baby name books. The night before my planned caesarean, I packed my bags, and I distinctly remember holding a set of baby girls' clothes and hoping that tomorrow I would be using them. The next day the platinum blonde-haired, blue-eyed, porcelain-skinned Fraser popped out. He wasn't a girl, but he was the total opposite of my gorgeous brown-haired, green-eyed, olive-skinned Fin, and I was in love. Other than knowing I would like a daughter when I was pregnant with Fraser, there wasn't a significant impact from maternal 'GD' at this point. I just loved my boys so much and relished being a 'good' mum. About two years later I fell pregnant for a third time. This

time, I remember thinking from the moment I found out I was pregnant about the sex of our baby. My mum had two of one sex and then the other, and so I thought I was bound to have my daughter this time. I wanted to find out the sex of our baby as early as possible, and at the 12-week scan, the sonographer told us that we were having another boy. It is from this point that my 'GD' journey took a different turn, one to a place that I did not know existed, one that I most certainly did not understand, and that was horribly incongruent with who I believed myself to be.

The pregnancy with Fred was physically fine, but at times emotionally challenging. The distress was not because of Fred, but because now I didn't know if I would have a daughter, and I did not know how to cope with that thought. One of the most difficult elements of the experience was the utter confusion experienced. I did not feel entitled to have such distressing emotions, especially because I wanted Fred. I was repulsed at myself for experiencing seemingly petulant longing despite the embodied and enduring way in which it was impacting me. I was completely disorientated and ashamed and felt incredibly guilty. I vividly remember experiencing a panic attack in the church at a friend's wedding after overhearing a conversation between some friends and my husband about whether I wanted a daughter. I used to drive to the place where we scattered the ashes of my Granny-Anne and Popar and cry hot angry and confused tears at the whole experience. I pride myself, then and now, on being a kind, integrity-led and grateful person, and this experience questioned all of my most important values; it was awful.

However, as Fred's birth approached, my feelings began to subside and when he was born, they had gone. Fred was born, and he was perfect. I threw myself into being a mum of three, which I absolutely loved. However, about 18 months later, and to my utter surprise, thoughts about wanting a daughter began to seep back into my mind, but this time it was different and intense to an unimaginable level. For the first time I began to think about why I wanted a daughter and what having a daughter might mean to me. I felt that without a daughter I would have no value or purpose on this planet. I didn't know who I was or why I was here without a daughter. These feelings became more intense, and for a while even sleeping became problematic. I would spend hours in the middle of the night looking for jobs that I thought would give me the purpose that I believed I would not have without a daughter. It got to a point where I knew I was going "down", and if I didn't stop "it", something bad would happen. But I did not know how to stop these intense emotions from taking me over. I did not believe I

could reach out to the GP or a therapist; they would think I was nuts, and I had no idea how to explain what I was experiencing. None of this made any sense. I felt alone and, if I am honest, scared. I did not share a word of the experience with my mum, sister or friends, only my husband. One desperate Saturday morning, I opened my laptop, went to one of the many 'GD' online forums and wrote what could only be described as a plea for help; I needed support, I was going under, but I didn't know what to do – could anyone help? A lady replied and said there was a private clinical psychologist in Surrey who had a PhD in 'GD', so I reached out to her. Amazingly, although she was three hours from my home, she was only minutes away from my sister.

My husband at the time, who although didn't understand the intensity and meaning of all this (and neither did I), came down to Surrey with me that first time. Over the next year or so, he was very supportive (both financially and practically) of me seeing the clinical psychologist every few weeks and I know I was lucky to be able to pay for this support. What did Fiona, the clinical psychologist, do? She helped me to validate what I was feeling and make sense of it. In essence, my formative life was shaped by many challenging male experiences, and the strong bonds I did have, and the places where I felt safe, were primarily with girls and women. Motherhood was also an integral part of who I saw myself as. Working through all this and making sense of it helped me to understand, and I believe this process was fundamental to me finding a new place in the world where I felt a sense of safety, value, and purpose. A little time later, having been told I would likely never conceive again, I naturally conceived my daughter.

Three and a half years after the birth of my daughter, and within weeks of starting my PhD, my life took a turn that made me question the societal value of motherhood and notions of maternal "power", causing me to once again seek renewed purpose and worth in myself. I had no choice but to leave my marriage and my home with my children as it was not a safe place anymore. But this process of redefining myself and my life was made phenomenally difficult because in my new life I had lost my place as the mother that I had been for almost the entirety of my adult life and was what made me who I was, it was who I knew myself as. The process made me think deeply about our young girls and women today and how we can prepare them for their futures and the role that motherhood might take in their lives. It has made me explore and question how being a mother intersects with notions of a woman's sense of value and purpose psychosocially, and importantly, the ways in which this intersects with the experience of maternal 'GD'.

During the first 18 months of separation, my ex-husband and his new girlfriend threatened that they would have my children taken from me because of the topic of my PhD. They said that because I had lived experience of 'GD', I was mentally unstable, not a good mother, therefore unfit as a parent. I had heard many women report these stories to me, even one of the participants in this very study, as well as it being highlighted in research on 'GD' (Monson and Donaghue, 2015) but never had I been on the receiving end of such threats and fear. But this made me want to shout and protect the women who experience 'GD' even more.

I recognise that there are many possible implications of my positionality. Following the example of Beauboeuf-Lafontant (2008), I was open with my participants, and if asked, I disclosed that the reason for my study was that I had had my own experience of 'GD'. If asked, I decided that I would explain how I found this experience profound and was surprised at the lack of research, knowledge and support for it; thus, I felt compelled to undertake a study that would hopefully act as a gateway for greater understanding and ultimately change. I hoped that this commonality with my participants would create trust and an element of shared understanding that would facilitate genuine rapport building and bring a depth to the data that may otherwise have been absent, and I believe it did this. However, I did not share the finer details of my experience as I wanted my participants to be able to freely explore their journey without a sense that if it did not align with my own, then I might not value what they had experienced.

I was also aware that my positionality would require reflexivity. At all stages of the research process I employed deliberate and active reflexivity so that I was able to remain conscious of the influences arising from my positionality. This engaged reflexivity took place through diary entries, keeping records of decision-making and noting factors that possibly influenced analysis, as well as engaging in regular reflections with my supervisor (Whitaker and Atkinson, 2021; Wilson et al., 2022). As suggested by Johnson and Clarke (2003), and also as part of the ethics of researcher safety, I sought the support of a clinical psychologist who was a specialist in GD' to give me another safe space to share any thoughts. In relation to any possible emotional 'rawness' arising from my own 'GD', there was not any. I had spent a long time seeking to understand my own experience, and although it was an extremely turbulent time in my life, it is peaceful now. In combination, the reflexive strategies I engaged in supported my reflexive processes, enabling me to reflect upon the implications of my positionality and to remain open to seeing things in my data that did not reflect my experiences (appendix 9).

1.2 Structure of the Thesis

This thesis is presented in ten chapters, broken down as follows:

Chapter 1: Introduction locates my positioning as a researcher and defines the key terms used throughout the thesis.

Chapter 2: Background outlines the foundational background that informs current understanding of maternal 'GD' and helped to shape the systematically informed literature review.

Chapter 3: Systematically informed literature review begins by addressing the understanding of 'GD' at the outset of this study and provides a synthesis the findings. I then discuss the most recent literature, which was published after the background chapter and literature review were written and data collected. This updated section of the review reflects development, providing a current understanding of how the conceptualisations of on 'GD' have evolved.

Chapter 4: Methodology locates this study in its ontological and epistemological foundations, detailing my methodological considerations and the alignment with the aims and objectives of the study.

Chapter 5: Methods describes my selection of procedures that align with the study's philosophical orientation, aims and objectives, and the ethical considerations arising from this.

Chapter 6: Case studies presents a case study for each of the six participants. Each case study comprises of the mother's story in her own words, an I Poem and the identification of two contrapuntal voices.

Chapter 7: Across the mothers' stories presents a reflexive thematic analysis by drawing on the previous layers of the LG to develop themes across the whole data set to inform a better conceptual understanding of the maternal 'GD' phenomenon.

Chapter 8: Discussion considers the findings of the case studies and thematic analysis by situating the findings in the wider body of literature. Terminology is discussed, and a new term for the phenomenon is proposed. A novel model of the phenomenon as experienced by the population in this study is presented.

Chapter 9: Conclusions presents the implications of this study, and concluding thoughts are offered.

1.3 A Note on Terminology and Abbreviations

1.3.1 Terminology

Gender	The socially constructed roles, behaviours and expressions of identity that are expected by individuals due to their assigned biological sex.
Lived reality	When a reference is made to the participants lived reality, it is referring to their experienced reality. From a critical realist perspective, this would be referred to as the empirical domain and constitutes a partial perspective of what critical realism conceptualises as a stratified reality that also includes the actual and real domains.
Sex	The biological sex categorisation of an individual into male or female.
Well-being	Refers to emotional well-being, not physical. Although, the emotional well-being may have physical consequences.

Note: The terms sex and gender are currently used interchangeably by society, causing confusion. This thesis will explore the use of the term 'GD' through this lens. But in addressing notions of sex and gender, I acknowledge the classification of inter-sex individuals as potentially relevant to the understanding of maternal 'GD'. However, this study's scope does not allow for these possible aspects to be covered in this thesis.

1.3.2 Abbreviations

ART	Assisted Reproductive Technologies
'GD'	'Gender disappointment'. The abbreviation is within quotation makes as it os the only available term at present, but it is an insufficient label for the

	complexity of the experience and does not fully capture the nuances and depth of the experience.
IPA	Interpretative Phenomenological Analysis
IVF	In Vitro Fertilisation
LG	Listening guide
'MDL'	Maternal Disenfranchised Limerence
MMN	Maternal Master Narrative
PGD	Pre-implantation Diagnostics

Chapter 2: Background

2.1 Introduction

In this chapter, I present the conceptual and contextual background on the psychosocial factors that have been posited as underpinning the maternal 'GD' phenomenon. I begin by exploring dominant social narratives and the sociocultural constructions of sex and gender that shape expectations of motherhood. The psychological elements of taboo and stigma, help-seeking behaviors, and maternal grief are explored. This chapter also addresses the importance of using informed and sensitive terminology when discussing maternal mental health challenges. Together, these discussions frame the landscape within which maternal 'GD' is situated. A systematically informed literature review is presented in Chapter 3, which will address the current understanding of maternal 'GD'.

2.2 Social and Maternal Narratives

2.2.1 Embedded Social Narratives

Embedded within sociocultural contexts are dominant social expectations that shape individual and societal experiences (Bamberg, 2004; Rogers, 2020, Thurer, 1993). These are often referred to as master narratives or dominant discourses. They prescribe a set of social behaviours that individuals are expected to adhere to (Bamberg, 2004; Hammack, 2011; Marecek et al., 2004), and non-compliance can lead to societal repercussions such as name-calling, aggression and ostracism (Rodrigues, 2025). It is argued that motherhood is shaped by such embedded social narratives (Burman, 2007; Kerrick and Henry, 2017).

It has been argued that in the Global North, prevailing discourses of parenting are rooted in embedded gendered ideologies that derive from historically patriarchal structures (Huppatz and Goodwin, 2010). For those assigned female at birth, societies often impose specific expectations that must be fulfilled to be a "proper woman", including becoming a mother (Afiyanti and Solberg, 2015; Chapman, 2016; Narciso et al., 2018). Society often deems motherhood to be an innate instinct for women, a biologically driven role that is characterised by overwhelming maternal desire and complete self-sacrifice (Hays, 1996; Hollins Martin et al., 2019; Huppatz and Goodwin, 2010; Kaplan, 1992; Ulrich and Weatherall, 2000). Kerrick

and Henry (2017) describe these societal expectations as forming the Maternal Master Narrative (MMN); a "blueprint" of idealised mothering expectations.

2.2.2 The Problems of the MMN

However, feminist theorists have criticised notions of 'ideal' mothering standards asserted by the MMN as problematic (Choi et al., 2005; Christopher, 2012; Khalid and Hirst-Winthrop, 2020; Malacrida, 2009; Stewart, 2021). It has been argued that the MMN perpetuates the unequal divisions of domestic labour and the myth of 'maternal instinct' as 'natural' and biologically formed (Choi et al., 2005; Takševa, 2017; Smart, 1996). Such arguments reject the assumption that motherhood fulfils all a woman's needs, referring to the current construction of motherhood as a performance (Malacrida, 2009; Rich, 2021). Judith Butler's gender performativity theory offers a helpful framework to explain how these roles are performed and normalised within society and supports the assertion that the societal concept of the 'good mother' is not reality, but rather a fabrication of reality that can only be met through performance (Bell, 1999). Similarly for men, Sabur and Rosy (2023) emphasise the concept of hegemonic masculinity, depicting how idealised masculine roles of being stoical, authoritative and the breadwinner discourage emotional engagement in caregiving, thereby upholding structural barriers to gender-equal parenting.

The socially accepted MMN remains, in part, due to the patriarchal society which advocates a hegemonic view of unachievable intensive mothering (Pedersen, 2016). Thus, mothers struggle to reconcile their motherhood experiences with what society expects and considers "acceptable" (Christiaens et al., 2013). Consequently, when mothers cannot achieve the standards set out by society, they may view themselves as "non-conformists" in a social structure that presents a woman's most purposeful role as motherhood, highlighting the internal conflict that mothers may face (Hays, 1996; Kaplan, 1992; Narciso et al., 2018; Ulrich and Weatherall, 2000).

2.2.2:1 The Limiting of Maternal Agency

It has been suggested that the socially accepted MMN is a reduction of womanhood to the role of a mother (Rich, 2021). There appears to be an acceptance that the desire to be a mother is biologically set and necessary for all women, but this is problematic as it denies agency (Walby,

1997). When there is social approval for a cultural narrative that suggests a woman is being guided and driven by something greater than herself, such as a maternal biological drive, there is an assumption that she is unable to consciously control her desires and actions, thus limiting her identity, autonomy and social roles (Afiyanti and Solberg, 2015; Letherby, 1994). When motherhood is presented in this way, it obscures the independent authority that women have over their fertility and their life more broadly; their motherhood journey is not viewed as unique or constructed by the nuances of individual experience (Johnston and Swanson, 2006; Pedersen, 2016). Thus, the historical image of a mother curtails a woman's autonomy and ability to achieve as an individual, creating an encompassing sense of failure when the social expectation of motherhood are not met, because they are unobtainable. As a result, women can struggle to find their individuality and agency (Johnston and Swanson, 2006; Khalid and Hirst-Winthrop, 2020; Pedersen, 2016). Consequently, the social ideals shaping the MMN raise concerns regarding power and hegemony (Anon., 2004; Thurer, 1993). The functional structure of the MMN has a propensity to "normalise" or "naturalise" thoughts, behaviours, experiences, and actions to the benefit of those in power and to the detriment of women (Andrews, 2004). The patriarchal establishment within which women find themselves creates disadvantages for women; they are dominated and discriminated against as the patriarchy promotes financial dependence and reliance (Koa, 2021). As these narratives are rooted in patriarchal functioning, they are resistant to change and so will continue to shape the expectations and experiences of motherhood in limiting ways (Hays, 1996)

An example of an assumption of motherhood is that it will fulfil every woman, and an infant can only flourish with the dedicated and devoted attention of the mother (Ponciano, 2010; Thurer, 1993). While some women may try to change these narratives, the assumptions and messages will remain embedded within the broader social structure within which she functions curtailing the impact of the changes she makes. As May (2004) argues, women "can change the narratives, but never fully escape them" (p619), indicating that change must take place at a societal level as well as an individual one. Moreover, the notion of 'escape' highlights the harmful impact of the MMN on women. Heley et al. (2020) suggest that the ability to change the narratives of motherhood is grounded in women's capacity to gain insight into the driving forces shaping the MMN. However, if this can be achieved, it will allow greater opportunities for change and growth, creating a more inclusive social model (Charles, 2002; Evans, 2002; Evans, 2003).

2.2.2:2 The Fallacy of the 'good' Mother

The MMN, as Kerrick and Henry (2017) defined it, is the socially dominant and individually internalised standard of what makes a 'good' mother; usually self-sacrificing, emotionally available, and completely committed to her children. The expectation that a woman must commit her whole self to motherhood, emotionally, physically, psychologically, every hour of every day and willingly sacrifice everything of herself for her children to be the "perfect mother" is unrealisable (Ennis, 2014; Forna, 1999; Huppatz and Goodwin, 2010). Hollins Martin et al. (2019) established that there is a chasm between the perceived 'ideal' and 'real' maternal experience, creating an intrinsically paradoxical experience than negatively impacts mothers' well-being (Lewis and Nicolson, 1998; Prinds et al., 2014).

The romanticisation of motherhood has limiting consequences (Afiyanti and Solberg, 2015). For example, Kim (2022) contended that the "intensive mothering" ideology creates unrealistic expectations of performance that exclude mothers who deviate from the white middle-class mother ideology (DeGroot and Vik, 2021; Johnston, 2003). Thus, mothers of colour, mothers who have a disability, single mothers, working mothers or mothers who may have been under the social care system were not deemed by society to be 'real' mothers (Christopher, 2012; Malacrida, 2009; Narciso et al., 2018; Rich, 2021). This view of motherhood was also seen in early feminist models (Koa, 2021). However, more recent studies are beginning to incorporate all types of mothers into the research process (Averett, 2021). Stewart's (2021) research attempted to break the 'good mother' concept free from its historic restraints. However, she concluded that despite the forward movement of current research, policy and social narratives are not developing at the same rate. While Thurer (1993) suggests that the 'good mother' concept is evolving with each generation, this evolution should not be assumed to occur universally across all areas of societal development. Feminist views challenge the concept that there is one ideal of motherhood, yet such accounts are still under-represented in the dominant culture and within the research literature (Averett, 2021; Groenewald, 2016; Young et al., 2021). One such area of under-representation is the phenomenon of 'GD', which my thesis aims to explore.

The 'good' mother myth also intersects problematically with parental sex preference. Maternal preference for a specific infant sex can elicit feelings of guilt as such a preference challenges

the narrative of unconditional maternal acceptance which upholds the view that a 'good' mother should be grateful (Jackson et al., 2024; Liss et al., 2013; Young et al., 2021). An infant sex preference can result in inner conflict because the mothers' longing is considered deviant (Groenewald, 2016; Duckett, 2008). In summary, MMN's in the Global North adopt narrow and often unattainable standards that restrict maternal individualism.

2.2.2:3 Maternal Ambivalence

The 'good mother' myth may contribute to feelings of maternal ambivalence (Takševa, 2017). Maternal ambivalence can be experienced in relation to the child when a mother holds a "polarity of love and hate" (Parker, 2015., p13) about her child which can cause feelings of guilt and anxiety because it goes against the socially embedded MMN of total love. Groenewald (2016) asserts that women can experience maternal ambivalence in relation to infant sex preference, and in this context mothers can feel silent disappointment if their desires do not match the sex of their child (Groenewald, 2016). Such maternal emotions may be repressed because of prevailing maternal ideologies that identify 'good' motherhood with unconditional acceptance (Pedersen, 2016).

Maternal ambivalence may also be felt in relation to motherhood as a role. However, Kerrick and Henry (2017) argue that "feelings of ambivalence are quite reasonable considering the drawbacks that accompany becoming a mother in a society that has extremely limited (and limiting) notions regarding motherhood" (p13). The modern mothering experience has been described by mothers as intensive, monotonous, unfulfilling, undervalued work with little opportunity for stimulating adult conversation, moreover, where mothers lack validation in their role (Boris, 1994; Ennis, 2014). The depth of these feelings is illuminated by Christopher (2012) who reported that mothers would consider seeking work outside of the home, even if not required, to "have a break" from the "drudgery" of motherhood. The experience was exacerbated by continually striving for the unobtainable set of socially enforced mothering standards (Johnston and Swanson, 2006; Garey and Arendell, 2001; Liss et al., 2013).

Even though mothers are constructed by society as authoritative in constructing and shaping their maternal roles, their power is bound by social expectations and institutional systems which resist maternal ambivalence as an acceptable maternal experience (Parker, 2015). Nayer and Bernardi (2011) differentiated the mothering experience from the institution of motherhood

by positing that the latter imposes ideological control upon women's reproductive and emotional choices leading to contradictory feelings. This generates a tension between individual maternal wants and social expectations. Feminist research advocates empowering maternal subjectivity, seeking spaces where maternal voices, even ambivalent ones, are affirmed rather than suppressed (Choi et al., 2005; Malacrida, 2009; O'Reilly, 2019).

2.3 Sex, Gender, Preference, and Social Constructions

It is widely accepted that sex is biologically set and categorised as female, male or intersex (Kimmel, 2004; Mckay, 2018), whereas gender is a socially created divide between femininity and masculinity, traditionally based on binary sex categories (Butler, 1990; Joel and Vikhanski, 2019). Therefore, gender presents "not as an intrinsic set of qualities, but as a social system that attributes meaning to sex, assigning different roles, status, and power to males and females" (Joel and Vikhanski, 2019, p105). Sex and gender are widely assumed by society to be hardwired and intrinsically linked; however, this is a problematic assumption (Kane, 2009), and it is further compounded by the interchangeable use of the terms "sex" and "gender", which creates social confusion (Duckett, 2008; Groenewald, 2016; Rippon, 2020). Current debates around sex, gender, and sexuality are ongoing and complex. This study is situated specifically within the experiences of cisgender mothers and does not explore the perspectives of trans or non-binary parents and their experiences, but I acknowledge the need for research to be conducted with this focus.

It has been suggested that gender essentialist thinking emerged from scientific sex-based research situated in the homogenous patriarchal society, where male superiority needed to be "proven" to further political agendas (Browne, 2017; Eliot, 2009; Eliot, 2009; Giedd et al., 2012; Heyman and Giles, 2006; Joel and Vikhanski, 2019). The outcomes of such research have been so deeply embedded that they are perceived as fact. Lueptow et al's (1995, 2001) studies found that students sense a greater sex divide than was perceived in the 1970s, which highlights how embedded essentialist thinking is, and until challenged, the assumed 'natural' gender tendencies of men and women create divides and shape the lives of individuals and society more widely (Anderson et al., 2021; Booth and Nolen, 2012; Kimmel, 2004; Oppenheimer, 1977).

2.3.1 The Problem of Gender Essentialism

It has been found, that from before birth, the categorisation of the infant into male or female can impact how a person's life is shaped. This is through the uptake of 'normative' and 'natural' gendered identities based on biological sex categorisation. These assumptions influence expected likes, dislikes, hobbies, career and expected psychological traits of empathy and care (Booth and Nolen, 2012; Eliot, 2009; Maccoby, 2002). The practice of using pink and blue in the UK to identify infant sex as a symbolic shorthand for femininity and masculinity illustrates how toy advertising homogenises products along strict gender lines (Rijke, 2020). Similarly, gender-reveal parties, while hailed as innocent enjoyment, are early arenas for the social construction of gender. Jack (2020) condemns these practices for their perpetuation of binary conceptions of identity, as they exclude non-normative gender expression and feed into societal intolerance towards gender diversity more generally. Although there is increased recognition of these problems, it is difficult to challenge and change dominant discourses, which sustain the intergenerational reproduction of gendered parenting roles (May, 2004). Consequently, when parents treat gender as biological, they unknowingly solidify constricting social roles (Fine, 2010). Within maternal contexts, this may translate into mothers internalising and reproducing these expectations and feeling knowingly or unknowingly compelled to bring up their children in gendered ways that are consistent with societal expectations (Schmidt et al., 2025).

In direct contrast to this historically held notion of dimorphism, Hyde (2005) presents "The Gender Similarities Hypothesis". This suggests the widely accepted psychosocial differences between men and women have been overinflated, a notion upheld by current neuroscientific research (Joel, 2021; Joel and Vikhanski, 2019; Mckay, 2018). A radical argument is emerging, one which rejects the notion of a discrete male and female brain (Joel and Vikhanski, 2019) in favour of the theory that brain anatomy and emotional intelligence cannot be categorised like biological anatomy as every brain is highly variable, regardless of biological sex (Mckay, 2018; Fine, 2010). Moreover, it has been suggested that if a sex category was assigned to a brain, "the majority would be classified as intersex" (Joel and Vikhanski, 2019. p42). Joel's (2021) extensive research into sex differences within the brain illustrates that while group-level differences between a male and female brain are identifiable, on an individual level it is impossible to distinguish between the two. However, the similarities between the male and female brain are not as widely publicised as they are not as sensational as sex-based differences.

This prevents a more balanced understanding of gender, thus, hindering progression on a societal level (Rippon, 2020).

In exploring the difference between male and female brains, it has been argued that due to the "potency of early experience, in modelling neuroconnections, it would be shocking if the two sexes' brains *didn't* work differently … sex differences in behaviour *must* be reflected as sex differences in the brain" (Eliot, 2009, p6). As girls and boys grow into adults, brain differences become harder to attribute to genes and hormones, and the role of social brain shaping becomes increasingly apparent (Giedd et al., 2012; Hayward and Sanborn, 2002; James, 2016). Accordingly, it is suggested that the greatest lifelong effect on gender differences is shaped by social exposure (Booth and Nolen, 2012; Joel and Vikhanski, 2019). Thus, the notion that you identify the sex of an individual by assessing their brain functioning is an inaccuracy that has been fuelled by brain science for centuries. But this is now being challenged (Rippon, 2020) as research is asserting that our brains reflect the gendered lives we have lived, not just the sex of the person they inhabit (Rippon, 2020). Thus, we must examine what is occurring outside of the brain, as brain function is shaped through the cyclical and generational learning that takes place through social experiences (James, 2016; Rippon, 2020; Joel and Vikhanski, 2019).

Rippon (2020) suggests that until gender can be viewed in a more flexible way, many scientists will continue to regard the brain as gendered. These traditional gender essentialist ways of thinking stand as a direct obstruction to the progress, equality, and opportunity of both individuals and society (Rippon, 2020) and for as long as they are perpetuated, we will remain in a gendered world, and "a gendered world will produce a gendered brain" (Rippon, 2020, pxxi). However, that is not to diminish the importance of the strengths and vulnerabilities that both sexes possess, which should be celebrated (Eliot, 2009; Nokoff et al., 2023).

Thus, traditional gender essentialism has led to harmful dyadic stereotypes existing at an implicit level (Fine, 2010) that "serve to display a sex category, which signifies to others how to respond" (Duckett, 2008, p 30). Dyadic stereotypes are powerful, enduring, pervasive, self-fulfilling prophecies regarding groups of individuals, dictating appropriate actions and reactions based on sex (Moè, 2009; Turner-Bowker, 1996; Yu et al., 2017). They do not allow for the individualism within society unless maintained within strict boundaries, including within motherhood (Averett, 2021; Goldberg, 2023).

2.3.2 Women are Empathetic, Men are Stoic

Due to being the childbearing sex, females are expected to display the feminine behaviours of nurture, submissiveness, care and empathy, whereas males are expected to be strong, stoic, pragmatic and logical, regardless of individual desire (Oakley, 1984; Turner-Bowker, 1996; Wood and Eagly, 2002). However, it is argued that sex differences have become exaggerated, especially in relation to mens' capacity for empathy, care, intuition and emotional intelligence (Kane, 2006; Kane, 2009). Kimmel (1994) states that "anti-femininity lies at the heart of contemporary and historical constructions of manhood" (p119). However, research suggests that there is scope for progression, as a lack of empathy is not a hard-wired trait of men, but a socially shaped gendered response to the expectations of the male sex (Goffman, 1977; Moè, 2009; Moè and Pazzaglia, 2006; Sharps et al., 1994). Consequently, it has been argued that if such stereotypes were removed and the individual was no longer stigmatised by a set of assumed behaviours, being born male would not lead to lower expectations of these traits (Duckett, 2008; Evans, 2002; Moè and Pazzaglia, 2006; Turner-Bowker, 1996).

However, despite the progression in our understanding of expected gendered behaviours, Wiegman (2006) argues that gender is "made and remade according to the political desire that seeks it in the first place" (Jack, 2020). Consequently, a disruption in the assumed natural link between sex and gender jeopardises the very foundations of our social structure; therefore, change may not be forthcoming (Sultana, 2011). Moreover, despite the challenges to gender assumptions, some scholars still seek to substantiate damaging historical male-female stereotypes (Baron-Cohen, 2004).

2.3.3 Sex, Gender, and Babies

Infant sex preference has been widely researched in Asian contexts where a male preference has been historically dominant (Kapoor and Kumar, 2017; Smith et al., 2018). This male preference has been attributed to a need for economic stability, with a preference for sons due to their value in labour (Bohnert et al., 2012). Although there has been a dissipation in the overt articulation of infant sex preferences, recent demographic studies indicate that infant sex preferences still exist, but a shift may have taken place away from the need for the economic labour value of sons. There is a growing suggestion that daughters are desired over sons (Saccio, 2025) because of a social assumption that girls are more emotionally intelligent than

boys (Young et al., 2021; Baron-Cohen, 2004). In their study Bornstein et al., (2008) found that daughters were more emotionally engaged than sons, but importantly they also found that mothers were generally more emotionally responsive to daughters. Furthering our understanding of this, Aznar and Tenenbaum (2015) found that mothers used more emotionally aware words with daughters than sons, potentially leading to differences in psychological outcomes between sons and daughters. These interactions are likely conducted due to gender essentialist assumptions of the emotional capacities of boys and girls.

Even before birth, stereotypically gendered societal norms shape a parent's understanding of what having a son or daughter may be like, and for this reason, parents are never truly ambivalent about the sex of their child (Eliot, 2009; Rippon, 2020). Beginning in pregnancy, parents often shape the life of their child due to their biological sex; there may be an entrenched belief that a daughter will have a greater tendency for empathy and that sons will be naturally troublesome, both physically and emotionally has been reported (Groenewald, 2016; Hendl and Browne, 2019; Kane, 2006; Mckay, 2018).

The prevailing gender stereotypes also impact the expectant mothers and fathers anticipated parenting roles and experiences (Johnston and Swanson, 2006; Khalid and Hirst-Winthrop, 2020; Pedersen, 2016). It has been suggested that a parent cannot easily break the expectations of each parenting role, as "doing of gender is undertaken by women and men whose competence as a member of society is hostage to its production" (West and Zimmerman 1987, p 126). That is, the accepted gender-imposed parenting stereotype is so deeply embedded within our society that if a parent does not adopt their prescribed role they are risking social condemnation, negatively impacting well-being (Kane, 2006).

The notion of a prescribed role applies not only to parents but also to boys and girls who may not conform to expected male and female child behaviours (Fine, 2010). Although there is a movement within the Global North to understand and accept those children that do not assume the "normative" gender traits ascribed to their sex (Wood and Eagly, 2002), it is disproportionately unacceptable for boys to function successfully outside of their assumed gender role. Yu et al. (2017) reported that it is increasingly acceptable for girls to engage in 'boy activities', however, no such acceptance was found for boys wanting to partake in 'girl activities' or behaviours. Moreover, Kane (2006) reported that when the biological sex and the assumed gendered behaviours of boys did not match their assumed male behaviours, their

parents were often actively concerned, sometimes leading to physical punishment. Thus, should a maternal infant sex preference be such a surprise.

2.4 Psychosocial Impact of Infant Sex Preference on Mothers

2.4.1 Taboo and Stigma

A taboo has been characterised as a social restriction placed on a practice, belief, thought or behaviour (Anderson et al., 2011; Beck et al., 2020; Wilcock et al., 2009). Consequently, it can be difficult or even impossible to communicate an experience that is socially taboo. However, not communicating a significant experience can negatively impact well-being and help-seeking behaviours (Anderson et al., 2011; Jones, 2019; Wilcock et al., 2009). Moreover, impede the research and theorisation of the phenomenon in question (Wilcock et al., 2009). A lack of social understanding can lead to stigma being experienced and the consequences can include demeaning comments, disparaging looks, or slights (Bresnahan et al., 2020; Smith, 2007; Tyler, 2021). This turmoil, compounded by a lack of individual and social understanding of the experience, can lead to internal questioning of the validity of the experiences (Baldisserotto et al., 2019; Hadfield et al., 2019) Accordingly, when individuals feel socially silenced misunderstanding can grow, therefore societal understanding and scholarly research of the experience, impeded (Nakku et al., 2016).

An individual who is the subject of stigmatisation may suffer debilitating psychological effects, such as emotional isolation, guilt, and psychological distress (Pinto-Foltz and Logsdon, 2008; Sultana, 2019) as well as a sense of decreased self-value and self-worth, leading to a sense of shame (Anderson et al., 2011; Tyler, 2021), all of which are detrimental to well-being. Bresnahan et al. (2020) reported that laws and policies have been implemented to protect mothers from stigmatisation, an example of which being breastfeeding. However, it was found that social narratives that strongly oppose breastfeeding in public can override these rules and render them insufficient to protect breastfeeding mothers. This finding highlights how prevailing embedded social narratives can override policy and procedure and have a significant detrimental effect on mothers and babies. Thus, embedded societal views must be tackled before policy chances are effective.

Conversely, taboos, stigma and shame surrounding motherhood can be reinforced by dominant social narratives that idealise a presumed maternal instinct, selflessness, and a mother's

unconditional acceptance of her child (Hays, 1996). Within this framework, maternal-infant sex preference, particularly when it is unmet and distress is experienced, becomes a stigmatised and largely silenced experience (Groenewald, 2016; Saccio, 2025; Young et al., 2021). Mothers who express "disappointment" or distress over their child's sex may view their thoughts and feelings as unnatural, ungrateful, or emotionally deficient, which they fear might lead to social judgement which can cause the internalisation of shame (Duckett, 2008).

Although research has identified that holding an infant sex preference is not uncommon (McMillan, 2012), it has been suggested that mothers in the Global North feel social pressure not to disclose any infant sex preference that they may have due to the stigma and taboo attached to such a maternal desire (Groenewald, 2016). The taboo is perceived to be intensified if a mother has given birth to healthy children of one sex but longs for a child of the opposite sex and vocalises this preference, and the taboo is further intensified if she expresses how the longing has detrimentally impacted her well-being (Groenewald, 2016; Young et al., 2021). In light of this, increasing evidence in perinatal mental health highlights the need to respond to diverse experiences of mothers to optimise mental health outcomes (Estriplet et al., 2022).

2.4.2 Maternal Help-Seeking Behaviour

It has been asserted that when a mother perceives she has not met the expectations of the MMN, she will experience feelings of guilt, shame, insecurity, inadequacy, and loss of identity (Kerrick and Henry, 2017; Spreckles, 2004), meaning that she is more vulnerable to mental health struggles (Ulrich and Weatherall, 2000). If a mother experiences mental health challenges, it has been found that despite wanting to seek support, her help-seeking behaviours can be hampered by the thought that a 'good' mother should not have such struggles. Such difficulties are perceived to be "inappropriate" because they contrast with the embedded social narratives of the 'good' mother (Dunford and Granger, 2017; Baldisserotto et al., 2019). Upholding this position, research that has found some maternal struggles are seen as socially taboo, meaning that mothers regard help-seeking as forbidden, which can compound their feelings of guilt and shame, negatively impacting their well-being (Duckett, 2008; Eliot, 2009; Gilbert, 2011; Groenewald, 2016; O'Reilly, 2010; Young et al., 2021).

Hollins Martin et al. (2019) reported that a mother's 'real' experience of motherhood contrasts so greatly with the 'ideal mother' found in the MMN that it has a negative impact on a mother's

mental health. However, the chasm between the 'ideal' and 'real' experience of motherhood is currently not included in the assessment for mothers who are struggling with their mental health. Hollins Martin et al's. (2019) scoping review developed questions for inclusion within a new measure; the Self-Image as a Mother Scale, developed through the comparison of the 'ideal self' against the 'existing self'. Acceptance of infant gender (p 234) was included among the themes that were identified as affecting the perception of self as a mother. However, the use of the term "gender" illuminates the confusion between the terms "sex" and "gender" (Fine, 2010) which may complicate mothers' and health-care professional's understanding of the experience.

2.4.3 Maternal Grief

Grief has been described as a socially contextualised, multifaceted, and enduring experience where grieving "norms" are expected (Arizmendi and O'Connor, 2015; Bonanno and Kaltman, 2001; Harvey and Miller, 1998; Kubler-Ross and Kessler, 2005). Grieving "norms" define what is permissible in expressions of grief and have been described as a shared understanding of the manifestation of grief, in the physical, emotional, and spiritual sense for the individual, and informing how society reacts to an individual's grief (Bonanno and Kaltman, 2001; Doka, 2002; Rando, 1984).

However, it has been asserted that the traditional understanding of loss and grief is naïve, as the model is too narrow (Bonanno and Kaltman, 2001; Harvey and Miller, 1998). The widely accepted notions of grief are associated primarily with loss through death. However, additional grief theories have emerged, which include ambiguous loss (Boss, 1999b), symbolic loss (Rando, 1984) and disenfranchised grief (Doka, 2002). This growing body of research has also found that non-death loss can have a significant impact on the individual who is grieving (Harvey and Miller, 1998; Papa et al., 2014).

When a person grieves for a loss that is not socially recognised, because it falls outside social norms of grieving, their grief may go unrecognised. This experience is known as disenfranchised grief, which, as Doka (2002, p5) describes is a grief that "is not openly acknowledged, socially validated, or publicly observed". Therefore, cultures can prevent some losses from being valued, but in another place, or at another time, those same losses may have

been recognised and rationalised (Doka, 2002). If society minimises non-death loss by applying a “hierarchy of loss”, then the individual experience is also minimised (Mitchell, 2018).

When a mother experiences grief related to her mothering role, the experience is shaped by social grief norms and the ‘good’ mother model (Kerrick and Henry, 2017; Popoola et al., 2022). When there is a culturally misguided understanding of the experience, as has been found for a stillbirth (Gillis et al., 2020), this can leave mothers uncertain about how to mourn (Layne, 2000). Perceived social restrictions placed on a mother’s ability to outwardly grieve prohibit a healthy grieving process (Popoola et al., 2022) and compound elements of stress and anxiety associated with the grief (Bonanno and Kaltman, 2001).

In the case of grief associated with failed IVF treatment, although a birth or even conception, may not have occurred, the women may have actively constructed there “would have been babies as real babies and themselves as real mothers, worthy of the social recognition this role entails” (Layne, 2000, p321). Layne (2000) asserted that space for the baby-to-be is made in the heart and the home of the mother before birth. It was found that the imagined child may have been given a name or nickname, family, friends and colleagues may have begun to ask about a hoped-for conception or birth, and the actual or imagined purchasing of items of clothing makes the baby real, especially when gendered clothing purchases have taken place. Thus, the baby-to-be is real to the mother-to-be, even though they have not been born (Ferrell et al., 2015). Such losses can raise questions for the mother about her identity and worth (Bonanno and Kaltman, 2001), which can create a need for her to re-identify herself after the loss of her imagined future (Creed, 2022; Kessler, 2019). Feminist theories are mobilising conversations about different forms of maternal grief and are enabling mothers to acknowledge the social pressures placed on their experience by MMNs and the shame that may be associated with their grief as a result (Ferrell et al., 2015). However, there is still progress to be made in understanding and validating the full range of maternal grief experiences (Frøen et al., 2016; Gillis et al., 2020; Mitchell, 2018). Papa et al. (2014) seek to widen our understanding of grief that can be experienced, arguing that the grief experience is shaped by the “centrality of the loss to one's identity” (p136). Where grief for the imagined child is experienced, it is reported that perceived loss and the associated grief are significant, but not widely researched (Harvey and Miller, 1998).

Mitchell (2018) concurs with this argument, pointing to the need for practitioners and policies to acknowledge maternal grief that is non-death loss related. Mitchell (2018) suggests that maternal non-death losses are currently disenfranchised by the very system that seeks to support mothers, which can lead to psychological and emotional turmoil, impacting maternal behaviours and outcomes.

Grief can be regarded as a multifaceted and enduring experience (Arizmendi and O'Connor, 2015) that has been researched in relation to miscarriage (Volgsten et al., 2018) and failed IVF (Lee et al., 2010), but not in the context of 'GD', or in relation to the sense of failure that a mother may feel when she produces multiple infants of one sex but fails to bear the other. Thus, there is a need for healthcare professionals to better understand and promote the legitimacy of all maternal experiences while promoting understanding and support through respectful, non-judgemental approaches (Estriplet et al., 2022).

2.4.4 The Importance of Terminology

The lack of unified terminology around an experience, such a disenfranchised loss, inhibits the development of conceptual clarity to support individual and professional understanding of the phenomenon (Kersting et al., 2020). The misuse of terminology around health matters can cause confusion (Gotlieb et al., 2022), whereas coherent terminology can facilitate the understanding and normalisation of an experience (van Maarschalkerweerd et al., 2021). This is because terminology shapes how expectations are recognised and validated, but also how mothers interpret what they are experiencing, their perceived conformity to social norms, unmet expectations, stigma, and grief (Fox et al., 2018). Consequently, inaccurate or absent terminology may perpetuate misunderstanding, minimise distress, and exclude some maternal experiences from acknowledgment, and thus appropriate care (Smith et al., 2020). Furthermore, in the absence of conceptual clarity, appropriate terminology, or definitions, and through the application of stigmatising labels, women may suppress their emotions, hesitate to seek support, or feel that their personal experience is not legitimate (Collins, 2022).

Unless healthcare professionals have adequate understanding of an experience, effective and tailored support may not be available (Ganann et al., 2020). However, challenges in training medical professionals have been raised. Gleisner and Johnson (2021) explore the challenges educators are faced with in supporting medical students' ability to manage their reactions to

distressing or sensitive topics. While Reid and Johnston (2018) discuss how in educating GPs on female-specific health concerns related to childbirth, menstruation, and menopause there was a need to challenge traditional patriarchal norms that have shaped inequalities and stigma in this area of healthcare. However, despite these challenges, the mental health of mothers remains an "urgent women's health concern" (Slomp et al., 2023, p8) with catastrophic effects if not addressed. If mental health concerns are not addressed during pregnancy reduced foetal growth, preterm birth, and an increased risk of postnatal depression have been found (Amaru et al., 2025). Moreover, if an infant or child is exposed to prolonged maternal distress, there is an association with the child experiencing significant mental health problems (Hope et al., 2019).

2.5 Summary of Background Literature

This chapter has examined how social narratives, gender constructs and maternal perspectives can intersect to produce maternal infant sex preference. It is evident that a lack of appropriate language and acknowledgement of sex, gender and the maternal experience can silence a mother. Chapter 3 will now explore 'GD' in detail.

Chapter 3: A Systematically Informed Literature Review

3.1 Introduction

This chapter presents a systematically informed literature review on the phenomenon of 'GD'. The purpose of this review is to explore how 'GD' has been conceptualised and understood and to identify gaps in the current body of research. Initially, eight papers were identified and critically analysed. Since the completion of the original literature review between January and March 2023 additional papers have been published. These more recent contributions (n=3) have also been included in this chapter to ensure the literature review reflects the most current understanding. Together, these papers are synthesised, and consideration is given as to how they inform or limit our current understanding of the phenomenon. The chapter will conclude by identifying significant gaps in the current literature.

3.2 A Systematic Approach

Systematic reviews have traditionally been considered the 'gold standard' of health-focused literature reviews (Munn et al., 2018) where an objective and unbiased process can be undertaken in the synthesising of available research. They are employed to answer specific questions through the combination of research findings, often to inform policy and practice (Aromataris and Pearson, 2014). However, this study is exploratory and concerns a little-understood phenomenon; therefore, there was limited research available to collate and synthesise. However, adopting a systematically informed approach offered several benefits to this literature review. While a 'traditional' systematic review is rigid, a more flexible approach to the systems being employed allows the use of diverse sources and methodological approaches, which is of particular importance when exploring complex, layered, and socially embedded experiences such as 'GD' (Grant and Booth, 2009). Yet, a systematic framework ensures transparency in the literature searches and selection, enhancing the trustworthiness of the review (Booth et al., 2012).

3.3 Research Question and Identification of Literature

There appears to be a lack of cohesive conceptual understanding of what 'GD' is (Groenewald, 2016; Hendl and Browne, 2019; Young et al., 2021). It has been asserted that a lack of clarity and consistency in understanding of a topic demonstrates a weak conceptual understanding (Cerdin and Selmer, 2014). The need for conceptual clarity is increased when there are disparities in the terminology surrounding the concept (Kersting et al., 2020; Schoen and Teddlie, 2008). This literature review aims to bring "clarity in the conceptual foundations" (Hardie, 2022, p1) of 'GD', leading to a unity of understanding (Schoen and Teddlie, 2008) to the concept of 'GD'.

A purposely broad question, "What is gender disappointment?" was set and acted as a compass for the literature review, directing the search for relevant literature (Eakin and Mykhalovskiy, 2003). In defining the scope of the literature to be included, I made the decision to focus on resources situated within the more industrialised and politically influential counties of the Global North. However, I acknowledge that distinguishing between research conducted in the Global North and the Global South risks reinforcing a binary that may lead to reductive assumptions about religion, culture, and social experience. This distinction is not meant to suggest an absence of religious or cultural traditions in the Global North, but to narrow the scope of the literature review to contexts where the concept of 'GD' is primarily framed as a psychological and maternal mental health phenomenon rather than being understood within a historical and cultural hierarchy defined by sex. Future work could extend beyond the geographical frame used in this study to explore how 'GD' is shaped by the experiences and expectations of religion and cultural tradition. For the purpose of this thesis, the focus on the Global North is considered as a strategic boundary rather than a culturally neutral stance (Solarz, 2019; Steger, 2003). Resources were also restricted to those published in the English language. ASSIA, PsycInfo, PubMed, ProQuest Dissertations, EThOS, and NUSearch were accessed to obtain relevant literature. These databases were searched, as they covered the domains of medicine, social sciences, psychology, and the grey literature of theses and dissertations. I also conducted a 'gender disappointment' search in NUSearch to locate any potentially missed literature.

The search was not restricted to academic findings; professional opinion pieces and relevant reports were also assessed when identified within the searches. There were no date enforcements as to obtain resources that may have been published before the term 'GD' came into use. Search terms were generated following discussions with my supervisors and academic

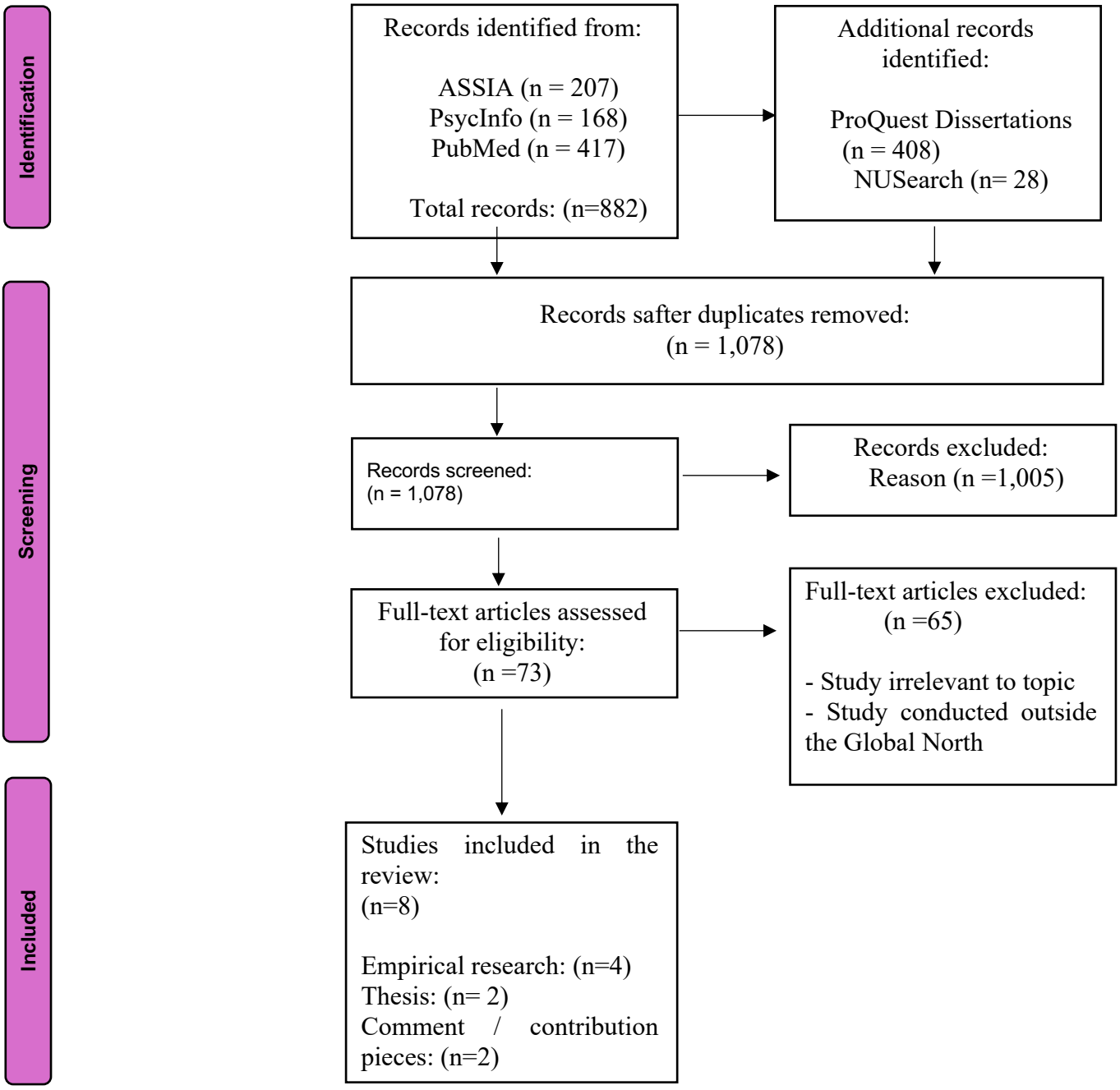
librarians. They included: “gender disappointment”, “daughter preference”, “son preference”, “parental sex preference”, “maternal help-seeking”, “maternal well-being”, “sex” and “gender”. Lemmatization, field options and Boolean operators were used to orientate the search.

After the deletion of duplicates, all articles underwent an initial screening process whereby the title of the text was assessed for relevance. The next stage of the screening process required reading the abstract to assess if the articles met the inclusion criteria for the review. The remaining screened articles were read in full, and their theoretical and empirical applicability determined inclusion.

3.4 Analysis and Reporting

Included studies were organised, by date and critically analysed in turn. Following this, the studies were analysed using the thematic analysis (Braun and Clarke, 2013). five overarching themes were identified: i) motherhood, ii) sex and gender, iii) conceptions of ‘GD’, iv) the emotions of ‘GD’, and v) support seeking. Recent developments in the literature of ‘GD’ are then addressed.

Figure 1 PRISMA Diagram to illustrate the inclusion and exclusion of texts



Shaped by the inclusion and exclusion criteria, eight texts were included in the review.

3.5 Studies Overview

When ascertaining the geographical location of the study focus, of the eight texts identified three were situated in the UK (Groenewald, 2016; Winter, 2021; Young et al., 2021) one Australia (Monson and Donaghue, 2015), two Canadian based (Krishnan, 1987; Slomp et al., 2023) one situated within English speaking online communities with the researcher based in Canada (Duckett, 2008). Two further texts, one scientific contribution and one comment piece drew on 'GD' research specifically but without a geographical focus, one researcher was based in the UK (Winter, 2021) and another in Australia (Hendl and Browne, 2019).

Three texts were located in health-related areas of study (Hendl and Browne, 2019; Slomp et al., 2023; Winter, 2021), two discretely in psychological research (Groenewald, 2016; Monson and Donaghue, 2015) and one bridging psychology and health (Young et al., 2021). One was sociology-based (Krishnan, 1987) and a thesis to obtain a Master of Arts (Duckett, 2008). Publication dates ranged from 1987 to 2023. Six had a qualitative approach (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Krishnan, 1987; Monson and Donaghue, 2015; Winter, 2021; Young et al., 2021) and two quantitative (Krishnan, 1987; Slomp et al., 2023). Six of the texts were based on empirical research (Duckett, 2008; Groenewald, 2016; Krishnan, 1987; Monson and Donaghue, 2015; Slomp et al., 2023; Young et al., 2021) and two comment or scientific contribution pieces (Hendl and Browne, 2019; Winter, 2021).

Seven of the eight articles had a discrete focus on 'GD' or maternal-infant sex disappointment or preference (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Krishnan, 1987; Slomp et al., 2023; Winter, 2021; Young et al., 2021) and one on the use of assisted reproductive technology for social sex selection (Monson and Donaghue, 2015). These findings are summarised in Table 1.

Table 1. Data chart

Authors (date)	Context (researcher location)	Discipline	Methodology	Focus
Duckett (2008)	Online (Canada)	Arts	Qualitative Content analysis	Gender disappointment in online communities
Greonwald (2015)	UK	Psychology	Qualitative IPA	Gender disappointment

Hendl and Browne (2019)	'Scientific contribution' (Australia)	Health	Qualitative Contribution	Gender disappointment
Krishnan (1987)	Canada	Sociology	Quantitative Survey	Maternal infant sex preference
Monsoon and Donaghue (2015)	Online (Australia)	Psychology	Qualitative Critical discourse analysis	Reproductive technology for social sex selection discussions online
Slomp et al (2023)	Canada	Health sciences	Quantitative Statical analysis	Relationships between maternal perinatal mood, sex of infant, and disappointment with infant sex
Winter (2021)	Comment piece (UK)	Health	Qualitative 'Scientific contribution'	Gender disappointment
Young et al. (2021)	UK	Psychology / health	Qualitative IPA	Gender disappointment

3.6 Terminology

Within the six articles and two theses included in this review, 21 reoccurring terms for describing the experience of 'GD' were identified (Table 2). Of the 21 terms, the four most frequently used terms were grief, guilt, desire, and the loss of an imagined future (child or self). These terms were identified in all 5 papers, 62.5%.

In the articles that had a discrete focus on 'GD', and were all empirical, nine terms were used consistently: sadness, shame, guilt, grief, intense, depth, painful, imagined future (child or self), and desire (Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021). See table 2.

Table 2. Terms used to describe the experience of 'GD' (n=8 articles)

Term	Article (%)	Author
Obsessive	1 (12.5%)	(Hendl and Browne, 2019)
Upset	1 (12.5%)	(Winter, 2021)
Mental disorder	2 (25%)	(Hendl and Browne, 2019; Slomp et al., 2023)
Preference	2 (25%)	(Krishnan, 1987; Slomp et al., 2023)
Profound	2 (25%)	(Groenewald, 2016; Monson and Donaghue, 2015)
Uncomfortable	2 (25%)	(Duckett, 2008; Monson and Donaghue, 2015)
Unexpected	2 (25%)	(Groenewald, 2016; Monson and Donaghue, 2015)
Disappointment	2 (25%)	(Slomp et al., 2023; Winter, 2021)
Overwhelm	3 (37.5%)	(Duckett, 2008; Groenewald, 2016; Young et al., 2021)
Enduring	3 (37.5%)	(Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015)
Stigma	3 (37.5%)	(Duckett, 2008; Hendl and Browne, 2019; Young et al., 2021)
Alienation	3 (37.5%)	(Duckett, 2008; Groenewald, 2016; Young et al., 2021)
Sadness	4 (50%)	(Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021)
Intense	4 (50%)	(Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021)
Depth	4 (50%)	(Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021)
Shame	4 (50%)	(Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021)
Painful	4 (50%)	(Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021)
Grief	5 (62.5%)	(Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021)
Guilt	5 (62.5%)	(Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021)
Imagined future (child or self)	5 (62.5%)	(Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021)
Desire	5 (62.5%)	(Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021)

3.7 Findings

The following section will systematically address the key findings, strengths, and limitations of each of the eight studies included in this review. Following this, five overarching themes will be presented to synthesise the current understanding of 'GD'.

Krishnan's (1987) study examined the sex preference of children for mothers in Edmonton, Canada. A multivariate analysis was conducted on quantitative data gathered between 1973-1974 and provides an early contribution to our understanding of a parent's infant sex preferences. A surprising finding of the study was that "the more sisters the wife has, the greater the pull towards daughter preferences" (p 374). It was also reported that infant sex preference operates differently for younger and older women, as does the influence of education level. Both older women and more educated mothers showed a son preference. The findings also showed that mothers from "less developed counties" (p375) typically showed a son preference.

The use of a multivariate analysis allowed for the examination of multiple variables simultaneously to understand how they may influence maternal infant sex preference. The study sought to establish if women that had a son preference differed from women who had a daughter preference in relation to variables such as education, place of birth, number and sex of siblings, and traditional gender role attitudes. Another methodological strength is the large sample size. The quantitative data was drawn from an initial sample of 1045 women, where 599 women responded, and of those, 550 also gave subjective reports on their husbands' or partners' views. The large sample size supports the inclusion of diverse populations, and a large sample size may reduce Type II errors (failing to detect a true false) (Faber and Fonseca, 2014). Moreover, it upholds the methodological choice of a multivariate analysis, which requires a 'sufficient' sample size (Faber and Fonseca, 2014).

However, there are limitations that must be acknowledged. The geographical restriction of the sample to Edmonton restricted the inclusion of populations across Canada, which may have given broader insight into sex preferences had they been included. Furthermore, the exclusion of women who had deceased child(ren) or more than six children may have resulted in the omission of important perspectives on infant sex preference. Additionally, the data collected in relation to the husbands and partners of the mothers was given subjectively by the women, which risks inaccuracy, as it is the woman's subjective interpretation of her partner's preferences and experiences that were consequently analysed. Finally, the data analysed in the study was collected 10 years prior to publication. This is problematic, as social attitudes, 'norms' and family planning can change significantly in a decade (Okigbo et al., 2018); thus, the views reported may not have reflected the views of the time. In conclusion, while Krishnan (1987) laid the foundation for understanding infant sex preferences in Canadian mothers, its limitations highlight the need for representative and qualitative research on the subject.

Duckett's (2008) study, '*Gender Dreams: The Social Construction of Gender Disappointment (GD) as an Affliction in Online Communities*,' represents the first study specifically exploring the phenomenon of 'GD' in the Global North. Using a grounded theory methodology, combining content analysis of online bulletin board systems with semi-structured e-mail interviews, Duckett (2008) argues that through the sharing of experiences online, the phenomenon of 'GD' has been conceptually medicalised,

Duckett (2008) reported four main themes i) 'GD' communities, ii) the medicalization of 'GD', iii) gender dreams, iv) living with 'GD', which in combination "revealed that among the women of the 'GD' online communities, 'GD' is an affliction from which one can suffer" (p 72). Duckett's (2008) study presents valuable insights into the process of lay medicalisation, particularly the demonstration of how an online community can come together and collectively understand and frame their experiences through sharing and finding similarities in their experiences of 'GD'. In doing so, the online communities within her study framed their 'GD' experiences as a chronic affliction, thus claiming legitimacy for their experience, which may have otherwise been socially dismissed or minimised. Importantly, Duckett's (2008) research illuminated the role of virtual communities in creating space to explore and validate the perceived socially marginalised experience of 'GD'.

Duckett (2008) adopts a grounded theory methodology; however, she does not discuss the study's philosophical orientation. The lack of philosophical transparency around the study's ontological and epistemological orientation raises some important considerations. A methodological approach is informed by underlying philosophical views, and not discussing them raises questions about the study's philosophical coherence. Moreover, there are multiple versions of grounded theory, each with a different philosophical foundation, and without direction on which approach is being used, there is a lack of clarity in the assumptions guiding the research. Duckett (2008) was unfamiliar with the 'GD' community and worked to develop her understanding of the community and the language that was being used so that she could "assess the content accurately" (p 61), which reflects the values of a constructivist grounded theory approach. In conducting online research as an outsider, despite taking an unknown amount of time to better understand the community and the language being used, there is a risk that subtle meanings and the depths of the emotion could be misinterpreted. This is particularly

relevant in online communities, where, without body language and intention, the language can conceal layered or coded meaning (Williams et al., 2012).

Duckett (2008) found that within online communities discussing 'GD' there are expressions of shame, inadequacy, grief, and deviation from idealised motherhood norms (Hays, 1996), and collectively the 'GD' 'sufferers,' as Duckett (2008) refers to the individuals experiencing 'GD', conceptualises their feelings as symptoms of an affliction. Consequently, Duckett's (2008) grounded theory illuminates how lay discourse can normalise and legitimise distressing maternal emotions such as 'GD' and conceptually medicalise them.

Groenewald's (2016) thesis *'"Slugs and snails and puppy dogs' tails" Exploring the 'gender disappointment*' experiences of nine White British mothers of boys who wanted a daughter: An Interpretative Phenomenological Analysis' (IPA) represents an important contribution to understanding the lived experience of maternal 'GD' in the UK. The decision to adopt IPA is clearly justified by the study's aim to explore the depth of individual experiences, facilitating a detailed exploration of the maternal 'GD' phenomenon (Pietkiewicz and Smith, 2014). A methodological strength of Groenewald's (2016) study is her reflexive engagement and transparency in her positionality. The explicit way in which Groenewald (2016) discusses her dual role as a researcher and a mother to sons enables transparent discussion around how her process and findings may have been shaped. Moreover, reflexivity in this form is consistent with IPA's hermeneutic and interpretive orientation.

Groenewald (2016) reports four superordinate themes: i) alienation, ii) loss, iii) control, and iv) commodification. Combined, these themes and their sub-themes assert that maternal 'GD' can be experienced as a socially taboo, impactful, and shameful experience intertwined with and shaped by dominant social narratives about motherhood, sex, and family composition. Groenewald's (2016) suggestion that the women in her study imagine their daughter as the 'vicarious baby' (Stern, 1998) is an interesting assertion. Groenewald (2016) argues that her findings suggest that viewing the imagined daughter as the 'vicarious baby,' "we can see how a child could become the embodiment of another chance to realise one's own dreams" (p 117). Groenewald's (2016) finding builds upon Duckett's (2008) study in the conceptualisation of 'GD' functioning not simply as a reaction to the sex of a child, but also as a possible reflection of deeper, unfulfilled personal desires or aspirations.

While Groenewald's (2016) assertion on the "vicarious baby" offers a psychologically rich suggestion about the experience of maternal 'GD', it must be handled with care to avoid reinforcing mother-blaming narratives or exposing women to greater stigma (Jackson and Mannix, 2004) especially as the population of mothers who experience 'GD' appear to already experience significant distress due to prescribed social narratives (Duckett, 2008). Without a broad and layered contextualisation of the mother's social, structural, cultural, and gendered constraints, the mother experiencing the significant distress of maternal 'GD' may become the focus of the problematisation without exploring deeper layers of the experience (Winett et al., 2016). When a mother becomes the 'problem', this can serve to consolidate feelings of shame, creating barriers for the mothers to voice their distress around what is already a social taboo (Hays, 1996; Wilcock et al., 2009; Winett et al., 2016). Moreover, this argument may be situated in a premature assumption that the mother's desire for a daughter is rooted in her possibly subconscious belief that she could have achieved more in her life. Groenewald (2016) did not set out to establish the origins of the mother's longing. As such, although this finding is important, it requires further empirical research. This is particularly important given the sensitive and potentially stigmatising nature of maternal 'GD' to prevent premature conclusions that may inadvertently harm mothers and hinder their help-seeking behaviours (Davidsen et al., 2023).

In conclusion, Groenewald's (2016) thesis builds upon Duckett's (2008) study, providing a rich account of maternal 'GD' from nine mothers in the UK who were all mothers to only sons and longed for a daughter. Groenewald's (2016) findings identify the ways in which some mothers make sense of their maternal 'GD' experience, reflecting a wider sociocultural "objectification of women, the denigration of men, and the transactional nature of the relationship between parents and children" (p 104).

Monson and Donaghue's (2015) study, '*You Get the Baby You Need": Negotiating the Use of Assisted Reproductive Technology for Social Sex Selection in Online Discussion Forums',* explores social options both supporting and resisting the use of ART for social sex selection within Australian online discussion forums. From a social constructionist position and employing a Critical Discourse Analysis Monson and Donaghue's (2015) found that social sex selection was "negotiated on two levels: whether the procedures should be available and whether people should actually want to use them" (p 310). Moreover, these negotiations were shaped both individually and socially. The findings of the study provide valuable insights into

the dual-level negotiation of ART for social sex selection, with a particular strength being the highlighting of the complex interweaving of personal and societal values, showing both how the desire for a certain sex child is both because of, and constrained by, embedded gender essentialist narratives. Additionally, the study highlights how the emotions of 'GD' are simultaneously expressed and censured due to "would-be sex selectors (being) framed as inappropriate and their fitness for parenthood is called into question by the existence of those feelings" (p310). Monson and Donaghue (2015) is the only study that specifically draws attention to the complex discursive positioning of 'GD' within discussions on assisted reproductive technology. This finding is important as it exposes the depth of moral scrutiny and condemnation directed at those who are perceived to deviate from the 'good' mother model. Monson and Donaghue's (2015) findings demonstrate that mothers who express a preference for child of a particular sex can be subject to damning social judgement, so much so, that their suitability for parenthood is brought into question because they violate the culturally entrenched ideal model of the 'natural', selfless, unconditionally accepting mother.

A notable limitation of Monson and Donaghue's (2015) study is the lack of verifiable demographic and identity information for the online forum participants. While Monson and Donaghue (2015) report that 80 posters were identified as female, one as male, and 16 unknown, the categorisation is based on inferred or self-disclosed information. Accordingly, there is the possibility that some posters may not have been parents or prospective parents at all, but individuals with alternative agendas, such as critics of ART practices, or representatives from fertility clinics seeking to promote their services to prospective clients. This uncertainty raises questions about the content being analysed. As such, the study's findings may not wholly reflect the views of parents or genuine prospective users of ART, but could also include voices with unknown interests and motives, thus potentially impacting the discourse used in the analysis.

In conclusion, Monson and Donaghue's (2015) study offers important insights into the use of ART for non-medical sex selection and parental desires for a certain sex child. An insightful and methodologically sound examination of how prospective users of ART negotiate the contentious issue of social sex selection. The use of Critical Discourse Analysis provides an insight into the way 'GD' is simultaneously expressed and censured, revealing the depth of the demand on mothers for unconditional acceptance of their children and complete selflessness. Uniquely, the findings highlight how women who deviate from socially embedded maternal

narratives, by desiring a child of a particular sex, are subject to intense moral judgement and accusations of being unfit for parenthood. Monson and Donaghue (2015) expose cultural and emotional tensions underpinning online discussions of ART and social sex selection in Australia.

Hendl and Browne's (2019) paper, '*Is 'gender disappointment' a unique mental illness?*' contributes to the ethical and diagnostic debates around 'GD' . Hendl and Browne (2019) argue that 'GD' should not be classified as a unique mental illness, as it is a response to socially embedded gender essentialist narratives and notions around family balancing. The paper asserts that pathologising 'GD' risks reinforcing harmful socially embedded gender stereotypes and medicalising socially produced distress.

Methodologically, Hendl and Browne (2019) drew on secondary data, including prior empirical research (Duckett, 2008; Monson and Donaghue, 2015) to better understand how 'GD' and non-medical sex selection are socially constructed and interlinked. By situating 'GD' within broader social narratives, the paper situates the distress of 'GD' in a sociocultural context.

A key strength of Hendl and Browne's (2019) paper is the critical attention drawn to the risk of premature or potentially inappropriate medicalisation of 'GD' as a unique mental illness. Whether 'GD' is socially constructed, psychological, or a combination, something that demands further research. Yet Hendl and Browne's (2019) paper illuminates the danger of turning complex emotional responses into individual pathology without adequate understanding of their origins. This caution is important in ensuring that the distress experienced due to 'GD' is not simplistically, or harmfully, classified as mental illness, which could lead to unnecessary diagnosis, stigma, or clinical intervention without addressing any deeper foundations of the distress (Jacob et al., 2014).

However, there are notable limitations; a significant one is the reliance on non-empirical data. The absence of empirical data that includes the voice of women who have lived experience of maternal 'GD' could lead to an underestimation of the depth and complexity of the emotional and psychological distress experienced by 'GD' sufferers (Blaikie, 2009; Silverman, 2006).

Moreover, Hendl historically appears to adopt a critical stance towards the use of social sex selection (Hendl, 2015). Consequently, Hendl and Browne (2019) may prioritise concerns

about the ethical implications of the suggested ‘fix’ for ‘GD’ such as social sex selection, over the lived experience of the phenomenon. This may limit our understanding of the nuanced individual meaning that maternal ‘GD’ may hold for some mothers. As a result, the analysis asserted in Hendl and Browne's (2019) paper risks reducing maternal ‘GD’ to a theoretical problem rather than acknowledging it as a deeply embodied and profoundly distressing experience for those mothers who experience it. This limitation highlights the importance of centring the voices of those who have experienced the phenomenon under review to ensure that ethical discussions are informed by lived experiences and are not detached from the embodied human elements that shape the theoretical debates taking place. This is particularly important for maternal ‘GD’ as it is situated at the intersection of individual experiences and deeply embedded social narratives. The reduction of the deeply distressing experience of ‘GD’ to theoretical and ethical critique runs the risk of minimising the emotional, well-being, and relational impacts of ‘GD’.

Finally, there is a danger that framing gender essentialism as the main reason for the experience of ‘GD’ oversimplifies the phenomenon and the depth of the impact of an individual’s life (Uwe, 2018). It risks positioning mothers as passive recipients of societal norms, rather than recognising and validating the nuanced complexities of the parents’ personal meanings, lived experiences, and subsequent lived experiences that may also shape the experience of ‘GD’ . Consequently, Hendl and Browne's (2019) assertions could serve to situate the mother as the problem, which could lead her to experience further stigma, shame, and mother blaming (Caldwell et al., 2021; Heley et al., 2020; Jackson and Mannix, 2004). However, Hendl and Browne's (2019) paper makes a valuable contribution to our understanding of ‘GD’ by discussing if the experience is a unique mental illness.

The study by Young et al. (2021) ‘*Exploring the lived experiences of mothers who identify with ‘gender disappointment*’ contributed to our understanding of maternal ‘GD’ due it the focus on the lived and emotional experiences of mothers who experience maternal ‘GD’. By using IPA like Groenewald (2016), an in-depth exploration of the complexities of the phenomenon was allowed. The use of online, semi-structured interviews facilitated rich data collection from six British mothers by providing a private space in which the sensitive topic of maternal ‘GD’ could be talked about (Uwe, 2018). The data identified shame and perceived social silencing as a significant part of the experience of maternal ‘GD’ making the methodological choices especially fitting. The analysis of the data identified three overarching themes with sub-themes:

i) society and gender (pity, unfulfillment, and the future mother-son relationship) ii) Who am I? (guilt and shame) iii) society and gender (lack of recognition, barriers to talking, benefits of talking), which provide valuable insight into the nuanced emotional and psychological impact of the experience of maternal 'GD'. A salient feature of the population in Young et al's. (2021) study is that although not a demand of the inclusion criteria, all the mothers were only mothers to sons. Another strength is the recognition of the barriers that the women perceived they face in seeking professional help. This illuminates a possible gap in the support for mothers.

Despite these strengths, the study is not without its limitations. The most significant of which is the way that the study does not explore the underlying structural or cultural mechanisms that may also contribute to the phenomenon of maternal 'GD'. Although the study captured the emotional experience of 'GD', there is scope to further develop our understanding of the mothers' lived experiences due to socially embedded narratives that may have served to shape the experience of maternal 'GD'. Finally, although the use of virtual interviews may have provided a private space to discuss a highly personal and sensitive topic, they may have limited rapport building and the embodied experience of the interview, where non-verbal and emotional cues may have been missed (Silverman, 2006; Uwe, 2018). However, Young et al's., (2021) study makes a valuable contribution in developing our understanding of the nuanced emotional experience of maternal 'GD,' which may be significantly shaped by embedded social narratives about what it means to be a mother to sons.

Winter's (2021) article '*Gender disappointment'*, published in the British Journal of Midwifery, provides a concise overview of the phenomenon of 'GD'. A strength of the article is the focus on the importance of midwives' awareness of 'GD' and that the birth of a healthy baby may not negate distress. Winter (2021) uses a small but diverse range of sources, both geographically and methodologically, in an attempt to map the development of 'GD' and the emergence of ART.

Despite these contributions, there are limitations to Winter's (2021) article. Firstly, it is a comment piece rather than an empirical or systematic or formal literature review. Therefore, it lacks both empirical data and systematic methodological processes. Winter (2021) does not explore the experience of maternal 'GD' from the perspective of those who experience it, and some of the studies he draws upon also fail to include such voices in their work (Hendl and Browne, 2019). This is highly significant, as it risks creating accounts of 'GD' that reflect

assumptions or understanding that is tangled in ethical debates rather than generating knowledge and understanding of 'GD' that is situated in the lived experience of the phenomenon. To conclude, Winter's (2021) article serves as an introduction to the concept of 'GD' for midwives, and its publication in the British Journal of Midwifery highlights a desire for knowledge on this subject.

Slomp et al. (2023) present a valuable contribution to the understanding of the relationship between the under-researched area of the '*Relationships Between Maternal Perinatal Mood, Sex of Infant, and Disappointment with Sex of Infant in a North American Sample*'. The study found that "Mothers of male infants may have slightly more depressive symptoms than mothers of female infants regardless of maternal preference for, or disappointment in sex of infant" (p 1). A strength of this study is its use of longitudinal data. Quantitative data was collected at up to four time points: during pregnancy and at one week, one month, and three months postpartum, thus, allowing for changes to be captured over time, an approach that has rarely been used in studies exploring what is commonly referred to as 'GD'. It is noteworthy that Slomp et al. (2023), arguably more accurately, conceptualise the phenomenon as a disappointment with the sex of the infant rather than with gender, which is socially constructed and not initially known (Fine, 2010). A further strength of Slomp et al's. (2023) study is the large sample size (N=207) and the use of a mixed-effects linear regression, which provided the ability to detect small but potentially meaningful points, allowing for a detailed analysis that looked at both biological and psychological impacts.

Despite these strengths, there are several important limitations. Firstly, the study's sample comprised of pregnant women who all had a history of mood or psychotic disorders. As such, the presence of mood or psychotic disorders in this group could confuse associations between infant sex and maternal mood. Secondly, although data of initial infant sex preference and subsequent disappointment was gathered, this was asked as a simplistic "yes/no" and therefore was not able to capture the depth and meaning of the maternal 'GD' experience. Consequently, there is the risk of minimalising what qualitative research into 'GD' has argued is a profound, multi-layered, emotionally distressing experience shaped by individual and societal narratives and norms (Duckett, 2008; Groenewald, 2016; Young et al., 2021). Therefore, the findings of Slomp et al., (2023) may not fully illuminate the breadth of the maternal 'GD' experience. Moreover, the absence of qualitative data limits the study's ability to understand why or how maternal 'GD' comes to be experienced by mothers and what meaning the feelings they have

mean for them. Thus, there is the risk of interpreting 'disappointment' as a transient feeling, rather than recognising its potential link to broader social narratives and personal experiences (Flick, 2018). Lastly, Slomp et al. (2023) do not account for the possible influence of the sex of the birthed child(ren), which may serve to shape maternal preference and 'disappointment'.

In summary, Slomp et al. (2023) provides a quantitative exploration of relationships between maternal mood, sex of infant, and disappointment with infant sex. A strength of the study is its longitudinal approach; however, the reliance on quantitative data prevents the depth of understanding of the finding from being illuminated.

Looking across the eight studies thematically, five overarching themes were identified: i) motherhood, ii) sex and gender, iii) conceptions of 'GD', iv) the emotions of 'GD', and v) support seeking.

3.7.1 Motherhood

Women who experience a desire for a child of a particular sex feel they "counter the normative bounds of conventional motherhood" (Duckett, 2008 p72) as they have birthed healthy children yet desire a child of the opposite sex, which is against the complete acceptance of the motherhood narrative and this experience is known as 'GD' (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Slomp et al., 2023; Winter, 2021; Young et al., 2021). Due to the phenomenon of 'GD' contradicting the 'proper' mother model it is widely viewed as an illegitimate maternal experience (Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Winter, 2021; Young et al., 2021).

The studies argue that once a woman is a mother, she assumes her primary identity (Groenewald, 2016) and this notion is shaped by traditional gender discourses (Hendl and Browne, 2019; Young et al., 2021). Within this conceptualisation of motherhood, the child's needs must be met foremost, even to the point of unconditional self-sacrifice by the mother. Moreover, if these social boundaries of acceptable and unacceptable maternal behaviours are broken, the mother may be viewed as selfish and an unfit mother not deserving to a parent (Monson and Donaghue, 2015).

The literature draws attention to a perceived judgement and pity felt by mothers of sons (Young et al., 2021; Groenewald, 2016). There was a sense that their life as a mother was somehow lacking by having only sons; that as mothers they would be unfulfilled as a fundamental part of motherhood was missing if they did not give birth to a daughter (Young et al., 2021).

3.7.2 Sex and Gender

The literature demonstrates societal confusion around the use of the terms "sex" and "gender". Compounded by the interchangeable use of the terms, despite having distinct definitions, social confusion is created around a phenomenon (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019). Seven of the eight papers in this review suggest that gender essentialist beliefs, underpinned by traditional and embedded gender discourses, shape the experience of 'GD' (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Krishnan, 1987; Monson and Donaghue, 2015; Winter, 2021; Young et al., 2021).

It is asserted that those that experience 'GD' believe that a mother-daughter relationship holds a level of emotional connectivity and bonding that is not possible with a son (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Slomp et al., 2023; Young et al., 2021). It is widely suggested by the literature that these beliefs are situated in entrenched social narratives around the obtainment of meaningful maternal son/daughter relationships based on assumptions of sex and gender traits (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Krishnan, 1987; Monson and Donaghue, 2015; Young et al., 2021).

3.7.3 Conceptions of 'GD'

The term 'GD' was initially adopted by online communities to represent a commonality in their experience (Duckett, 2008; Monson and Donaghue, 2015). Within the literature reviewed, 'GD' has been described from a simple 'disappointment' to an intense maternal anguish with a sense of loss and profound grief (Monson and Donaghue, 2015; Slomp et al., 2023; Winter, 2021). Some articles suggest that the 'disappointment' is about the birthed child who is the 'wrong gender' (Hendl and Browne, 2019; Krishnan, 1987; Winter, 2021). However, empirical studies with a discrete focus on the experience of 'GD' suggest that the anguish is not due to the birthed child being 'wrong', but rather the grief for a long-imagined child and future self (Duckett, 2008; Groenewald, 2016; Young et al., 2021). This misalignment in understanding

may have contributed to the sometimes intensely negative social perception of parents who associate with the experience of 'GD' (Duckett, 2008; Groenewald, 2016).

The disparity within the literature around current conceptions of 'GD' appears to be linked to the literature's research focus. Those resources that are scientific contributions or have a research focus on, for example, the ethics of sex selection for social reasons, seem to flatten and reduce the 'GD' experience to "disappointment" and "obsessive" "misplaced desire" (Winter, 2021; Hendl and Browne, 2019). However, empirical studies that have a discrete focus on the experience of 'GD' explore the depth and complexities of the experience; accordingly, the phenomenon is conceptualised as an intensely distressing, guilt-ridden, shameful experience (Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021). Moreover, the empirical studies in this review suggest that parents are not disappointed with their birthed children; to the contrary, they persist in highlighting their love for their birthed children (Duckett, 2008; Krishnan, 1987; Monson and Donaghue, 2015; Young et al., 2021). The "disappointment" is the absence of the mother's long-imagined child, not the birthed child(ren) being "wrong" (Duckett, 2008; Groenewald, 2016; Krishnan, 1987; Young et al., 2021). The lack of clarity about what is causing the parent's "disappointment" may be contributing to a misplaced social judgement towards 'sufferers' (Duckett, 2008).

3.7.4 The Emotions of 'GD'

The literature reviewed highlighted a contrast in the way that the emotions of 'GD' are presented. Hendl and Browne (2019) describe 'GD' as an "unfortunate event" that comprises of "obsessive yearning (when) they (parents) do not have the child of the sex they want" (p292). However, research that aimed at exploring the experience of 'GD' from the perspective of the 'sufferers' suggests that the phenomenon is "uncontrollable" and "unwanted"; moreover, it is knowingly against the accepted narrative of a 'good mother' and so further resisted (Monson and Donaghue, 2015; Duckett, 2008; Young et al., 2021; Groenewald, 2016), while guilt and shame are framed as central pillars in the experience of 'GD' (Duckett, 2008; Groenewald, 2016; Monson and Donaghue, 2015; Young et al., 2021). Although Hendl and Browne (2019) conceptualise parental emotions of 'GD' as unsatisfied "petulant" parental "wants" (p292), they do acknowledge that 'sufferers' experience a sense of "grieving", with a "strength and depth". Grief for the imagined child was a recurring theme in the emotions of 'GD' across the

papers (Duckett, 2008; Groenewald, 2016; Hendl and Browne, 2019; Monson and Donaghue, 2015; Young et al., 2021).

3.7.5 Support Seeking

Duckett (2008) found that despite 'sufferers' "strongly desire(ing) to find a way to no longer feel gender disappointment" (p90) and seek ways to reduce and manage the experience, they feel unable to seek support (Hendl and Browne, 2019). Moreover, question if or where support is available (Young et al., 2021). Some 'GD' "sufferers" drew parallels between the mental health struggles associated with PND and those experienced due to 'GD' , this seems to indicate a genuine struggle that the 'sufferers' want to understand (Groenewald, 2016; Hendl and Browne, 2019). The absence of a label may be a barrier to accessing support, as 'sufferers' seem unsure for what they would be asking for help with (Young et al., 2021). Thus, some 'sufferers' suggest that a label would support their help-seeking, as it would create a socially understood experience, which in turn would reduce the stigma currently associated with the phenomenon (Duckett, 2008). However, Hendl and Browne, (2019) assert that 'sufferers' desire a label for the phenomenon so that they can justify their "negative emotions to support their contention that 'gender disappointment' is a real phenomenon" (p283).

3.8 Conclusion

This literature review has sought to identify possible social mechanisms to support an understanding of the emerging phenomenon known as 'GD'. Through the exploration of empirical data on 'GD' and theoretical literature, notions of motherhood, sex and gender, conceptions of 'GD', emotions of 'GD', and support seeking have been identified. However, there was a disparity in the way the 'GD' experience is conceptualised between empirical studies with a discrete focus on the experience of 'GD' and scientific contribution articles. This disparity reflects differences in the perceived level of distress and the legitimacy of the 'GD' experience and reasons for help-seeking.

Therefore, a piece of research that aims to develop a more informed conceptual understanding of maternal 'GD' is required. An informed conceptual understanding of the maternal 'GD'

phenomenon is necessary to support knowledge and understanding amongst society, healthcare professionals, and "sufferers".

3.9 Recent Developments in 'GD' Literature

Since completing the critical systematically informed literature review, three relevant studies that further our understanding of 'GD' have been published. This section critically analyses these contributions and discusses their implications for the findings of my study.

Jayarajah (2024) aimed to deepen understanding of 'GD' by exploring whether it should be conceptualised as a mental health issue, a sociocultural concern, or both. Jayarajah's (2024) study draws on both clinical psychiatry and social science perspectives to develop a novel perspective on 'GD' and its position in relation to mental health and sociocultural issues. It identifies 'GD' as a growing phenomenon in Western contexts, where it is often linked to a desire for gender balance within families and is furthered by social media ideals of perfect motherhood. Jayarajah (2024) juxtaposes this with findings which identify a preference for boys in South and East Asian cultures, influenced by traditional gendered roles, religious beliefs and economic considerations. Upholding assertions by Hendl and Browne (2019), Jayarajah (2024) argues that although 'GD' is not classified as a mental illness, it may intersect with other perinatal mental health concerns such as depression and anxiety. Jayarajah (2024) also explores possible social implications of technologies such as prenatal testing and IVF, thereby drawing attention to the ethical tensions around sex selection due to societal gender expectations. The paper asserts that 'GD' requires professional attention within the maternal mental health area and a wider understanding of "gender issues in mental health" (p 378) experiences.

Jayarajah's (2024) paper offers an interesting clinical and cross-cultural perspective on 'GD', particularly through its examination of how this phenomenon may be experienced in different cultural contexts. A strength of this paper is its novel integration of a psychiatric position with a sociocultural approach, enabling development of a new perspective on 'GD'. However, it makes assertions based on narrative syntheses drawn from other papers and uses professional observation rather than empirical research. Significantly, many of the paper's assertions go unreferenced; the bold claim in the opening paragraphs that in Western cultures, 'GD' is

“mostly related to the desire for ‘gender balance’ in the family” (p355) is not referenced. It may be based on Groenewald's (2016) finding that mothers “felt that genetics weren’t as important as the mother-daughter bond and the balanced family dynamic” (p77). However, Groenewald (2016) proceeds to argue that this assertion by her participants was made as a means to “alleviate their guilt about the ‘selfish’ desire” for a daughter (p93). Moreover, Groenewald (2016) asserts that her findings suggest that a maternal desire for a balanced family may be shaped by deeply embedded social messages about what constitutes being a ‘good’ or ‘ideal’ mother and may not align with the mother’s personal infant sex preferences. Strengthening this possibility are empirical studies into ‘GD’ which have consistently suggested that preference for a girl may be due to a longed-for mother-daughter relational bond and not the socially assumed desire for a “balanced” family (Groenewald, 2016; McMillan, 2012; Saccio, 2025; Young et al., 2021).

However, Jayarajah’s (2024) paper upholds an overarching assertion of my study that maternal ‘GD’ is psychosocially complex; it is not just an internal experience but is also socially shaped. This paper complements existing literature by connecting psychiatric clinical insights with the literature of ‘GD’. Its inclusion in this updated review of the current literature of ‘GD’ reinforces my framing of the maternal ‘GD’ phenomenon as a valid and complex psychosocial experience.

In early 2025, a thesis was published that aimed to explore American mothers’ subjective experiences of ‘GD’ (Saccio, 2025). Following a qualitative study design, in-depth virtual interviews were conducted with 12 participants. Six themes were identified by Saccio (2025): 1) illusions of control, 2) longing for female bonds, 3) emotional distress, 4) social comparisons, 5) silencing and 6) grief toward acceptance. The findings show that maternal ‘GD’ is an emotionally complex maternal mental health experience with severe effects. Saccio (2025) argues that ‘GD’ is a valid, complex and under-researched maternal mental health concern that deserves greater recognition, empathetic response, and targeted support, especially in American contexts. Saccio asserts that acknowledging the emotional impact of maternal ‘GD’ and dismantling the stigma surrounding it will create a more supportive, understanding social context for mothers navigating the experience of maternal ‘GD’.

A strength of Saccio's (2025) thesis is its focus on an American population, representing a cohort of “sufferers” who had not yet been included in research. By using a qualitative

methodology and conducting in-depth interviews, the study offers rich, nuanced insights into the lived experiences of mothers, which capture the emotional complexity of the maternal 'GD' experience. The study argues that those who experience maternal 'GD' would benefit from a more empathetic social context.

The use of online interviews**,** while convenient and accessible, may have limited the development of genuine rapport or non-verbal communication, which could possibly have affected the richness of the data collected. Although the study is described as qualitative, the researcher states that she "off-set biases and remained neutral, the primary researcher adhered strictly to the predetermined interview questions and prompts" (p37). Notions of bias and neutrality are not aligned with qualitative research (Silverman, 2021); furthermore, strict adherence to the interview schedule could have constrained the flexibility and responsiveness typically valued in qualitative inquiry. Thus, the approach raises questions about how open-ended or participant-led the interviews were**,** potentially limiting the identification of unanticipated and nuanced insights. Saccio (2025) references researcher bias but does not provide any reflection on the researcher's positionality or reflexive practices.

Saccio's (2025) study offers an important contribution to the literature of maternal 'GD' by highlighting the emotional complexity of 'GD' in an American context. However, its limited degree of reflexivity means that its analysis lacks methodological depth. By contrast, my study offers a more critical and contextualised understanding of maternal 'GD'.

Stahnke and Cooley (2025) conducted a systematic review of the current literature on 'GD'. By providing a synthesis of "current knowledge" (p1), the primary aim of their review was to develop knowledge of and responses to the experience of 'GD', and its secondary aim was to better support families affected by 'GD'. Published peer-reviewed articles from 1974 to the present day were examined, and seven articles were identified for inclusion. The review included studies employing both qualitative and quantitative methodologies, with two employing longitudinal designs.

The review positions 'GD' as a legitimate, distressing experience for some parents, with symptoms resembling mental health disorders (e.g. depression, shame, isolation). It asserts that 'GD' is under-researched and poorly understood in academic literature, especially in comparison to the vast and active online communities that discuss the phenomenon. The review

suggests the need for more diverse, inclusive, and methodologically rigorous research. It asserts that there is limited empirical work on treatment or support strategies for those experiencing ‘GD’, and it identifies five questions that should be addressed in future research. My study addresses three of their recommendations (at least in part) by asking how the mothers’ feelings about ‘GD’ had changed over time; whether they would change their child’s gender now if they could and whether ‘GD’ had impacted their ability to live a satisfying life.

Stahnke and Cooley's (2025) systematic review is the first to synthesise existing research on ‘GD’, offering a structured critique of current literature, mapping a clear agenda for future investigation, and helping to legitimise ‘GD’ as a psychosocial experience worthy of scholarly attention. It supports my argument that maternal ‘GD’ is a multifaceted, little-understood experience that requires psychological and sociocultural attention to further develop our understanding of the phenomenon.

However, one limitation is that several of the studies included did not have ‘GD’ as their primary focus. This could lead to inconsistencies in data depth and quality across the review. Moreover, although the authors report adopting a comprehensive search strategy using academic databases and Google Scholar, it is notable that a qualitative, in-person UK-based study (Young et al., 2021), published after Groenewald’s (2016) thesis and appearing as the fourth result in a Google Scholar search for ‘gender disappointment’ was not included in the review. The reasons for this omission are unclear, which raises questions about the completeness of the study selection process for inclusion in the study. Therefore, although the review offers a valuable starting point in legitimising ‘GD’ as an important area of study, and it highlights key themes and addresses current gaps in the literature, it could be argued that it has limited scope due to its omission of relevant studies and that its reliance on data in which ‘GD’ was not the main focus could lead to possible misinterpretations.

Together, Jayarajah's (2024) paper, Saccio's (2025) thesis, and Stahnke and Cooley's (2025) review further our understanding of ‘GD’. They position it as a complex, culturally embedded, and intensely emotional experience. In combination, these studies call for more compassionate, context-sensitive research that focuses on lived experiences to develop and deepen our understanding of the maternal ‘GD’ phenomenon.

3.10 Summary of the Research Gap

This literature review has demonstrated that although 'GD' has been increasingly acknowledged in both empirical and theoretical literature, there remains a significant gap in how this maternal experience is conceptualised and understood. Existing empirical research is limited, and much of it relies on data from online forums, where the identities of contributors, their motivations for sharing, and the context of their experiences often remain unknown. Meanwhile, literature and opinion-based contributions frequently simplify the maternal experience of 'GD' into reductive categories such as "disappointment" and "wanting" (Hendl and Browne, 2019) rather than recognising it as a complex, enduring, and grief-like experience. This disconnect has resulted in a fragmented understanding of 'GD', with inconsistency in how its severity, legitimacy, and implications for help-seeking are portrayed. Consequently, our current conceptual understanding of maternal 'GD' is inadequate, leaving many mothers unsupported in their distress.

3.10 Research Focus

In response to this gap, the present study seeks to develop a more informed conceptual understanding of maternal 'GD' by centering the voices of mothers with lived experience of this emerging phenomenon. The following chapter outlines the methodological decisions taken to address this gap, including the use of walking interviews and an adapted LG approach to enable a deep exploration of the impact of the phenomenon on mothers' emotional, well-being and help-seeking experiences.

Chapter 4: Methodology

4.1 Introduction

This chapter presents the epistemological, ontological and methodological position upon which this study is founded. I begin with the study's aims and objectives before presenting my reflexive position. Next, I explain the decision to use a qualitative approach informed by a critical realist ontology, combined with a constructivist epistemology seen through a feminist lens. I then articulate the "strategic undressing" (Thurairajah, 2019) of my positionality before summarising my methodological approach.

4.2 Aims and Objectives

4.2.1 Aims

The aims of this study are to explore the phenomenon of maternal 'GD' and to develop a more informed conceptual understanding of its meaning.

4.2.2 Objectives

From the perspective of mothers:

- To explore the emotional impact of maternal 'GD', focusing on the range, depth, and expression of the emotions experienced.
- To examine the impact of maternal 'GD' on the mothers' sense of mental and relational well-being.
- To investigate the processes of help-seeking by examining how the mothers talk about seeking support, understand their experience, and feel validated in their maternal 'GD' experiences.

4.3 Reflexive Position

Reflexivity is an integral aspect of this research project and is woven into each element of the research process. Jaggar (2004) asserts the importance of the researchers' exploration of and reflection on their own preconceptions, thoughts and feelings, which will enable them to define their position with greater clarity and honesty whilst identifying the possible multidimensional influences on the research. There are debates about how reflexivity is embedded in a study. For instance, Nencel (2014) suggests that the philosophical lens applied to a study will guide the researcher in their contextual reflexivity and influence the extent to which they write themselves into the text. In this study, combining the framework of a critical realist ontology with a constructivist epistemology provides the framework that underpins the chosen methods for data collection and analysis. These choices are further shaped and enhanced by a feminist lens that emphasises the importance of highlighting reflexivity, voice, and power relations throughout the entirety of the research process. Reflexivity is embedded throughout the thesis, indicating its value and importance to the entirety of my research process. Rather than being confined to a single section or moment in the study, reflexivity was ongoing throughout the whole process; thus, reflexive pauses are woven into the thesis.

4.4 Research Methodology

4.4.1 A Qualitative Approach

Research is carried out in the pursuit of new knowledge. Philosophical orientation is fundamental to a study because it "support(s) the legitimacy of research" (Moon and Blackman, 2014, p1167). Crotty (1998) defines ontology as being concerned with understanding the structure of reality and epistemology as the world view an individual takes in the process of making sense of our world.

Historically, research within the social sciences has been situated within the positivist paradigm (Bello et al., 2014), which seeks to unify patterns within experience and reduce these to a neat, singular account (Creswell, 2009). However, the effectiveness of the positivist paradigm as a means to research human experience has been said to be problematic as it is distorted by hierarchical and patriarchal power structures (Cohen et al., 2022). In response, there has been a shift in the philosophical lenses now being applied to social science research. It is widely accepted that reality can be understood and knowledge can be gained through many philosophical orientations (Thompson et al., 2018). Traditional natural science has approached research from an objective, rational and distanced stance, which Haraway (1988) describes as

the “God trick”. This refers to a mistaken belief that researchers approach their subjects with no preconceived thoughts or ulterior motives, but rather see themselves as omnipotent, omniscient and objective. However, the failure to acknowledge that as humans we hold personal perspectives (some that may even be hidden to ourselves until we begin operationalising a study) that will inevitably shape our research and could bring the reliability of the study into question (Matthews and Ross, 2010). This failure may also have ethical implications (Harding, 1991). Harding (2004) argues that a view always comes from somewhere, and that knowledge is situated. Research is approached with experiences and preconceptions from a position of gender, race and ethnicity (Rose, 2004) which further shapes the situated knowledge. Additionally, feminist critiques of traditional science suggest that it fails on its own terms, in that it claims to be neutral and objective, yet it embodies the integral societal values held by the dominant group in society: men (Harding, 2004b; Hesse-Biber and Leavy, 2007).

This study aimed to gain a deeper conceptual understanding of the experience of maternal ‘GD’ by exploring the perspective of mothers with multiple children of a single sex. It did not aim to uncover the ‘reality’ or ‘truth’ of this experience (Howell, 2013), but rather to explore its complexity and the contextual facets of the maternal ‘GD’ experience from the perspective of mothers who have not yet, or never did, give birth to their longed-for child of a certain sex. The experience of ‘GD’ is shaped by individual perceptions, societal narratives, and nuanced emotions (Duckett, 2008; Groenewald, 2016; McMillan, 2012) that cannot be meaningfully captured through statistical measures alone. Thus, a qualitative approach allows for the complex, nuanced, and deeply emotional experience of maternal ‘GD’ to be explored in a way that a positivist stance would risk flattening (Creswell, 2009).

4.4.2 Ontology: Critical Realism

This study adopts a critical realist ontological position. The critical realist paradigm asserts that a reality exists independently of our knowledge of it, yet it recognises that an individual’s construction and understanding of this reality are mediated by psychological and societal experiences (Bhaskar et al., 1998; Collier, 1994). Critical realism is particularly useful for exploring the lived experiences of complex psychosocial phenomena such as maternal ‘GD’, as it allows for a layered view, one that uncovers the seen elements of an experience and also aims to explore the unseen (Starbuck, 2006). A critical realist approach encourages the

exploration of the empirical, the actual and the 'real', allowing a movement beyond easily accessible observations, seeking to understand the causal mechanisms and layered explanations of experience (Hastings, 2021; McEvoy and Richards, 2003) including both psychological and sociological elements of experience (Danermark et al., 2005; Drost, 2011; Fiske, 2014). Accordingly, a critical realist approach asserts a philosophy of the world where reality is stratified and differentiated, undergoing continual change (Eastwood et al., 2021).This means that critical realism accounts for both the structural conditions and subjective interpretations, unlike an objective, deductive methodological approach (McEvoy and Richards, 2003; Popper, 2002; Sayer, 2000).

Critical realism supports a methodological approach to research that is sensitive to the impact of both lived and emotional experiences as well as the socio-material realities that individuals navigate. Sims-Schouten et al. (2007) outlined a "systematic critical realist discourse analysis" (p101) and used it to analyse women's talk of motherhood, childcare, and female employment gathered through in-depth semi-structured interviews. They argue that a critical realist approach enables the inclusion of how people's material conditions are relationally intertwined with the stories, language, power, and cultural meanings that individuals use to understand and articulate their experiences. Thus, using a critical realist approach, we 'see' the combination of internalised social norms, embodied realities, structural expectations, and power discourses that shapes a mother's experience. Thus, from the perspective of a critical realist ontology, while the maternal 'GD' experience is shaped by complex and nuanced emotions, it is also influenced by causal mechanisms arising from normative social structures and cultural ideals of motherhood that may not be immediately apparent in the women's narratives (Starbuck, 2006). A critical realist paradigm therefore allows for the exploration of how social structures and embedded assumed narratives influence individual nuanced experiences without reducing the experiences to such structures or narratives and without denying their significant emotional impact on the women's daily lives.

4.4.3 Epistemology: Constructivism

A constructivist epistemology asserts that people construct their realities within a social context and interpret their realities to make sense of their experiences and being (Berger and Luckmann, 1967; Guba and Lincoln, 1994). From this perspective, knowledge is not fixed, nor is it universal; rather, reality is socially constructed through individual, cultural, historical, and

economic contexts (Mertens, 2005). Thus, "reality is not external to human existence but is determined and defined through social interactions" (Howell, 2013 p89). This epistemological stance is particularly appropriate for my study as 'GD' has been positioned as a nuanced, yet socially influenced experience (Duckett, 2008; Groenewald, 2016; McMillan, 2012; Young et al., 2021).

Within a constructivist epistemological stance, the researcher's own identity, experiences, emotions and assumptions are recognised as integral and related to knowledge production (Mackenzie and Knipe, 2006). That is, knowledge and meaning are forged by the research participant alongside the researcher, undergoing continual refinement due to their personal, professional, historical, and social context. This means that knowledge is co-created through the social interaction between researcher and participant (Creswell, 2009; Howell, 2013). Accordingly, the continual interaction between researcher and participant can produce unforeseen epistemological outcomes (Howell, 2013). This stance is especially relevant to my insider position in this study as someone with relevant lived experience, because constructivism legitimises the use of reflexive journalling, empathetic responses and seeking ways to co-create reflexive knowledge with participants (Berger and Luckmann, 1967).

Critics of constructivism argue that despite its strengths, if all knowledge is socially constructed, it becomes difficult to analyse the power structures and the unspoken, yet embedded, social narratives and assumptions that shape experience (Barbehön, 2020; Philips, 1998). However, my study strives to mitigate this limitation by combining a constructivist epistemology within a critical realist ontology (Bhaskar, 1975) viewed through a feminist lens (Alcoff and Potter, 1993). My approach is grounded in the argument that while knowledge is constructed, it is constructed within and by lived experiences that are situated in nuanced social and cultural structures.

4.4.4 A Feminist Lens

A feminist lens informs my study's methodology and permeates its methods, and it is therefore woven into the entirety of this study. Although the term "feminism" implies a singular approach (Campbell and Wasco, 2000), "feminism" is an umbrella term for many different feminisms (Jaggar, 2004). Feminism therefore represents an intersectional, multi-perspectival, and

socially constructed philosophical stance (Leavy and Harris, 2018). As this study evolved, I drew on multiple forms of feminism, including feminist standpoint theory, matricentric feminism, and reflexive feminism (Cain, 1990; Harding, 2004a; O'Reilly, 2019). Feminism takes the view that biological women are embodied in a way that biological men are not, as seen in menstruation, child-birth, lactation, and the menopause (Rose, 2004). Being female does not make you a feminist, nor does being male make you anti-feminist (Hooks, 2015). Consequently, "on an epistemological level, feminist social science legitimates women's lived experiences as sources of knowledge" (Campbell and Wasco, 2000, p775). The concept of a guiding feminist lens resonates with my study as research has shown that mothers do not feel that 'GD' is regarded as a legitimate experience worthy of attention (Duckett, 2008). Afeminist lens validates the experience of biological women and acknowledges its worth in shaping our understanding, with the aim of informing social practices for the better.

Seeking to increase knowledge from a feminist perspective aligns with the ontological and epistemological stance of my study. The distinctiveness of the knower is of significance as their conception of the world and attitude towards what is being studied has a direct impact on the epistemological stability of a study (Grant, 1993). A feminist position facilitates the deconstruction of possible power relations between researcher and participant (Haraway, 1988), leading to the empowerment of the participant (Ellis and Bochner, 2000). Haraway (1988) suggests that this approach allows for rich data collection and a deeper understanding of the research topic. Applying a feminist lens to this study of maternal 'GD' involves seeking to respect, understand and accept women's accounts of maternal 'GD' as legitimate sources of knowledge (Campbell and Wasco, 2000).

Adopting a feminist lens means taking the view that the essentialist thinking that has traditionally shaped research is damaging, not only to women but to all of society (Comack, 1999; Weisman, 2017). However, it has been suggested that feminism itself is based upon essentialist assumptions (West and Turner, 2017) and views women as a whole, attributing to them a singular female perspective, making a dualistic separation between "them" and "us" and asserting a singular philosophical truth (Leavy and Harris, 2018). Moreover, this singular truth is said to be disproportionately representative of middle class, white, Western women (Campbell and Wasco, 2000; Walker, 2001). Smart (1995) suggests that feminism does attempt to praise difference, but that paradoxically it is this valorisation that upholds essentialist views. Grant (1993) expands on this argument, suggesting that it is the very move to acknowledge the

differences within the "category of women" that continues to uphold the view that women remain a distinctive group However, criticisms of essentialist thinking within feminism have dissolved somewhat as feminist stances have increasingly abandoned the notion of a unified and singular female perspective in favour of a multiple, diverse and intersectional approach, standing against all gender inequalities (Comack, 1999; Hooks, 2015; Leavy and Harris, 2018; Noddings, 2013).

Adopting a feminist orientation means that the researcher needs to be actively and wholeheartedly engaged in the study at hand, caring about the research, the participants and the objectives of the study (Rose, 2004), and it is imperative for them to remain constantly reflexive. It is not just the notion of reflexivity and immersion that I am drawn to as a researcher, but also the suggestion by Rose that the researcher's heart should be involved in the study. With a passionate researcher comes dedication and a desire to undertake rigorous and well-informed research, which I am committed to. My life experiences drew me to this topic, and they undoubtedly shaped the project. My acknowledgement of this and my continual engagement in the reflexive process bring a greater level of clarity, credibility and rigour to this research.

A feminist position is reflexive and traditionally women-centred, with a focus on exploring women's lived experiences from their unique standpoint, and in doing so it represents members of society who have suffered due to sex and gender inequalities (Brooks, 2007). A feminist lens also allows for an exploration of "different, sometimes conflicting, legitimate political and theoretical needs of women today" (Harding, 1991, p 88), which leads to a valued and legitimate knowledge production (Campbell and Wasco, 2000). Additionally, feminism spans multiple fields, and it is highly philosophical and inherently political (Campbell and Wasco, 2000), while allowing for rich and diverse research processes and outcomes (Doonan, 2022; Weisman, 2017). These principles not only align with the aims of this study, but also uphold the creative, novel, person-centric methods that have been chosen.

4.4.5 The "Strategic Undressing" of My Positionality

In this study, I occupy a partial insider position, as I have lived experience of maternal 'GD'. No empirical research into 'GD' has been conducted by a partial or full insider until my study. This shared identity with my participants offers both opportunities and challenges,

necessitating a critical examination of how my insider status may have shaped the research process. Holding an insider status can enhance the rapport with participants and lead to greater levels of trust, enabling the collection of richer data (Mauthner and Doucet, 2003) and a deeper and more nuanced understanding of the subtleties in participants' experiences (Perry et al., 2004). However, occupying even a partial insider position can present ethical and methodological challenges. Maintaining professional boundaries while sharing personal experiences can be challenging and thus requires careful reflexivity to ensure that the research remains participant-cantered and addresses power, hierarchy and social dynamics (Day, 2012). Furthermore, the researcher may make assumptions about the experience that can cause them to overlook questions and not probe into aspects of the experience thoroughly (Mercer, 2007). Thus, Shai (2020) cautions insider researchers to remain reflexive at all stages of the research process, as assumptions may be made which hinder the depth and authenticity of the research.

Hayfield and Huxley (2015) reflect on their experiences of an insider-outsider position at each stage of their PhD research projects, suggesting that an insider-outsider researcher dichotomy does not always have clear boundaries and may require ethical considerations. For example, the ethical implications if the participant were to view the researcher as a friend and share more than they might otherwise be comfortable with this would have ethical implications. There are also ethical considerations about how much the researcher shares of their own experience and their motives for such research. An insider-outsider position involves having similar experiences to the participant (insider) yet also remaining separate from the population of the study(outsider). Furthermore, researchers may experience being on a continuum between an insider and outsider position, at times holding a dual role (Couture et al., 2012; Thurairajah, 2019). Shai (2020) reflects on her insider-outsider position in her gender-based violence and HIV prevention research. She had links with the South African community within which she was carrying out her ethnographic research, which gave her insider status, but she also played an outsider role because she was doing research with those who had experienced gender-based violence and HIV which she had not. Shai (2020) posits that it was her insider status that enabled her to access deeper layers of meaning in participants' experiences despite holding elements of an outsider positionality.

Thurairajah (2019) introduces the concept of "strategic undressing", where researchers strategically reveal aspects of their identity in a shift from being an outsider to becoming an insider. This undressing is undertaken to build trust while also seeking to maintain analytical

distance. Thurairajah describes this process as conscious decision-making that may change throughout the course of the research, and different levels of "uncloaking" (Thurairajah, 2019) may happen with different participants. Thurairajah's (2019) uncloaking analogy resonated with me, and it is a method I adopted throughout my participant interactions.

Indeed, being an insider researcher offers valuable opportunities for connection and depth in qualitative research (Etherington, 2004). However, it also demands a high level of reflexivity and methodological rigour (Couture et al., 2012), and even this approach cannot prevent possible missed nuances in the data (Mercer, 2007). However, by critically examining my positionality and its impact on the research process through the use of a reflexive journal (Olmos-Vega et al., 2023) and by making audio recordings on the way to and from each interview about how I was feeling at that time and in relation to that specific interview (Day, 2012), I aimed to conduct a study that would be both empathetic and analytically robust, that would contribute meaningful insights into the phenomenon of maternal 'GD' and that would lead to a more informed conceptual understanding of the experience.

4.4.6 Rigour

Due to my lived experience, I was aware that I could possibly make assumptions and overlook important questions or probes. However, I was not simply an insider who had experienced maternal 'GD' and was now conducting research; I had spent almost a year working with a clinical psychologist to understand my experience. I felt this made me knowledgeable about my own experience, but I also knew that my experience was unique, and so I tried to remain alert to all accounts of 'GD' and particularly different facets of the experience, particularly those that were different from my own.

To enhance the rigour and trustworthiness of the study, several strategies were employed. I held regular, at least once monthly, meetings with my supervisors to discuss decisions relating to sampling, data collection, and interpretation, which provided opportunities for critical reflection and challenge. I also sought informal feedback from colleagues and experts familiar with maternal wellbeing, and maternal 'GD' specifically. I met with qualitative researchers who had recently employed the LG to better understand how I might best operationalise this method for my study. This supported the refinement of my analytic approach and ensured alertness to alternative viewpoints and interpretations. The use of a reflexive research diary

enabled me to record and reflect on my thoughts, possible assumptions and emotional responses during all stages of the study. In addition, I revisited the data multiple times, engaging in iterative readings while using multiple methods of data analysis (the LG and reflexive thematic analysis) to check for consistency and coherence within and across the mothers' accounts. Together, these strategies supported transparency, reflexivity, methodological integrity and rigour.

4.4.7 Reflexive Pause: Methodology

My lived experience suggested to me that it was likely that my holding an insider status would enable the mothers to feel comfortable and safe in sharing their deeply personal and distressing experiences. All the women expressed gratitude for the opportunity to share their journeys in a validating and empathetic space and for giving a voice to the women who experience the maternal 'GD' phenomenon. All the mothers asked about my own experience of 'GD' because they said that they had not spoken with anyone who really understood; owing to their personal experience of maternal 'GD'. I was humbled that the mothers shared their stories in the ways in which they did. Although I had been a complete insider, the birth of my daughter seven years before conducting this research meant that now I was a partial outsider, and I was aware that this may create a layer of complexity to my positionality, which will be explored further in Chapter 5.

However, there is one aspect that I knew could be problematic. I consider myself to be a kind, loving person and a 'good' mother, and the experience of maternal 'GD' brings both of these traits into question on an individual, introspective, and social level. I did not want my analysis and findings to position the mothers in my study as not being 'good' mothers and open them up to any more social judgement that they are already navigating. I was also acutely aware of my evolving notions of what it means to be a 'good mother' moreover, how I felt society values mothers, or otherwise. I addressed these through my reflexive practices.

4.5 Summary of the Methodological Approach

Regarding the relationship between research methodology (philosophical orientation) and methods (recruitment, sampling, data collection, interpretation and analysis), research methodology guides the research project. It connects the underlying philosophical principles

with the research methods chosen for the study and propel the research aims into action (Creswell, 2009; Crotty, 1998). Below is a table outlining the philosophical position of my study and the contribution each element makes.

Table: 3 Philosophical Contributions to this Study

Element	What it contributes to this study
Critical realist ontology	Grounds the idea that something is *really* happening to participants.
Constructivist epistemology	Recognises that *how* something is known and narrated is shaped by context.
A feminist lens	Challenges traditional power dynamics, centres reflexivity in all stages of the research process and centres the voices of women.

In this chapter I have outlined the philosophical orientation of the study. I have demonstrated how critical realism, constructivism and feminism worked together symbiotically to provide a robust and reflexive foundation from which to explore the nuanced and complex psychosocial experience of maternal 'GD'. The next chapter will illustrate the methods employed to achieve the study's aim of developing a more informed conceptual understanding of the maternal 'GD' experience.

Chapter 5: Methods

5.1 Introduction

Gaps within the current body of research have been identified in chapters 2 and 3. Chapter 4 demonstrated reflexive feminism as the overarching qualitative orientation with a critical realist ontology and constructivist epistemology. Chapter 5 will now detail the research design and demonstrate how it aligns with the study's methodology.

5.2 Participants

5.2.1 Participant Eligibility

Potential participants were deemed eligible to take part if they:

- were biological mothers;
- were over 18 years old;
- lived in the UK;
- had two or more biological children of the same sex;
- had longed for, or still longed for, a child of the opposite sex to those birthed.

Mothers were excluded from the study if they:

- had experienced a miscarriage, stillbirth or live death where the child was of the longed-for sex;
- had a diagnosed mental health condition;
- were pregnant with a child of the longed-for sex.

The above exclusion criteria were set mainly to protect mothers and also to uphold the aims of my study. Exclusion due to miscarriage or death was put in place to protect the mother from unnecessary psychological harm and to avoid confusing grief and loss for an actual child and an imagined child. The second exclusion criterion was put in place to protect the participant, as the researcher has no discrete training in supporting mothers with a mental health condition.

The last exclusion criterion was set because if a mother was pregnant with her desired sex, this may have impacted her maternal 'GD' experience in a way that is not a focus of my study.

5.2.2 Sample Size

Sample size within qualitative research varies between fields (Teff-Seker et al., 2022). Questions of sample size standardisation within qualitative research have been raised, especially when a study uses an iterative, emergent methodology (Sim et al., 2018). However, pre-determined sample sizes are often required for purposes of ethics and the manageability of a project (Bryman, 2008). Factors influencing sample size can include the methodology, epistemology and philosophy of the study, as well as logistical considerations such as time and resources (Bekele and Ago, 2022).

The inductive methodology adopted by this study meant that the final sample size was determined during the iterations of the study and was not pre-set (Bekele and Ago, 2022; Bryman, 2008; Sim et al., 2018). However, this study required a sample that was small enough to allow for the rich and deep iterative analysis of each participant's narrative while still offering sufficient breadth to address the research aims. A sample of six participants provided a depth and richness of data appropriate for the semi-structured, walking interview method and for the LG and thematic analysis undertaken (Silverman, 2021). This number of participants enabled close engagement with each participant's story and allowed for the development of rich, nuanced, and contextualised interpretations of the maternal 'GD' experience, thus upholding the study's aim.

I initially had 11 responses from women who were interested in taking part in the study, all from the online adverts, before I made the decision not to recruit any more participants. Eight of the responses came within the first week of the advert being posted, and the remaining three came in the following week. Five interviews that did not take place were due to either location (for example, one of the potential participants lived in Jersey for example) or because communication stopped. It was analytically significant that all the mothers who made contact with me about possible participation in the study were mothers to only sons.

5.2.3 Recruitment

The recruitment strategy and participant interactions are outlined below.

1. Adverts for the study were shared with members of a range of local female-focused groups, such as the Women's Institute and mum and baby groups, to encourage mothers of all ages to participate. The study advert (Appendix 2) was also posted online by "The GD Psychologist" Lindsay McMillan and by a local postnatal fitness expert, Jo Helcké who runs the company "Zest for Life". All recruited participants came via the online adverts. My neighbour, who is a grandmother, mentioned my study to her friends; one of her friends, who is a mother to four grown-up sons, said I could contact her. However, she was not eligible as she "didn't long for a daughter. As long as each baby was healthy, I was happy. Even after the fourth boy!!".

2. After being directed to the study webpage, potential participants contacted me, the researcher, via email. Although a temporary mobile phone number for the purpose of the study was set up, none of the mothers made initial contact via phone.

3. Following the initial email three was a short series of email exchanged (or a phone call for Alba). Potential participants were then sent the study advert, PIS, and consent form (Appendix 2, 3 and 4) and offered the opportunity to ask any further questions.

4. After I had received the signed consent form, a series of emails or WhatsApp messages ensued (the method of communication was led by the participants) to arrange the date, time and place of the walking interview or to agree on an indoor backup location and an alternative date.

5. I met each mother for the interview. Although consent had been gained via an electronic consent form, verbal informed consent was also obtained. Our conversation was audio recorded via two Bluetooth collar microphones. Prior to commencing data collection, I piloted the method with a colleague.

6. At the end of the interview, participants were debriefed: they were reminded of their right to withdraw and where to seek additional support if required.

5.2.4 Reflexive Pause: Recruitment

Despite sharing the advert in a broad range of places to encourage a diverse age range and intersectionality of biological mothers (including lesbian mothers) to be interviewed, I was unsuccessful in this. Although my study aimed to recruit biological mothers of any gender and sexual orientation; however, upon reflection, I do not feel that I made this clear enough. The recent increase in societal conversations around sex, gender and sexual orientation (Holleb, 2019) highlights the complexities of these topics. Although my population may represent the largest and most representative group affected by maternal 'GD', my inability to recruit only cisgender heterosexual mothers illuminates another layer of complexity in researching maternal experience, owing to diverse understanding of what motherhood means to different people, amplified by changes in generational perspectives on socially normative mothering behaviours, as highlighted by the interactions with my neighbour's friend.

Nevertheless, the fact that only heterosexual mothers with young children, who were all boys, participated in the study is analytically significant. This population may have internalised dominant and embedded societal gender discourses. The inclusion of lesbian mothers, for example, may have reflected differing experiences of desired family formations or a resistance to embedded social gendered expectations (Boyer, 2018; Hesse-Biber and Leavy, 2007). In this sense, the sample's limits may reflect the intersections of where and for whom maternal 'GD' is applicable and narratable.

I had anticipated a level of snowballing within the recruitment; however, this did not materialise as I had hoped. This may be due, in part, to maternal 'GD' being taboo and perceived as a shameful maternal experience (Duckett, 2008; Groenewald, 2016; McMillan, 2012; Young et al., 2021). As such, mothers may have been unwilling to share details of the study for fear of judgement. Such mothers, as my data shows, were often socially very isolated.

5.3 Data Collection

5.3.1 Interviews

Semi-structured interviews were particularly suitable for my research, as they facilitate a guided yet fluid conversation between interviewer and participant (Fusch and Ness, 2015), enabling a high level of complexity to be accessed (Bryne, 2012). Through the untangling of participants' thoughts, reactions, descriptions, and justifications that semi-structured conversations allow, the interviewer is given the privilege of entering the participant's world

(Roulston, 2019; Rubin and Rubin, 2012; Silverman, 2021). The nuanced flexibility of semi-structured interviews, which emphasise researcher responsiveness, allows participants to explore how their experiences were constructed and how they have impacted them. Moreover, semi-structured, participant-led conversations are a core element of the LG (Flick, 2018; Gilligan et al., 2006; Woodcock, 2016). In alignment with the philosophical underpinnings of this study, conducting semi-structured interviews with potentially probing questions (see Appendix 5) (Longhurst, 2006; Owen, 2014; Silverman, 2021) enabled me, the researcher, to "explore in detail the experiences, motives and opinions of others and learn to see the world from perspectives other than their own" (Rubin and Rubin, 1995, p3).

The interview schedule (see Appendix 5) was designed to provide a flexible framework to guide the interview, rather than a fixed sequence of questions that must be adhered to. Each interview began with a broad, open-ended prompt inviting participants to reflect on their experiences of maternal 'GD'. From this initial account, I asked follow-up questions that remained in alignment with the semi-structured interview guide. The only exception to this was Nora, who chose not to share her experience until she had asked about my own, which I briefly disclosed. My follow-up questions were designed to encourage elaboration and clarification, with probes (more specific questions on particular points) used to explore emerging themes in greater depth. While the overarching topics of emotions, well-being, and help-seeking were consistently addressed in each interview, the wording and order of questions varied to allow for the natural flow of conversation and to enable participants to explore memories and thoughts as they arose. This flexible approach enabled participants to guide the direction and pace of the interview, consistent with the semi-structured and relational ethos of the study.

5.3.1.1 Walking Interviews

Despite the advantages offered by semi-structured interviews, it has been suggested that traditional static interview settings do not succeed in illuminating the numerous factors that can influence an experience (Carpiano, 2009; Kusenbach, 2003), as they remove the participant from their environment, meaning that important elements of the experience may remain uncovered (Lőrinc et al., 2022).

The walking interview is an emerging qualitative interview technique (Lynch and Mannion, 2016) that is referred to in various terms: a go-along (Carpiano, 2009), which can be on foot:

"walk-along" or on wheels: "ride-along'" (Kusenbach, 2003), a "visual tour" (Peyrefitte, 2012) and "walkarounds" (Emmel and Clark, 2009). Leaving the name aside, the walking interview is the accompaniment of the participant on an outing (D'Errico and Hunt, 2022; Odzakovic et al., 2020) which can be conducted on foot, using other means of transportation or a combination of different means (Kusenbach, 2003). The commonality is that the researcher has the immersive opportunity of walking through the participants' lived experience while conducting the interview; thus, the location is significant, and the nuances of the route chosen by the participant are also significant (King and Woodroffe, 2019).

Studies in different locations have used walking interviews to explore participants' responses to place: in Italy, following a volcanic eruption where the participants' responses to a natural disaster were explored (D'Errico and Hunt, 2022); in Leeds, UK, to explore the complexities of living in networks, neighbourhoods and communities (Emmel and Clark, 2009), and in Minnesota, USA, to better understand the relationship between home, neighbourhood and urban space (Finlay and Bowman, 2017). However, Lynch and Mannion's (2016) research moved away from a geographical focus to an educational one. Perhaps most relevant to my study is the research by Lőrinc et al. (2022), whose paper reflected on their use of walking interviews with older migrants in the UK to explore mobility, health and well-being, and the study by Odzakovic et al. (2020), which used walking interviews to learn about the lived experience and meaning of neighbourhood for people living with dementia. Both studies concluded that "walking interviews can elicit rich and complex data that would be difficult to collect through other methods" (Lőrinc et al., 2022, p 832).

However, despite the body of growing research employing walking interviews, their use remains largely confined to studies in which physical place, physical movements or geographical experiences are central to the research aims (Carpiano, 2009; D'Errico and Hunt, 2022; Emmel and Clark, 2009; Finlay and Bowman, 2017; Lynch and Mannion, 2016). To my knowledge, walking interviews have not been employed to explore emotionally experienced phenomena that are not inherently connected to the physical place of the interview location, or where the purpose of walking is not itself therapeutic or intervention focused. In this study, walking interviews were employed to access participants' experience of maternal 'GD' extending the methodological application of walking interviews beyond spatial, health or mobility-orientated research. While previous studies have often emphasised the significance of place for the aforementioned reasons, in this study the location was intended to hold significant

personal meaning in relation to the mother's experience of 'GD'. This approach demonstrates the novel potential of walking interviews to elicit nuanced, rich accounts of experiences, even when the research focus is not obviously tied to environment or movement.

The personal significance to the participant of the walking interview location "triggering appropriate memories, thoughts, and emotions about the topic of the interview" (D'Errico and Hunt, 2022., p364) allows for in-depth, rich and nuanced data, making this method a novel tool for research in the social sciences (Carpiano, 2009). As the participants move through and interact with their chosen social location (Kusenbach, 2003), the walking interview facilitates the examination of the multifaceted nature of their experience by drawing on the interactions of its physical, social and psychological dimensions within and through time (Cummins et al., 2007). The successful implementation of walking interviews in a range of disciplines enabled me to appreciate the value that this method could bring to my study. If I was able to walk with my participants at a place that held significance in relation to their maternal 'GD' experience, then there was the possibility that I too could gather a depth of data that had not yet been obtained in relation to maternal 'GD'.

Kusenbach (2003) suggests that due to the static nature of traditional interviews, talk becomes the focus; interruptions and deviations are generally unwelcome. By contrast, in a walking interview, these are the very moments that have the potential to provide depth and richness to the data through the exploration of unexpected elements of the experience that is being researched (Emmel and Clark, 2009; Lőrinc et al., 2022). The walking interview puts the power firmly in the hands of the participant (Carpiano, 2009), removing the traditional dyadic interview relationship, which can lead to a sense of power imbalance (Flick, 2018).

During my initial correspondence with the mothers, I explained the walking interview process and why I had chosen that method for data collection, and I asked them to consider a place of meaning relating to their maternal 'GD' experience where they would like to walk or visit. However, the outcome was not as I had expected. One mother did not want to walk at all and asked if I could visit her home, which I did, and she showed me photographs of her boys during our interview. Four of the mothers picked a place close to home to walk, but it held no specific meaning in relation to their maternal 'GD' experience. One mother, Anna, picked a National Trust location. Before meeting for the walking interview, she had not explained about her choice of location, and when I asked her she said:

"So yeah, it's like when you said about thinking of somewhere to walk for the interview, we went randomly for a walk the day after we found out we were pregnant with our little boy Ben, and I thought about suggesting that place, but we've never gone back there since. I don't want to go back; it was such an awful walk".

Turning to the literature to make sense of this experience, there is a dearth of studies conducted in nature that have a focus on something other than nature. However, existing research highlights the broader psychological benefits of exposure to nature, which can be extrapolated to an interview context. Studies have reported the benefits of walking in therapy. Walk-and-talk therapy has been found to positively impact well-being by supporting emotional regulation, allowing individuals to feel more emotionally safe, and enabling them to open up about their experiences (Prince-Llewellyn and McCarthy, 2025). These findings suggest that natural settings can create a calming atmosphere conducive to open and reflective conversations. Exposure to natural environments contributes to improved mental health outcomes, including reduced stress and enhanced emotional well-being (Bratman et al., 2019). Schertz and Berman (2019) found that interacting with natural environments enhances cognitive functions, which can help participants articulate their thoughts and feelings more effectively during interviews. Thus, while direct studies on the effectiveness of conducting interviews in nature are scarce, the therapeutic effects of nature suggest that such settings can help participants feel more at ease, potentially leading to richer data because they are better able to access and talk about their feelings. The calming influence of natural environments may reduce the emotional overwhelm that can be experienced when reliving a difficult lived experience (Silverman, 2021) and may help explain the emotional regulation of my participants (Bratman et al., 2019).

I found that the walking interview had a significant positive impact on the exploration of a deeply complex, nuanced and emotional experience. I believe that walking interviews supported me as a researcher to resonate with my own embodied experiences of collecting data. This could be framed as a decolonial way of collecting data (Thambinathan and Kinsella, 2021), as it is antithetical to the idea that research is conducted in specific spaces created for the purpose of research (Mafile'o et al., 2024). The walking interviews also offered philosophical alignment with a sociological lens by emphasising how the construction of knowledge and "reality" are shaped through social and interactional experiences and constructions (Carpiano, 2009). Furthermore, walking interviews support an ontological stance

grounded in the co-construction of knowledge**,** where meaning is generated collaboratively between researcher, participant, and the surrounding environment (Foley et al., 2020).

5.3.2 Reflexive Pause: Walking Interviews and Location

When I decided to use walking interviews, I had imagined that the women would choose a location that they would go to reflect on their feelings of maternal 'GD', or a place where they had received impactful news in relation to the experience; I was not sure. What I did know, is that when I reflected on my own experience of maternal 'GD', there were a few particularly significant moments that were emotionally intense for a variety of reasons, and when I recall my experience of maternal 'GD', I am transported back to that place. Therefore, I felt that by enabling the mothers to become immersed in a location that held personal significance in relation to their experience of maternal 'GD' I had initially hoped that their multidimensional, nuanced and personal experience of maternal 'GD' could be more vividly recounted, leading to rich data collection by "triggering appropriate memories, thoughts, and emotions about the topic of the interview" (D'Errico and Hunt, 2022., p 364).

Yet, the walking interviews did not take place at a location that held meaning in relation to the participants' maternal 'GD' experience and this raises an important point. It appears that the thought of going to a place that particularly resonated with their 'GD' would have been too painful for the mothers, as it represented an emotional place and time that they did not want to revisit. Perhaps they were unsure if they may become overwhelmed with emotion in a public place. The second point it draws attention to is the need for a philosophical orientation that values and validates the needs of the population being explored; Kate brought her son along to our interview, so her location was influenced by needing it to be a balance bike-friendly place. By allowing Kate to determine the time, location, and duration of the interview, I positioned her as an active agent in the research process. This approach not only honoured her commitments and responsibilities as a mother but also reflected the ethical and philosophical underpinnings of this study.

Although walking interviews have not previously been used to facilitate the emotional regulation of participants, my reflexive practices suggested that my walking interviews, which were carried out in woodlands, parks, and along coastlines, may have supported emotional regulation. After conducting the first two interviews, my reflexive endeavours highlighted that

during a previous study I carried out (Young et al., 2021), all but two of the participants had cried, some continually throughout the interviews, which were conducted remotely via online platforms. In this study, only one of my participants cried; this was the mother who was interviewed at her home, Alba. One other mother came close; this was Nora, as we stood shoulder to shoulder overlooking the valley in a deeply embodied and emotionally moving moment. She did not cry, but we both shed a silent tear and acknowledged this to each other as we turned to descend the valley.

Another unanticipated impact of conducting a walking interview was experienced during data analysis. As I was transcribing, and later when I was analysing the transcripts, recalling emotional or unexpected moments of the interview became an embodied experience. I was transported back to that moment and place on our walk: what was around me, my bodily movements, what the mother was sharing and how that made me feel. I reflected at length on this and the particular moments in each interview where this experience was more predominant. Sometimes the mother was sharing something unexpected, and I felt surprised; at other times it was something deeply emotional, and I felt such empathy, and at other times it was shared knowledge of the distress that a certain experience caused. This encouraged me to further engage in deep reflexivity, considering my own position and how these stories may be shaped by me and my experiences. The embodied element of this process is something that I had not experienced with a static interview in the same way.

5.3.3 Considerations for the Walking Interview

5.3.3.1 Practical Considerations

However, walking interviews also pose limitations that must be considered (Carpiano, 2009). The time of day that the interview is conducted could have an impact on daylight and also social movement within the chosen location at a certain time (Kinny, 2017). Interviews were scheduled no later than 1pm, and all locations were outdoors in nature, so the potential movement of people became less problematic. Each participant had an inside location or alternative date planned in case of adverse weather. However, there was good weather for each interview.

The equipment needed for an interview must also be given due attention; audio equipment that is not invasive and able to eliminate background noise is imperative (Emmel and Clark, 2009).

After research and testing, I used a Hollyland Bluetooth lapel audio recorder. This recorded high-quality audio and had no wires; the participant and I both wore one on our lapels. The device connected via Bluetooth to my phone, where the interview was recorded.

5.3.3.2 Ethical Considerations of the Walking Interview

The consideration of confidentiality is perhaps the most significant ethical issue for walking interviews (Clark and Emmel, 2010; King and Woodroffe, 2019). Due to the interview taking place in a public area, confidentiality may be compromised; the participant may be heard or seen by friends and approached while the interview is taking place, and enquiries about what is happening may be made (Clark and Emmel, 2010). The ethical issues may be more significant where there is stigma attached to the nature of the experience being explored (King and Woodroffe, 2019). Moreover, ethical consent would be needed from anyone who approached during the interview, because of the recording and their spontaneous involvement (King and Woodroffe, 2019). Although being explicit with participants about the impossibility of total confidence when undertaking a walking interview which may prevent some participants from wanting to participate, it is a point that cannot be compromised. All the participants who walked freely chose a location close to their home, and so I ensured the mothers were fully aware that we might see people they knew. None of the mothers were concerned about this, but had they been, we would have created a plan of what we might say if a friend saw them and what would happen if the friend became curious as to what we were doing.

There is also a "small but not insignificant" (King and Woodroffe, 2019, p1283) physical risk to participants and researcher. This can be in the form of unsafe paths or the age and physical ability of the participants. However, this can be somewhat overcome by preplanning the route and its duration. When the walking interview puts the participants in a place of power, as they lead the pace and any rest stops, this concern is reduced (Cummins et al, 2007). Furthermore, variations in the pace and duration of walking interviews has not been found to affect the quality of the data collected (King and Woodroffe, 2019). All the participants in my study were fit, middle-aged women; however, we did walk along cliffs and up valleys, so the risk of physical harm could not be completely mitigated. I had an emergency contact on my phone for me; however, if I were to conduct walking interviews in the future, I would also take an emergency contact for my participant. Interestingly, although the interviews lasted between one and two hours, all the participants who chose to walk wanted to continue walking and

talking as we returned to our starting point. Thus, we added shorter laps of either nearby playing fields or the streets around where they lived.

5.3.3.3 Recording and Transcription

The Bluetooth audio recordings were transcribed verbatim within 48 hours of the interview. Ethical compliance was upheld at every stage (Appendix 1).

5.3.4 Reflexive Pause: Considerations of Walking Interview Planning and Participants

My own lived experience suggested that the mothers may not freely share their maternal 'GD' journey due to feared judgement and shame, and therefore assuming an insider position would support trust and rapport, leading to deep and rich data. However, I was acutely aware that I was no longer a full insider. But more than that, having previously been a mum to only boys, I now had what they wanted and so deeply yearned for; a daughter. I knew that when I was in the depths of maternal 'GD' I may have found taking to someone who had a daughter about my maternal 'GD' emotionally challenging, and so I had to undergo a complex navigation of my insider-outsider position. I decided that I would tell all my participants that I had lived experience of maternal 'GD' and had three sons and that it was from my experience that this research had been born. However, deciding how to tell them about my daughter was more complex, as I did not know what this revelation would mean for the mothers and whether it would render them silent. However, I felt that if I was able to build enough genuine and wholehearted trust and rapport, then if I was faced with needing to share the information about my daughter, it may be more gently received and be less of a reason for the mothers to "close up.' In taking the stance of initial limited disclosure, I decided that I would not freely share about my daughter, but if asked directly, I would not lie and would navigate that interaction with sensitivity. However, due to the walking interview methodology, this approach was not as simple as it had appeared to be at first.

I would meet my participants for their walking interview at a location of their choice. I could not wholly predict where I might park or if they would come to my car, and thus I had to prepare. My daughter's pink car seat would normally be in the car, along with an array of "girly" paraphernalia. Before each interview I diligently emptied my car of all girl-related items so as not to cause my participants any distress. However, I arrived for my penultimate interview

and walked to the boot of my car to put on my walking boots, and as I was putting them on, my participant walked over to meet me. As we happily greeted each other I spotted the water bottle that I use for my Westie – an old one of my daughter's, and clearly a girl's water bottle. My heart raced and I hoped that my participant had not noticed it tucked into the pocket of the boot. However, she had. Less than 10 minutes into an almost two-hour interview with Nora, she said;

> *"I've been noticing things a lot more in the last week. But like, when you opened your boot, I was like, there's a pink water bottle so I was like, she's got a daughter and then I find myself thinking, did it fix you? Like did having the girl fix the ... actually was that just ... like will I never essentially fully be fixed without that?"*

In this moment, "strategic undressing becomes a necessity" (Thurairajah, 2019, p140) and my instinctive response was to empathise and to feel that feeling with her, thus, I responded simply by saying *"I know, I know that feeling",* because I did. I did not try and answer her question, and I did not try to justify the pink water bottle, but I walked that fear and feeling with her. Whether because of my genuine empathy, or my commitment to rapport and reflexivity at every stage of this study, the interview with Nora then became so incredibly rich. Nora shared experiences and emotions with me that she had not shared with her mother or best friend, and we shared tears together on the top of the most beautiful valley when she asked for her most deeply held hope, that for a daughter, to be taken from her because the pain was so great and she did not know what to do while her hope remained.

5.4 Data Analysis

5.4.1 The Listening Guide (LG)

Within an emerging research field, exploratory research is required as it allows for adaptation in the methodologies and methods employed (Silverman, 2021). This is important for this research where the outcomes were largely unknown because the phenomenon being studied is emergent (Stebbins, 2001). Although maternal 'GD' is an emerging phenomenon, it has been established that it represents a complex, personal and relational experience (Groenewald, 2016). Thus, in the transformation of personal experience into data, this study demands a method that preserves the voice of the participant as well as upholding the tenets of reliability and validity within the qualitative paradigm (Golafshani, 2003). The LG does not shy away from the widely debated topic of credibility in qualitative research (Flick, 2020; Silverman,

2021); rather, it directly engages with it. The LG focuses on the unique researcher-researched relationship, not as a methodological weakness but as a site of meaning-making and ethical responsibility. The LG method recognises the influence of relational dynamics that are integral to the research process (Woodcock, 2016), aligning with the philosophical orientation of this study.

The LG rejects the traditional linear research model; rather, it highlights the multitude of ways in which data can be interpreted, leading to the generation of varying results (Mauthner and Doucet, 1998). All qualitative research recognises the multi-layered, multi-dimensional, non-linear, contradictory nature of human experience (Hollway and Jefferson, 2000; Koelsch, 2015; Mauthner and Doucet, 1998). However, the LG goes beyond this recognition, as it supports the unpicking of the intertwined and complex relationships that the social sciences aim to explore. The LG is an analytical tool designed primarily for interview data that is personal and relational.

The LG has been used as a flexible analysis method in a range of disciplines, from education (Zambo and Zambo, 2015), to social (Beauboeuf-Lafontant, 2008; Edwards and Weller, 2012; Thompson et al., 2018) and health domains (Milligan, 2008; Robins-Browne et al., 2019), as it offers a means of engaging with multiple variations in voice and relations. Critically, the LG has been used to disrupt embedded cultural narratives that risk reducing participant experience. This is shown by Beauboeuf-Lafontant's (2008) use of the LG, which allowed her to navigate internalised narratives of Black women's emotional strength that obscure expressions of distress. Similarly, Milligan (2008) used the LG to listen for layers and conflicting moral voices as a means to understand prenatal decision-making, illuminating how women's prenatal ethical decision-making could be understood. Thus, not only does the LG represent an analytical tool, but it also acts as a feminist praxis.

A further tool that has been found to support the inclusion of all voices in research through embodiment and as a catalyst for social change is the use of poetic forms in data analysis and presentation (Faulkner, 2016; Hesse-Biber and Leavy, 2006) which the LG also does. Acccordingly, Hordyk et al. (2014) discuss poetry as a form of feminist data representation, whereby the embodied voices of under-represented populations are presented in novel ways to capture and transform the readers' imagination and engagement. Maternal 'GD' has been described as an emotional, yet taboo experience that is met with perceived social disapproval

(Duckett, 2008; Groenewald, 2016), and it is currently perceived by mothers who experience it as being socially misunderstood (Duckett, 2008; Groenewald, 2016; Young et al., 2021). Therefore, it is hoped that presenting data in the form of a short, yet powerful poem may allow the reader to engage with the phenomenon on a more personal level, supporting a deeper understanding of maternal 'GD' thus creating meaningful impact. Alternative poetic structures could be employed in the future, such as a tanka poem which has the scope to actively engage researcher and participant in the creative process (Breckenridge, 2016), which may lead to further insightful findings not facilitated by a walking interview.

Mauthner and Doucet (1998) developed the LG to encourage an active exploration of narratives in light of the "broader social structural and cultural contexts within which they (the participants) live" (p126). The interlacing of psychology and sociology within this analytical method is significant as it reflects the origins of my thesis. My study bridges these two disciplines, creating a psychosocial approach to analysis which intentionally amalgamates multiple analytical methods (thematic analysis, narrative analysis and grounded theory), yet which is unique in its employment of a series of listening activities and the flexibility that is encouraged throughout the analytical process (Gilligan, 2015; Kiegelmann, 2000; Mauthner and Doucet, 1998).

This study presents a psychosocial approach to research in the domain of health science. In this domain, there remains a gap in methods for capturing and analysing the depth, contradictions and construction of lived experiences in which psychological and sociological aspects of well-being are intertwined. The LG addresses this gap by offering a recognised methodological framework that goes beyond traditional qualitative techniques. Conventional qualitative analytical methods such as thematic analysis, when used alone, can fragment complex human experiences into themes (Sundler et al., 2019). The LG's structured multiple listening can support the identification of complex, often contradictory, social undercurrents and internal voices. This is especially valuable for my study, which explores an experience that is morally, socially and personally sensitive (Groenewald, 2016). Some qualitative analytical methods marginalise the researcher-participant relationship, whereas the LG explicitly positions this relationship centrally to meaning-making (Gilligan et al., 2006). By embedding reflexive journalling and layered listening within the framework, the LG allows for, and values, how individual experience and relational dynamics between researcher and participant shape both the data and its interpretation. Thus, the LG addresses analytical gaps by offering a method that

is inherently relationally attuned and capable of illuminating both psychosocial and sociological elements of complex and nuanced female experiences, aligning with my study's philosophical orientation.

5.4.1.1 Implementation and Adaptation of the LG

The LG (Gilligan et al., 2006) is unique in its advocacy of four stages with four discrete types of listening, each with a unique focus on the narrative:

Stage 1. First listening: The plot – the mother' story in her own words. Listening for the plot, trail of evidence and researcher response.
Stage 2. Second listening: focuses on the voice of I in the form of an I Poem.
Stage 3. Third listening: contrapuntal voices, with a sociological focus (Mauthner and Doucet, 1998).
Stage 4. Composing an Analysis

I will now address each of the stages in detail.

5.4.1.2 Stage 1. First Listening: The plot. Listening for the Plot, Trail of Evidence and Researcher Response.

Plot and Trail of Evidence

Listening for the plot provided an opportunity to listen for the mothers' stories (Woodcock, 2016) whilst establishing the 'landscape' of the stories being told (Gilligan, 2015). Elements that I identified as constructing plot were words or phrases that indicated emotional intensity, contradictions, revisions, omissions and changes in the use of first, second and third person (Belknap, 2000; Brown and Gilligan, 1992; Way, 1998). Using the adapted method proposed by Mauthner and Doucet (1998), I also included in this step a conscious reading from a sociological stance to explore the plot from the participants 'social location'. I also drew on the critical realist concepts of the empirical, the actual and the real (Hastings, 2021; McEvoy and Richards, 2003). To identify these intertwining elements of plot, I used a multi-coloured coding system on a paper version of the transcript to organise the themes as they appeared (Woodcock, 2016), creating a trail of evidence that later helped support the development of patterns

(Gilligan, 2015). I extracted and organised the plot and trial of evidence, but the participants words were not changed. The plot represents a unique, rich and nuanced experience for each individual participant that the researcher must be receptive to.

Reader Response

Upholding the philosophical orientation of this research, the LG encourages embedded and ongoing reflexive immersion in the data through dedicated and continual engagement in the "nitty-gritty" of my reactions (Mauthner and Doucet, 1998., p 138). This process supported the location of myself in relation to that data (Gilligan, 2015) and so directly facilitated my considerations of the implications of my intellectual, social and cultural position (Mauthner and Doucet, 1998). This reflexive immersion brought a greater sense of validity to the research (Woodcock, 2016).

5.4.1.3 Stage 2: The Voice of I

The second listening focuses on the voice of I and the creation of an I Poem (Gilligan et al., 2006). The researcher uses the transcript to create an I Poem. The purpose of this step is to listen to how the participant talks about themselves in relation to the experience being explored (Brown and Gilligan, 1992). The I Poem seeks to demonstrate a narrative that is not directly vocalised by the participant, yet is central to the experience at hand, cutting through the overt narrative (Gilligan et al., 2006).

The use of poetry within qualitative research has grown in popularity. Various poetic forms have been employed to collect, analyse, and present data (Faulkner, 2016). Arts-based approaches more broadly, but poetry specifically, have been found to be particularly well-suited to exploring and representing sensitive or taboo experiences (Barak and Leichtentritt, 2014; Breckenridge, 2016; Furman, 2006; Robins-Browne et al., 2019). Moreover, the use of poetic form can be a catalyst for social change, as it has the ability to present data in an accessible and powerful form (Faulkner, 2016; Hesse-Biber and Leavy, 2006).

An example of this is Milligan's (2008) doctoral thesis, which considered the ethical practices of prenatal screening. Below is an extract of one of her I poems. It presents a striking and

emotive representation of a delicate yet complex human experience of giving informed consent:

"I did ask questions
(maybe) I just didn't ask the right questions
I certainly mustn't have
I was concerned
I would say there was a lapse in communication" (Milligan, 2008, p 101)

I have given no significant level of detail concerning her study, yet in a few short words this striking poem demonstrates and validates the rawness of multifarious feelings, intricate experience that emotionally engages the reader (Koelsch, 2015). It thereby provides an engaging form of data presentation (Koelsch, 2015).

I Poems have been widely adopted in studies that have employed the LG. Geib (2012) created long I poems. Balan (2005) included "my and "you" statements and argued this "adds to the context" (p69), while September (2022) completely omitted the I Poem as she felt that it created an assumption that the I is the primary voice. However, September did use stanzas of poetry between paragraphs in her own words to create a sense of self for the participant, avoiding prioritising one voice. From the perspective of analysis, Gilligan et al (2006) suggest that creating I Poems from a range of passages within one data set to draw attention to variances in narratives, themes, constraints, harmonies and contradictions and furthers the depth of engagement with the data (Koelsch, 2015).

I used a two-stage approach in constructing the I poems (Gilligan et al., 2006). I began by selecting significant passages within the interview that I believed were resounding for that specific woman and her maternal 'GD' experience. Within these passages I underlined every I along with the verb and any perceived important additional words (Gilligan et al., 2006). I excerpted these short phrases, ensuring the order was maintained, and placed each I phrase on a separate line to create the I Poem. However, I used I phrases from only one paragraph as I felt that by combining sections of transcript in undefined ways could lead to the known and unknown manipulation of the data.

Existing data on 'GD' suggests that the phenomenon may be socially misunderstood (Young et al., 2021); thus I felt that the incorporation of an I poem in my study would enable the voice of each mother to be prominently brought to the fore, addressing such misconceptions with purpose and impact. Moreover, presenting findings in a form that is striking and accessible may broaden engagement beyond an academic audience, thus enhancing the potential for meaningful impact through engagement with the topic, providing education around the phenomenon, and hopefully eliciting a degree of compassion (Crawford et al., 2014) and understanding towards the mothers.

5.4.1.4 Stage 3: Listening for Contrapuntal Voices

The term contrapuntal comes from music theory and relates to a counterpoint, a musical technique where two or more melodies are played simultaneously in harmony. Figuratively, contrapuntal can be used to describe a way of holding multiple, possibly opposing experiences at once. Thus, contrapuntal voices can be understood as when people speak about their stories, they don't use one singular narrative voice but multiple voices because their experiences can be complex, contradictory, and confusing that one person can hold multiple interpretations of themselves. Listening for contrapuntal voices required me to undertake multiple readings of the transcripts to examine the multiple facets of each participant's voice and the unique combination that spoke to the research questions (Gilligan et al., 2006; Gilligan and Eddy, 2021). These voices sometimes appeared in harmony, opposition, or contradiction (Gilligan et al., 2006). This approach to analysis provided a means for understanding the several layers that constructed each mother's individual experience in light of the research question. These readings had a primary focus on relationships and "the broader social, structural, and cultural contexts within which they (the participant) live" (p126).

The visual demarcation of each participant's contrapuntal voice identified within the transcripts provided a way to examine the interlinkage of experiences. It enabled an awareness of the interconnection of voices within a mother that moved and reacted to one another in unique ways for each participant (Doucet, 2018), and when applied across the whole data set, larger common patterns or themes became distinguishable (Gilligan et al., 2006).

5.4.1.5 Stage 4: Composing an Analysis

Gilligan et al. (2006) highlight that when composing an analysis, the listenings are not separate entities, and therefore they should be analysed in relation to one another. However, there appeared to be two approaches to stage four analysis. Stage four has been used to present a "summary in which all three listenings were pulled together and summarised" for each individual participant in turn (Milligan, 2008). Stage four has also been used to illuminate the similarities and differences across the whole data set (Gilligan et al., 2006).

Accordingly, I looked to studies which applied this latter method. Gilligan and Eddy (2017) suggest that in the fourth stage, the researcher's voice comes back into the analysis and can be incorporated with elements of thematic analysis. Consequently, September (2022) reported that with a thematic lens she sought to identify "similarities and differences" (p62) in her data and described this stage of systematically identifying themes and patterns across participants' accounts as "gazing across the women's stories" (p62). I adopted this phrase in my study, operationalising it as a rigorous and systematic thematic analysis conducted across the entire dataset. In line with Braun and Clarke's (2013) reflexive thematic analysis, I conducted a thorough review of all six case studies and associated transcripts. I coded themes and compared them across participants to identify consistencies, variations, and overarching patterns relevant to the research question (Braun and Clarke, 2022; Gilligan et al., 2006). Analytic notes were maintained throughout the process to document decisions and reflections at each stage, thereby, upholding transparency.

5.4.1.6 Adaptation of the Listening Guide to Include Thematic Analysis as a Final Stage

Thematic analysis draws the researcher to analyse the most socially meaningful themes across a data set, not necessarily the most frequent (Braun and Clarke, 2013). Thematic analysis provided a systematic approach to identifying, analysing and presenting themes (Dawadi, 2020), and combining this with reflexivity through reflexive thematic analysis (Braun et al., 2019; Terry and Hayfield, 2020) was an appropriate analytical method to integrate with the methodology and method of the LG, as it allowed for flexibility.

Reflexive thematic analysis comprises of six stages, some of which overlap with the LG stages, as shown in Table 4. The overlap in the analytical approaches enabled a successful integration of the two analytical methods. Stages one to two of the reflexive thematic analysis method sit within stages one to three of the LG. Stages three and four of the LG create interaction between

the two methods, and reflexive thematic analysis provides a systematic series of flexible stages through which stage four of the LG can be effectively implemented. My movement through the two methods is shown in blue.

Table 4. Integration of the LG and Reflexive Thematic Analysis

LG Stages	Reflexive Thematic Analysis	Presentation
1. The plot		Case studies were presented for each mother, comprising of three parts: Listening for plot, I Poem, Contrauntal voices.
2. I Poem	1. Transcription	
3. Contrapuntal Voices	2. Familiarisation/immersion in the data	
4. Gazing across the mother's stories	3. Coding	'Gazing across' the mother's stories was presented as a rigorous, systematic, reflexive thematic analysis that followed Braun and Clark's (2013) thematic analysis process.
	4. Searching for themes	
	5. Reviewing themes and thematic mapping	
	6. Defining and naming the themes	

The integration of a thematic lens allowed for "rich, coherent and meaningful" (Braun and Clarke, 2013, p249) patterns across the data set to be collated and synthesised. Integrating the two analytical methods enabled a stage of standing alongside the participants with the LG, followed by a stage of gazing across the whole data set with a thematic lens (Edwards and Weller, 2012). It was important to transition to a gazing across stance because this enabled the identification of patterns which generated a more informed conceptual understanding of maternal 'GD'. The identification of important patterns in the maternal 'GD' experience, whilst acknowledging individual experience allowed for the complexities and nuances that were experienced, to be valued thus supporting the meeting of the research aim (Braun and Clarke, 2022; Naidoo, 2011).

5.4.1.7 A Psychosocial Approach

The disciplines of psychology and sociology have generally been thought of as separate from one another (Vogler, 2000); however, the psychosocial approach that this study takes is not without precedent. In 2003, Clarke (2003) merged psychology and sociology while conducting research into envy; he advocates a multidisciplinary approach to the study of human experience and emotions to enrich our understanding. As a means to address the perceived polarity of academic disciplines, Clarke (2003) suggests referring to an amalgamation of the aforementioned viewpoints as psychoanalytic sociology, also referred to as psychosocial study. This interdisciplinary approach assumes elements of both disciplines.

Clarke (2006) argues that the use of a psychosocial method in qualitative research elevates the importance of the researcher and participant experience, which enhances the quality of the data being collected. The union of these two disciplines resonates with this study due to the complex personal and social dimensions that shape the experience of maternal 'GD' (Groenewald, 2016; Young et al., 2021). Thus, an approach that amalgamates psychology and sociology enables an exploration of maternal 'GD' that validates the intertwining elements of personal experience and embedded impactful societal narratives.

5.4.2 Summary of the Listening Guide

The LG encourages a multidisciplinary approach to qualitative research, which embraces the psychological and sociological elements of my study. The relational underpinning of the LG upholds the notion that humans exist within a deeply complex system of interrelated social systems and relationships that are uniquely interpreted by each individual (Gilligan et al., 2006; Gilligan and Eddy, 2021; Robins-Browne et al., 2019). The LG provides an active movement away from rational, objective thinking where individuals are seen as separate and independent from one another and from their context. The relational ontology of the LG draws upon sociological assumptions that are consistant with the philosophical orientation of my study, placing an emphasis on understanding the dual nature of individual experience within the social context within which the individual lives (Mauthner and Doucet, 1998). Moreover, it supports the feminist methodologies underpinning this study (Brown and Gilligan, 1992; Gilligan et al., 2006). Thus, making the LG a logical analytical choice.

5.5 Ethical Considerations

5.5.1 The Topic

The sensitive nature of the data and possible implications for the mothers was acknowledged (Bourne and Robson, 2015). Therefore, "extra thought around consent, anonymity, confidentiality, and data security" (Sipes et al., 2020, p 235) was given. Consequently, all participants, husbands and children were given pseudonyms. The chosen pseudonyms were arbitrary; they had no meaning. References for geographical locations were kept vague, and any possible identifying data was removed. Post-interview mothers were directed to MumsAid and the PANDAS Foundation UK for support of any unexpected emotions arising from the interview (Sipes et al., 2020).

5.5.2 Data Collection

Because the walking interview method diverged from the traditional academic setting, the ethical consideration of confidentiality and the disclosure of sensitive topics in public took on particular significance (Clark and Emmel, 2010; Foley et al., 2020; King and Woodroffe, 2019). In the initial communications with mothers, the nature of the walking interview was discussed to ensure the participants fully understood the implications of agreeing to such an interview, including the sharing of possibly highly sensitive experiences in a public place (Hennell et al., 2020; Emmel and Clark, 2009).

5.5.3 Researcher Safety

In relation to my emotional safety, I kept a reflexive journal during the entirety of my research (Dickson-Swift et al., 2009; Fahie, 2014; Hanna, 2019). I had regular (at least monthly) meetings with my supervisors, and I made contact with a practicing psychologist who has also undertaken a PhD in 'GD' and who was able to further support my well-being and reflexive processes.

In conjunction with following the university's lone worker policy, the physical safety of both the participant and myself required additional attention. The route for the interview was considered in terms of physical safety and the impact of adverse weather (Emmel and Clark, 2009; Evans and Jones, 2011); interviews were conducted in daylight, and isolated locations

were avoided. I carried a mobile phone which was sharing my GPS location with a trusted colleague, and I called them at the end of the interview. In terms of physical comfort, I wore (and the participant was advised to wear) comfortable walking shoes and layered clothing and to bring water and snacks (Finlay and Bowman, 2017).

5.5.4 Summary of Ethical Considerations

The novel data collection method for my study generated data that is comparable to that of a 'traditional interview' where rigorous protocols of data collection, privacy and storage protocols were employed (Hart et al., 2016; Nosek et al., 2002). This study was subject to thorough processes of ethical checking and approval employed by the University of Nottingham. It followed the ethical guidelines of the University's Code of Good Research Practice and lone working policy.

5.6 Eliminated Methods

While a range of qualitative analytic approaches were considered, including PAR, focus groups, ethnography, and IPA, due to the emotionally complex, taboo and nuanced experience of 'GD', each of these was deemed less suitable than the chosen methods. PAR was not appropriate, as this study's aim was to explore personal experience to develop a more informed conceptual understanding of the phenomenon, rather than to mobilise group-based social change (Mcintyre, 2007). Focus groups were excluded due to the way in which literature has framed 'GD' as taboo, creating the potential for an exacerbation of perceived judgement and consequential shame in a group setting (Acocella and Cataldi, 2021). A one-on-one approach was necessary to maintain psychological safety and elicit an emotionally rich and vulnerable account of the mothers' experiences (Walton et al., 2022). Ethnography was not an appropriate choice given the invisibility of the maternal 'GD' phenomenon (Hammersley and Atkinson, 2019). Although IPA was considered for its focus on lived experience, it was not employed due to its emphasis on cognitive meaning-making, leaving possible sociological aspects of the phenomenon uncovered (Smith et al., 2009).

Creative methods such as painting or collage are increasingly recognised within qualitative and feminist research as meaningful methods to access embodied, emotional, and non-verbal dimensions of experience (Vacchelli, 2018). However, while considered, these methods were

not employed due to the possible additional discomfort caused by asking participants to visually represent their experience and also because of the practical and ethical complexities of interpreting and managing the ownership of such data (Hauber-Özer and Call-Cummings, 2020; Temple and McVittie, 2005). Additionally, the decision to use walking interviews and the LG already enabled a layered, and participant-sensitive approach that aligned closely with the study's philosophical and psychosocial foundations.

5.7 Summary of Research Methods

With the aim of developing a more informed conceptual understanding of the maternal 'GD' phenomenon, thereby contributing to a better understanding of "the world of human experience" (Cohen and Manion, 1994, p36), walking interviews were employed for data collection, and a merging of the LG and thematic analysis provided the method for data analysis.

In this chapter, the process of participant recruitment and the methods used for data collection have been described and justified. A number of ethical considerations were detailed due to the novel method of data collection and used throughout data collection, analysis, and the discussion. The importance of proactive and embedded reflexivity has been highlighted as being central to all aspects of this piece of research. Chapter 7 will present Listenings one, two and three as a case study for each mother in turn. Chapter 8 will present Listening four, which incorporates a thematic lens to gaze across the women's stories.

Chapter 6: Case Studies

6.1 Introduction

This chapter presents a case study for each of the six mothers who took part in my study. Each case study illustrates the layers of the maternal 'GD' experience and is presented in three parts: (i) listening for plot (ii) an I Poem, and (iii) contrapuntal voices.

In the first part, listening for plot, I constructed a thematic narrative using the participant's own words, selecting and arranging excerpts drawn from across her transcript to illustrate different dimensions of her experience. Words in brackets are mine and have been added to support flow and clarification; ellipses (…) indicate where text has been removed without altering meaning; and references in brackets (e.g. p34) identify the page number in the transcript from which each extract was withdrawn to support transparency. This approach allowed me to retain the participant's voice while shaping the narrative thematically to highlight key elements of her account.

The second part of each case study presents an I Poem. These were created by me from a selected section of the transcript chosen for its emotional or narrative intensity. Following the LG approach, I extracted the participant's use of the first-person pronoun ("I") and arranged these lines as they appeared in the transcript to reveal patterns of self-expression, agency, and emotion that might otherwise have remained implicit.

The third part of each case study explores the participant's contrapuntal voices: different voices (the voices included emotional states, psychological processes, motivational drives, and social or relational dynamics) that worked to shape the mother's maternal 'GD' experience. I identified initial voices during early readings of the transcript and then traced each voice throughout the data, compiling them into an interweaving paragraph that illustrates their interplay. Extracts are presented in largely chronological order, with minimal reordering made only to aid readability rather than to influence meaning.

Following each of these three analytic layers is what the LG refers to as the researcher response (Doucet and Mauthner, 2008; Gilligan et al., 2006), and I refer to as a reflexive pause. These

short reflections articulate my emotional and analytical responses to each mother's story and acknowledge how my positionality may have shaped my interpretation of the data.

Together, these multi-layered, interpretively constructed case studies offer a nuanced, stratified understanding of each mother's experience. The synthesis of these understandings across the six cases is developed further in Chapter 7, where the findings are integrated with reflexive thematic analysis which was conducted across both the case studies and entire transcripts.

Table 5. Participant Overview

Mother	**Age**	**No. of sons**	**Ages of sons**	**Work**
Alba	40	3	10, 6, 5	Supporting parents back into the workplace
Anna	37	2	5, 1	Therapist
Georgie	38	3	6, 4, 2	Manager
Ottillie	33	3	6, 3, 1	Administration
Nora	40	2	10, 7	Eco focused
Kate	40	3	6, 4, died at 20 weeks gestation	Vet

Table 6. Case Study Themes Overview

Overview of the themes in each mother's story in her own words, identified in stage 1 of the analysis:

Alba	**Anna**	**Georgie**	**Ottillie**	**Nora**	**Kate**
Girls and boys as opposites	I really fundamentally thought	She's real to me	We'd do everything together	Make sure they're not a chauvinist pig	I'd suddenly found my purpose
A lot of mixed emotion	They think you're disappointed with your boys	Boy, they're going to go and leave me	Preparing myself	What the fuck	A son's yours until he's got a wife
They'd say to me	Next time I'd be getting a girl	Everything about the whole thing is horrendous	It's not a disappointment	She just didn't get it	Grieving the loss of a daughter
That sounds like I was disappointed in him	My life is destined to be crap	I find it really difficult	I felt complete anxiety	Termination	That's horrifying
I wasn't the only mum	I need to talk to somebody about this	My boys are everything	I just fear judgment	I'm grieving a loss	I felt like she'd stolen my life
No information out there		I am on the corner	You're being silly	I was in a tunnel	It's not a disappointment in them being boys
Things I never imagined I'd do		Depression	I'm not going to allow myself to spiral	I want to move on	Am I normal?
It's not turned out better, just different		A taboo subject			I'm sort of evolving
		Tablets			
		Hope			
		It's quite scary			

Table 7 – Contrapuntal Voices

Contrapuntal voices for each mother, identified in stage 3 of the analysis, and the alignment to research objectives:

Study objectives	**The *emotions* of maternal 'GD'**		**The impact of 'GD' on *well-being***		**The impact of 'GD' on *help-seeking***	
	Kate	Georgie	Nora	Alba	Anna	Ottillie
Voices of	Should Anxiety	Logic Love	Seeking Silencing	Autonomy Protection	Alienation from others (internal) Ostracisation (external)	Intentionality Risk

6.2 Alba's Story

First listening: The Plot

Girls and boys as opposites

It's a bit confusing, you know, I was probably disappointed in their sex because I don't know their gender. (p16). So, I suppose, (because they were boys), that's why I felt like, at the time I felt like, well that's it. Your boys are all gonna play football, and gonna wear blue, and they're gonna be really masculine (p 7) I was born with girls and boys as opposites (p16). (But) mine go to a boy's street dance class (p16), the lines feel more blurred in a positive way to me (p16).

A lot of mixed emotion

(When I was pregnant with Isaac), the sonographer told me she thought it was a girl (p 7) (but) (when we went back) and they said it was a boy I just burst into tears (p 7). I felt so fiercely protective of this little life in me and it's not that I didn't want him, it's just that, that's it, I knew I was never gonna have a girl now (p 8). I had a lot of mixed emotion (p 8); I felt really guilty p8 (and) shame … because I felt like I shouldn't feel like that (p 14). (But) I think it was grief if I look back (p 13). It felt like a loss of the future I had imagined instead of particularly about him (p 13), (it's) not about him (p 14).

They'd say to me

Before he was even born, when I tell people I'm having a boy they'd say to me, "Oh well, you have to have one more then to have a girl" and I just find it really hard (p 19). (People kept saying) "oh are you going to have another baby so you can have a girl" (but) the thing that people have consistently always said to me is… "you need to have another one to have a girl" (p 18) they're questioning your kind of mothering … as if they're judging you as a mum (p 20).

That sounds like I was disappointed in him

I don't really like (the word disappointment) because that sounds like I was disappointed in him (p14). But that's not right; I'd got this little life inside of me and that I didn't want anyone to

ever think that I didn't want him or him to ever think that I hadn't wanted him (p8). (The word disappointment) doesn't feel quite the right term because, I don't know what is though, but, it feels more like it's a loss of something you imagined and that it is, I suppose, it is a disappointment in a way, isn't it (p14) (but) it kind of, I don't know, maybe it minimises it somehow (p15).

I wasn't the only mum

I knew because I was working with parents at the time, like that I wasn't the only mum that felt like that (p8) and I did write a post on my social media for the parents that I was working with (p9). But I did *also* talk about it with my husband and my mum (p8), I felt really glad that I had found out and that I'd got time to process it and talk about it with people that I felt safe with and then that I could get excited by the time I had him (p9) I do think acknowledging it and talking about it definitely helped me (p10). (When I started talking about it) I already felt like it was going to take over my whole life (p22) but I massively think the fact that I did acknowledge it meant that it didn't affect me long-term. Had I not, oh my goodness, I don't know what would have happened (p27). (But) it wasn't something that I shared openly with everyone (p 24). I just thought they wouldn't get it (p25), I was cautious about the way I did it (p 26). (I worried) that people thought I wasn't grateful because I've got three children that, you know, I hadn't gone through late miscarriages and I hadn't gone through IVF (p24) – (like) I'm upset because I'm never going to have a little girl and you don't even have a baby (p 8).

No information out there

(Although I talked about it there is) no information out there (p 30). (When I got upset at the scan) the staff, they didn't really say much. So, they didn't say anything that was inappropriate, but they also didn't say anything particularly (p8). There never felt like an opportunity to … burst into tears and be like, yeah, vulnerable (p30). I do think there's a real gap in just acknowledging it's a thing (p31).

Things I never imagined I'd do

My children are kind of, free in their own choice … growing their hair (for example) I ended up learning how to do French plaits for my son. So, some of the things I never imagined I'd do

(p9). I found as they've got older, that I feel less like gender matters because they are also unique (p4). I found it helpful to kind of see it as, I can be happy I've got a life growing inside me as a boy, but sad that I'm not going to have a girl at the same time. And I think being able to do that and see it as two separate things probably helped me … being able to separate it as two things and acknowledge it as two separate feelings that you can have together helped (p28).

It's not turned out better, just different

The things I guess I thought I would feel sad about having three boys, I don't as they get older. (p1). In many ways now, I would say, you know, it's not turned out better, just different. (p14). I'm just really liking soaking that up and enjoying it as much as possible (p32). I thought, I could choose to see the terrible thing or I can choose to realise that it's going to happen, but if I work hard at those relationships I can probably prevent it a bit, life is what you make of it isn't it (p32) so yeah, I just look at it positively now (p34).

Reflexive Pause: The Plot

Alba and I are similar ages, and we live in the same part of the country; we both have three sons, and one of mine also has a top knot like Alba's sons. Alba's career is similar to mine before I returned to study, so we had a lot in common. But I also found that our personalities were different – Alba seemed to have an inner and overt strength that was almost tangible; she seemed confident and direct in her convictions and dialogue in a way that I do not think I am. I wondered if this may have made me subconsciously shy away from the more 'emotional questions', or perhaps there were fewer emotional responses from Alba because she was less comfortable answering them. It may, however, have been that Alba had processed much of her journey and did not want to vividly revisit the experience, or maybe that she had not processed it and it was too hard to go there. I felt hopeful talking with Alba, as she appeared to be emerging from her experience of maternal 'GD'.

Second listening - I Poem

Alba's interview was the first time I'd heard a participant talk about being in a more positive space after the intense emotional experience of maternal 'GD' and I sought to illustrate this through the I Poem.

I have these thoughts
I choose to be like, well
I can either get upset
I'm so crazy
I might thank
I have thoughts
I'm not going to get you
I had my Mum
I looked at my cousin
I just think …. life is what you make of it isn't it

Reflexive Pause: I Poem

In creating Alba's I Poem I aimed to seek out Alba's forward motion through the maternal 'GD' experience. However, after engaging with the transcript to identify the I statements, I was surprised. I engaged with the transcript at the point where she had described her journey of autonomy to regain agency, making a conscious effort to see the positives in her life, but in engaging with the transcript this new way, a layer of confusion, uncertainty and self-doubt emerged where what I had previously heard was a sense of self-assured forward motion.

The intersections of Alba's self-worth "I'm so crazy", life experiences "I had my Mum", social structures "I looked at my cousin" with the possibility of autonomy "I can either get upset" with what I perceived as positivity "life is what you make it" but actually, is it a relinquishment of hope "I just think" suggested that Alba's ability to move through her maternal 'GD' experience was complex and layered. It seemed Alba was not able to fully overcome her emotional distress; rather, she chose action within limitations to move forward.

This I Poem created a reflective space to consider how the women who experience maternal 'GD' might find a way to see a future without their long-imagined daughter; I felt some hope for Alba and other mothers who experience maternal 'GD'. But within the transcript, as illuminated by the I Poem, I identified layers of hopelessness from Alba that I had not previously recognised, so much so, that I had initially set out to identify her hope.

Third listening – Contrapuntal Voices

I heard two particularly strong voices in Alba's story: the voice of autonomy and the voice of protection. These two voices seem to work in harmony for the majority; however, it appeared that the voice of protection had the ability to quieten the voice of autonomy when Alba is drawn to protect her boys.

I initially found it hard to name the voice of autonomy. It was similar to and had overlaps with the voice of agency. I also explored if it was the voice of social defiance or the voice of determination, but what resonated most was that it was the voice of autonomy: a voice generated from within where an individual acts on their own motives and not that of society more broadly (Dworkin, 2015).

The voices of autonomy and protection ebbed and flowed throughout Alba's story. The voice of autonomy was i) initially misplaced ii) then spoke up (leading to the rise of the voice of protection), and iii) there was a merge of the voices of protection and agency.

The voice of protection spoke in three different ways i) to protect her boys ii) to protect herself from social deformation iii) to protect other mothers who experience maternal 'GD'.

Voice of autonomy
Voice of protection
(my words to aid flow)

I always did. I always imagined that I'd have three children. I always felt that I would have three children, my husband didn't really want three. **I feel so fiercely protective of this little life in me, *I didn't want anyone to ever think that I didn't want him or him to ever think that I hadn't wanted him*,** *I did write a post on my social media (because) it was something people didn't really talk about.* (**My social media post), was thought out in a way to make it clear that I very much wanted Bert… I mean I don't not want the baby. I was weirdly fiercely protective of him, but feeling really sad about what I felt, like, that it was never going to be. Grief that I wasn't going to have what I'd envisaged, not about him. (The word disappointed in 'GD') sounds like I was disappointed in him,** *that life hasn't turned out how*

you'd imagined. But actually, in many ways now, I would say, you know, it's not turned out better, just different. It's different, ***it's not worse in any way****. It's just different. Mine go to a boy's street dance class. Well, that wouldn't have existed when I was younger….* ***if it's not hurting anyone else, does it matter?*** **(He has a top knot and so) I bought him a T-shirt that said, "yes I'm a boy, I just have better hair than you", because he's got amazing hair, and he was so clear that he wanted long hair. (But) like they (people) think I don't love my kids as they are, or that I'm trying to change them (because of the hair and the dancing) … and I remember being like "Are you sure you want to wear that (head band) to school" because I thought he's going to get bullied.** *(But) I've really tried to let my kids be who they want to be. (And people say) I wouldn't have known what to do with a girl, (and that) angers me and upsets. Someone said to me, "oh are you going to have another baby so you can have a girl"... now I realise it's just not (a) helpful thing to say. I've just been reading a bit about this (Hearing another Mum's story of maternal 'GD') gave me the encouragement to talk about it more… I wanted to process this… to acknowledge it rather than deny I felt like I did….I want to address this…it was very much almost trying to acknowledge that…* ***I probably wanted to change people's perceptions a little bit****… it's OK to feel disappointed, and we can feel grateful and disappointed together. I thought I could choose to see the terrible thing or I can choose to realise that it's going to happen (and) work hard (and) prevent it a bit. So yeah I just look at it positively now.*

Reflexive Pause: Contrapuntal Voices

Alba's story appears to begin with a misplaced voice of autonomy. Although Alba recognises that conceiving a child entails intercourse with her husband, and her husband would be the partner who decides the sex of the child (He et al., 2022), her firm assumption that she would be a mother of three appears to be thought of as an autonomous decision. This suggests an entrenched social narrative about and how much 'power' is held by motherhood and reflects something that I had recently been grappling with, and so many have been prominent for me. Her mothering assumption appears certain in her mind, and she has no doubt that she will be a mother of three.

However, as Alba's maternal 'GD' journey progressed and she birthed three boys, the illusion of autonomy in deciding to have a daughter dissipated. As this realisation grew, Alba began to use her voice of autonomy to contest social narratives around the experience of maternal 'GD'

and her perceived socially assumed disappointment in her birthed children. As these social narratives about being a mum to only boys became louder, her voice of protection started to emerge and strengthen.

The voice of protection appears to had a dual purpose; to protect her sons before they were born and again as their voices of autonomy grew. Simultaneously, protecting herself from perceived maternal condemnation because she was experiencing difficult feelings about wanting a child despite having given birth to healthy children. Fuelled by her voice of autonomy, Alba illustrated how her voice of protection refused to be silenced. She sought to address her perceived social misconceptions as she felt they were incorrect and unhelpful.

Two of Alba's boys wanted long hair and to go dancing but she feared their choices might reinforce the misplaced perceived societal belief that she was disappointed in having boys and was attempting to impose 'girls' activities and behaviours on them. Alba's voice of protection responded by not only wanting to protect herself against the anticipated social judgement but also shielding her sons from perceived essentialist narratives and social expectations being placed upon their behaviours and desires.

Thus, Alba created a social media post to address what she perceived as widespread misunderstandings about maternal 'GD'. This act of autonomy resulted in other mothers sharing their own stories of maternal 'GD' and offered her support. This may have solidified her view that the social construction of maternal 'GD' was misplaced, buying her son a t-shirt to celebrate his long hair. However, the recognition that social assumptions about maternal 'GD' may be flawed also appeared to give rise to her protective behaviours. Concerned that her son might get bullied, she asked them to reconsider wearing a sports headband to school. In this moment, her autonomous voice was somewhat silenced by the louder voice of protection for her boys.

As the interview drew to a close, Alba's voice of protection and autonomy grew together in a desire to rebuke the social narratives of the maternal 'GD' experience. This entwined voice seemed to lead to the emergence of the voice of agency - one that not only sought to protect her own sons but also to protect other mothers who experience the phenomenon of maternal 'GD'.

The entwining of these voices and renewed purpose due to her experience may have been the catalyst for Alba to reframe her future to one where she has the opportunity to view in a way she chooses, not as dictated by society.

6.3 Anna's Story

First listening: The Plot

I really fundamentally thought

I really fundamentally thought (a daughter) was going to be part of my life (p50), we'd already kind of discussed our girls names many times (p27). I hate to be stereotypical about it, but I suppose I did think about the things you do with a girl versus the things you do with a boy (p5). (My son) keeps telling me he likes singing and dancing and I'm like, great. There's a real social narrative about oh, you know, girl stick around, you have that best friend for life, and boys, they're just a different class (p36). (People say) "Oh two boys, you'll have your hands full" or "you'll have to try for a girl next time" (p39). (Even) the health visitor, on day three, you know like that hormone or peak (post birth), she had three boys and she spent the entire time talking about how awful it was to have boys (p39) Like I think there's some sort of thing in my head that's like they're not going to love me when they're older and that's the thing that kind of just goes in my head all of the time (p33).

They think you're disappointed with your boys

(I feel that the opinions and jokes of others are) defining that somehow I'm not happy and complete with what I've got (p57). I think people take that disappointment and they move it to the children you have, not the children you're hoping for (p2). (This) absolutely has nothing to do with the children I have, they are my world, and I could not be without them, I would not choose not to have them (p50). They're completely missing the point (p58). I don't want (my boys to) ever to think I didn't want them (p50).

Next time I'd be getting a girl

(With my 1st son) I felt a bit upset about it, but it was very fleeting (p1) I kind of almost boxed it off in my head, "well next time it will be a girl and it won't be a problem" (p1) when I first found out the second time that I was having a boy, I was absolutely devastated (p1), complete overwhelm (p48). For a few days I thought I just can't have this baby, or like, what would it be like if this baby just didn't make it? maybe they got it wrong. All these horrible thoughts (p69).

It was just, is visceral the word? Just like the absolute, just body overtaken by a grief that I have never experienced at that level (p48). That is that, like, that is me done (p26) there's no way to fix it (p48). Whilst most things can be fixed, this can't. So how do you sit with it not being fixed and having to live with it and be OK in it and still kind of flourish and have a nice life within it? (p49). (It would mean) just closing the door on kind of that thing of, would I ever have a daughter? (p16).

My life is destined to be crap

(Not having a daughter has) made me feel like I was less than or that I've not achieved something that I should have achieved all that somehow my life is destined to be crap (p42). I feel like I am not part of a gang that I want to be part of (p55). Like I get this immediate reaction of like, for fuck sake, how have you got another girl (p20)? (When I become a mother-in-law I worry) I'm the one on the outside asking for permission to go in (p17). If I'd had two girls, I wouldn't be here talking to you (p62). (There is a) running joke with the dads about me and my husband ending up having a third to try and get a girl (p57). So, whilst I know they're kind of joking, I'm like, I just wish you wouldn't because it's not funny. It's really not funny (p57). (Even my husband), he was struggling as well with my reaction. He was saying it was ruining the fact we are expecting a second baby (p23). But I just (didn't) want to feel the way I was feeling (p25), I didn't know what to do with myself (p27). (For) me it's more about the future than actually what's happening right now (p17).

I need to talk to somebody about this

(I wanted help because) this is happening for me and I don't know what to do … like I need to find somebody … I need to talk to somebody about this (p44). Luckily, I have therapy (p2), I probably (hoped) she would give me the golden answer (p45). (But sharing the experience isn't always easy) because as mums we meant to say that life is wonderful, everything is great (p62). So, it was really nice to go and speak to (my friends who have only boys, they) understand like all of the in's and outs of what's going on for me (p33). (They have) no judgment (p27) (that's) so important (p28) (it's) validating (p13) (it helped me) kind of think, where is my level of like, okayness with this (p13). Getting it off my chest it was kind of like it's done (p58). (Talking) helped me to rationalise (p53).

Reflexive Pause: The Plot

Anna was my second participant and the first with whom I conducted a walking interview. Building rapport with Anna came naturally; she was friendly, gentle with a quiet strength that I found familiar. This familiarity may have been a helpful in building trust, which likely enabled me to ask deeper questions as the interview progressed and helped her to feel more comfortable answering them.

Two elements from Anna's interview stuck with me. The first was the dissonance I felt between Anna's gentle, kind nature and how she saw no future without a daughter. It made me uncomfortable that such a warm person, who had so much to offer, felt that her life was destined to be "crap" as she had not achieved something in not being a mother a daughter. The emotional weight that Anna was carrying struck me.

The second element that struck me was that Anna had sought professional help for her maternal 'GD'. Drawing on my previous research into maternal 'GD' and my work as a coach with mothers who experience 'GD', seeking professional support is rare. But unlike so many mothers that I have talked with, Anna had acted on her knowledge that help would be beneficial, and she was able to reflect on what that meant to her and what it was about the space the therapist created that was particularly important to her. Maybe it was Anna's professional work as a therapist that helped ger to feel 'safe' in taking the leap to seek support. I too, had sought professional help and have experienced how important it can be, I wondered how we can support other women to find such support.

Second listening - I Poem

To aid my creation of Anna's I Poem, I was drawn to my reflective journal that I used after each interview. Anna was my first walking interview and so I was keen to reflect upon what my initial response had been as time had passed between the interview and this aspect of the analysis. The most impactful response that I noted was Anna's feeling that she had 'ruined' the experience of pregnancy for her husband. This is where I started my analysis, and deeper immersion in the transcript. However, despite this resounding with me so deeply, I realised that Anna spoke only one sentence about what her husband had said. Anna did, however, talk at

greater length about the confusion, sadness, disembodiment, and shame she was feeling prior to her husband's comment and in combination this created Anna's I Poem.

I just didn't want to be with
I just didn't want to be in my body
I don't
I just don't want to feel
I was feeling
I cried the next day
I didn't cry when we found out
I'm very practical
I had to go
I just wanted to get
I felt really awful
I had to kind of say
I wanted a girl
I was kind of
I just
I just felt awful and upset
… and my husband halfway around was saying, "I'm just really upset that you feel like this because it's ruining it"

Reflexive Pause: I Poem

The extraction of the I statements before her husband's comment creates a deeply emotional struggle for Anna, one seemingly filled with confusion, sadness, loss of direction and shame. Then there is a single sentence from her husband. So why did this single sentence resonate so deeply with me that it was the first thing I wrote in my reflexive diary? The I Poem has illuminated the brutal journey that Anna found herself on, she found the bravery to share this with her husband, yet his response appeared to lack empathy or validation of the depths of what Anna had experienced. It created a sense that, despite the depths of her emotional turmoil, she does not feel supported, heard or understood by her husband, the person who you would most likely think would be the one to provide meaningful support. However, Anna also wanted to stress that her husband was very supportive.

Anna's I Poem highlighted to me how the maternal 'GD' experience can render women silent. Despite Anna's best attempts and vulnerability in sharing, she is not heard. This may suggest a misunderstanding of the experience by her husband, or a sense that he feels helpless and he himself does not know what strategies to use to support her, therefore looking inward to his feelings of frustration. Anna's I Poem vividly highlights how such an experience could lead to a compounding layer of isolation, silencing and further layers of shame, intensifying an already emotionally distressing experience.

Third listening – Contrapuntal Voices

When searching for Anna's contrapuntal voices, I became aware of a sense of 'aloneness'. Alone from herself, from who she thought she would be as a mother, and a subjective feeling of disconnection from mothers who had girls. Thus, I focused my analysis on the times when Anna talked about a broad sense of alone. I noticed there were two distinct voices of alone, the voice of alienation and the voice of ostracisation. Anna's voice of alienation draws attention to her internal feelings of disconnect from her wider social group. The voice of ostracisation draws attention to how Anna felt she had been actively excluded from hers and her husband's friendship group through a deliberate, although not intentionally unkind, act of humiliation, positioning her as the butt of jokes due to her silenced maternal 'GD'.

Voice of alienation from others (internal)
Voice of ostracisation (external)
(my words to aid flow)

Every single one of my friends has a girl (p29). But you (the 'girl mums') don't have to deal with it (not having a daughter) and I do (p29). Oh, this is feeling really like, really unfair that I'm having to deal with this… having to deal with all these feelings that if I'd had a girl I wouldn't have had to address what all of this is about (p30) I am not part of a gang that I want to be part of (p55), I feel like they're all in this club that I am not in (p56). **(Me and my husband are part of a group of couples) and there was this running joke with the dads about me and my husband ending up having a third to try and get a girl (p57), about how I'm going to be fuming and how me and my husband are going to have to go again tonight (p58)All of this stuff that I was just like, I burst into tears again (p58) I just found that really hard**

to take (p59) being butt of jokes. And you know, they're lovely friends, we're a lovely group, but that is the one bit. I said to my husband if it happens again, I actually need you to, on behalf of me, to talk to them about it (p 59). I'm longing for this girl and you've all got one and we need to be part of the gang (p 57).

Reflexive Pause: Contrapuntal Voices

Alienation is thought of as an internal subjective feeling rather than based in 'fact', but it seems Anna attempts to ground her subjective alienation in 'fact' "every single one of my friends has a girl", perhaps as a way of rationalising and understanding her sense of alienation. As Anna's sense of alienation is rooted in an experience that is little understood, this may compound her sense of isolation as she may struggle to find information to help her understand her own maternal 'GD' feelings. Thus, Anna may be trying to justify her emotional responses to alienation as a protective strategy.

Anna appears to harbour emotions of resentment toward 'girl mums'. Resentment that she has to deal with the experience of maternal 'GD' "Oh this is feeling really like, really unfair that I'm having to deal with this", moreover, "address what all of this is about". Here the emotion of resentment seems to be leading to feelings of anger, disgust, unfairness and disapproval. These feelings of resentment appear to lead Anna to feel isolated from a group that she had always imagined being part of. Isolation from her friends, her husband and also herself. Anna's emotional reaction to the 'girl mums' may create feelings of a perceived barrier between her and 'them', leading to a more entrenched sense of alienation, thus, greater feelings of disconnect from the very people she wants to feel connected to. This may serve to further her feelings of isolation, thus having the ability to impact her well-being and ability to seek help as voices of shame (emotional self-disconnection, feelings of deficiency and inadequacy) begin to creep in.

In seeking to understand Anna's perceived sense of social connection, another voice I was drawn to was the voice of ostracisation. This voice spoke to Anna's perceived exclusion by others from what was previously a 'safe' friendship group shared with her husband and other couples. Being on the receiving end of a prolonged joke was especially emotive for Anna because of how deep the longing was for a daughter. The voice of ostracisation suggested an embodied, distressing emotional experience of loneliness, sadness and frustration.

This may have led to a further layer of loneliness when the voice of ostracisation highlights how the group-level joke impacted Anna's sense of self. The joke was at Anna's expense and created a sense of exclusion and inferiority for Anna. Anna's ostracisation from the group, layered with the deep-rooted emotions associated with the content of the joke, may have been the reason Anna suggested some insertion of boundaries in the group if the jokes continued. Anna's reliance on her husband to place boundaries to prevent emotional overwhelm and create a more respectful and validating space suggests a sense of alienation from herself or a perceived lack of agency to speak up It may, however, also indicate a self-protection strategy, as the emotions Anna experienced with maternal 'GD' were so challenging; therefore, she feels the need to create distance between herself and her emotions as a way of managing them, thus creating another layer of perceived alienation, this time created by the voice of ostracisation.

6.4 Georgie's story

First listening: The Plot

She's real to me

I've made no, I've not hidden the fact that I've always wanted a daughter (p1), it was never an option that I wouldn't have a daughter … I was having two girls (p2). I've tried all the methods (*to conceive a daughter) (p*32). This person that I've made in my head, she's real to me (p4).

Boys, they're going to go and leave me

The stereotypical girl works hard, quiet, gets on with things, whereas the boys have got an energy that they want to run around and fight (p5). I always feel like (boys) get judged harsher than girls (p49), I know what people say, there's nothing different, you can bring them up gender neutral, but I just don't believe it (p63). I just feel like if I have all boys, they're going to go and leave me when they're older. I will always be the mother-in-law (p5).

Everything about the whole thing is horrendous

Everything about the whole thing is horrendous, and I hate feeling like it (p2). This is so deep-rooted, I don't know where it comes from (p4). I don't know what's wrong with me (p11), it shouldn't even matter (p12). I get like a grief (p4), (that) doesn't go away for me even though that person wasn't real (p26). It's mourning a life that you thought you would have (p31). I'm mourning something that I thought would happen. It is like a grief. People can't understand that… that person is alive to you (p86).

I find it really difficult

The guilt is unbelievable (p5), (it's) something else and I don't want to feel like this (p86). I've always been able to achieve what I wanted in the past and now I'm, it's out of my control (p17) (but) I don't want to feel incomplete (p5). I just felt the unfairness … but it's not like, I hate using the word unfair because I've got three perfectly lovely boys who are amazing (p5). I go

into this like crazy mode where I'm like, I must do everything. So then my husband will let me have another (p36).

My boys are everything

And you read, like gender disappointment things on the internet, and like, people, like you should just be grateful for what you've got (p5). (People) probably think you don't want your child and you don't love them or whatever, which is ridiculous. I love (my boys) very much, and this doesn't detract from that (p86); my boys are everything (p43).

I am on the corner

There is kind of a group (of Mums) with one of each (sex) … I am on the corner, like, I try and, I guess I try and keep away from them (p5). Having three boys kind of puts you on a... puts you out. You don't really fit in with the boy-girl families (p 3).

Depression

I had really severe post-natal depression after James, and I don't know whether that was probably with gender disappointment. That's probably the main cause of it (p3). And (next time) I had really bad depression in my pregnancy (p3). (My husband) never imagined his life would be like this… just the sadness around it (p30).

A taboo subject

People don't know how to deal with it (people don’t) know really about it (p24), it's a bit of a taboo subject (p2). Some people get it, some people don't at all. You need to test the water with people (p38). But I'm probably more open about speaking with my friends than perhaps some people are (p1), but maybe they don't know the full extent of it (p1).

Tablets

(I got signed off by work when I was pregnant but) I couldn't even talk to them on the phone like I was so upset about everything (p24). It wasn't very helpful actually (p13), I don't think

the woman understood, I think she was probably cross. She just wasn't very helpful. Maybe she thought it was a non -issue (p14). I sometimes feel guilty talking to counsellors because I'm like, well, maybe they can't have children (p 15). (I did go and see my doctor but) I was a bit on edge … this is a really horrible thing to go and ask or talk about … I just didn't feel comfortable talking to her…. she offered me tablets. She said, do you want to get on an antidepressant? (I said yes) (p25). (When I went to see a different doctor she was) so nice.. (she) could understand and she took the time to listen to me and she was like, this isn't your fault, like this is just how you feel, like don't beat yourself up about it. She was just so nice and understanding. I was so grateful (p27).

Hope

I still haven't ruled it out in my mind having another baby (p41) (but) I couldn't risk having another child naturally, I'd have to go to Cyprus (where I can have PGT IVF to have a girl) and that's like crazy (p4), (but) at least then I could say I'd tried everything (p41). Sometimes he throws in the odd, oh, maybe we could have another (p54) it's just a little glimmer of hope isn't it (p 56)? It's just hope, hope, that my husband will one day change his mind (p81). I've joked with (my husband). I'm definitely joking. I hope. I'm gonna leave and go to the sperm bank, get IVF (p52).

It's quite scary

I'm in a better place than I was back then (p1). I would not have been able to talk about it quite like I do now (p11). (But) I don't think there's any way that I could get over it as such. I just think I have to learn to live with it , (but) it's quite scary to give up the thought of having a daughter, petrifying, yeah, because that's part of me (p43).

Reflexive Pause: The Plot

Georgie's story suggests a sense that the sex of her children should be in her control; she has always achieved her goals, but as she comes to realise she does not have that control, her journey unfolds into one of almost bargaining. Bargaining to find help, barging to try and conceive a daughter, and through the bargaining, a sense of isolation, ostracisation, guilt and grief unfolds. The sense I had when walking with Georgie was that she felt stuck; she was not

in a place where giving up hope for her imagined child was a remote possibility, despite the torturous place she found herself in, and she did not know what to do. Georgie spoke about a positive experience with her doctor when she sought help; not only was this unusual amongst the mothers, but I felt so pleased for Georgie because I understood from my own lived experience how much this would have meant to her. Georgie did not feel ready to accept that she may never have a daughter. It was hard to walk beside someone in so much distress and not be able to help her.

Second Listening - I Poems

Reflecting on Georgie's interview and my reflexive notes, I left the interview with Georgie feeling that she was incredibly stuck. She did not seem stuck still in a suspension, but stuck in a tangled tussle of layered emotion, wanting, desire, need, confusion, silencing and an inability to want to move forward despite the pain she was experiencing being so great she had taken medication. At the point of our interview, it was like she didn't want to be in the place where she found herself, but nor could she leave or would even entertain the possibility of leaving, as this would require her to let go of the hope for her imagined daughter, and that would be too painful. The tussle of love and logic that Georgie found herself trying to survive was tangible throughout the interview, but the below section of the transcript struck me as it seemed to highlight the multidimensional tussle of the maternal 'GD' experience that Georgie was navigating.

I gave birth
I used to have panic attacks
I'd had a scan
I thought they were
I can't not have another baby because this person is real
I get like a grief
I feel like that's numb
I don't know

Reflexive Pause: I Poem

The opening of the poem signifies when the maternal 'GD' experience possibly began to come alive for Georgie. This is followed by a vivid illumination of how anxiety has been interwoven with Georgie's experience in the form of "panic attacks". Georgie seems to be searching to understand the panic attacks and where they came from, because maybe, if she can understand what she is experiencing, then the anxiety may vanish?

For Georgie, her daughter is real this therefore makes the decision not to have another child as unimaginable. Georgie gives us an insight into what she may be feeling when she lets herself believe that she won't have any more children; it feels like a death, and she experiences "grief". However, the use of the word "like" suggests it is not a socially conforming grief, but "like" the grief that society accepts. This implied disenfranchisement grief appears to be compounded by a layer of numbness, direction and possibly purpose in life.

"I don't know" suggests a loss; the potential loss of her imaged daughter, the loss of her knowledge and a loss of autonomy in a highly personal, deeply impactful, multi-dimensional and uniquely complex and layered experience. The notion that the person experiencing this phenomenon is stuck in a tussle of love and logic, which they do not understand, demonstrates the complex seen and unseen layered nuances of the maternal 'GD' experience.

Third listening – Contrapuntal Voices

Georgie appeared neither willing nor able to relinquish her hopes for her long-imagined daughter; thus, she was stuck, unable to live in the moment or move forward. Her need to hold onto her dream of a daughter appeared to be so strong that she had accepted medication enabling her to stay in a place where she could avoid her distressing maternal 'GD' emotions or, ultimately, find peace in her reality.

The most resonant voice I identified with in Georgie's story was the dream of her imagined future. Within the voice of the dream, there appeared to be two voices which were at opposition with each other. I have called them the voice of logic and the voice of love. The voice of logic represents Georgie's known reality and the voice of love talks to Georgie's long-imagined daughter which appeared to keep her stuck in the grips of maternal 'GD'.

Voice of logic

Voice of love
(my words to aid flow)

this person that I've made in my head, *this female is real to me (p4).* **I can't not have another baby** *because this person is real (p4) there's something in there that makes it real to me (p39). I just feel like, it's just someone that's missing, that's all* **(p43), it's quite scary to give up the thought of having a daughter, petrifying,** *yeah, because that's part of me (p43),* **someone that existed in my mind and isn't going to exist now, and I really find that difficult (p51).** *I feel like this is what I was meant to do (p 60)* **the thought of not having a daughter is still scary to me (p62).** *My daughter (p68), if my daughter was anything like me (p68)… she's still very much alive* **in my mind (p81).** *That person is alive. (p86).* **(But) logically, this person doesn't exist (p86),** *she's in my heart.* **Maybe that makes it even harder (p86).**

Reflexive Pause: Contrapuntal Voices

Georgie's voice of logic and love holds a tension; they seem to create a narrative of contradictions and tussling. Georgie knows she hasn't birthed a daughter and her existence is within her mind, but that doesn't stop the voice of love from signalling how real her daughter is to her despite the reality. The voice of love talks about a person that is "missing", but the voice of logic attempts to rationalise either side of that statement by downplaying the loss with " it's just" and "that's all". If a child had gone missing, the voice of logic would not be downplaying that situation but would be acting in harmony with the voice of love. But what I see is an attempt by the voice of logic to rationalise the loss. As the voice of love is starting to feel silenced it begins to talk about Georgie's long-imagined daughter as "my daughter…like me", there seems to be a new element of possession over her imagined daughter, maybe in an attempt to show the voice of logic, that despite not being physically here, she belongs in Georgie's heart. But the voice of logic comes swiftly in to remind Georgie that her daughter is "in my mind". There is then a swap in the order in which the two voices speak, and as at the start of the interview, the voice of logic speaks up first, perhaps in an attempt to be heard the loudest, but the voice of love insists on ensuring that the voice of logic knows that she is alive "in my heart". The tug of war between these two voices makes Georgie's emotional journey with maternal 'GD' "even harder".

The tension between the two voices is vivid at times, as if they are in a heated competition to be heard the first and loudest, one trying to shut down the other and validate their perspective. This discord pivots around Georgie giving up the dream of a daughter and this creates further layers of emotion. Georgie seems confused; “there is something in there that makes it real to me” but she seems unable to articulate what that “something” is. But Georgie can’t seem to accept the voice of logic, which then creates confusion. There seems to be a lack of clarity for Georgie between which voice is ‘right’, that of logic or love. Thus, Georgie seems unable to align her actions and thoughts with one of the voices and so is stuck, unable to make a decision. Being stuck in this tug-of-war between logic and love adds an emotional layer of fear that “someone is missing” is “petrifying” for Georgie. The fear of letting go of her imagined daughter seems to create even more fear than being stuck in the place of emotional distress that is her current reality.

The voices of love and logic are both talking about the dream, and this made me curious to explore what the voice of the dream meant to Georgie, thus making the voice of love loud and insistent, despite her knowledge that it wasn’t her reality, as pointed out by the voice of logic. If the absence of the dream leads Georgie to a place of anguish, pain and fear then the dream may offer inclusivity, fulfilment and contentment. Yet the voice of the dream is that; a dream. It is not her reality, so perhaps indulging in the voice of love offers Georgie temporary relief from her distress. Georgie appears stuck in the voice of the dream which is perpetuated by the voice of love, despite the efforts of the voice of logic to keep her in her reality. Although it can not be ascertained from the voices of logic and love what the dream means to Georgie specifically, we do not need to know to understand the level of anguish being endured. The voice of logic and love illustrates an ongoing and intense emotional tug of war that creates layers of further emotion that seem to create a compounding cycle of confusion, grief, anxiety and sadness.

6.5 Ottillie's Story

First listening: The Plot

We'd do everything together

I've always known I actually only wanted girls. I didn't want boys at all (p7); I felt a very strong connection to wanting girls (p7), (and) I know exactly where it came from. So basically, my mum died when I was little (p10). So, I think I felt very alone (p11); I didn't get to have any of the mother-daughter stuff that you get growing up And I just wanted that, I think. Like, I'm never going to get her back, and I just wanted that (p11). I just wanted girls so I could have what I didn't have (p11). I just imagine this ridiculously close bond (with a daughter) (p11), and I always imagined, like, I'd have daughters, and they'd be my best friends, and we'd do everything together (p11). I just imagined going through life together and being there for each other and doing their hair, and I don't know. It's a bit fantasy for me because I didn't have it (p12). You hear all these horrible things about the mother-in-law getting pushed out. And I've got it in my head (too) (p13) (and) boys, they just want to be outside and just playing, exploring (p13).

Preparing myself

I was very much preparing myself for the eventuality that I've ended up with (boys) (p3). I've always felt that if I didn't have a girl I knew it was going to be really, really hard for me (p3) (so) I needed to know (the sex during pregnancy) I think I was preparing myself because I was like, if he is a boy, I needed that time because I didn't want to give birth and then be sad ... I was really scared (p4).

It's not a disappointment

I don't think I'm disappointed with them at all … I don't think I could love a girl anymore than I would love them (p15). I couldn't imagine anything better than them as individuals (p16). It's not a disappointment. That's something quite minimal to me… it's very much worse (p14). I don't really feel like you can control it (p15). I definitely think it's more towards the future that I worry about (p24), (and) I imagine it will always sit with me (p27).

I felt complete anxiety

I had complete insomnia, and I was crying every day and I felt really, really low (p6). I couldn't sleep I didn't eat very well. I just, I felt complete anxiety, like really, really stressed, like very, like almost like shaky in my body at times. When I got pregnant with Ed, that was when I was really struggling because I knew that was my (last chance because) we only wanted three kids (p7). I was so scared that if I don't have the girl, I wasn't sure if I was going to be all right. And I worried about how my mental health would be, I worried (p15). You kind of are made to feel like you're being a bit ridiculous because you've got healthy children and you should just be happy (p15).

I just fear judgment

(It's) something I find really hard to talk about with other people … I just fear judgment (p6). My husband, he understands my point of view, but even he's like, he doesn't feel it the same way (p18). I think maybe some therapy might have helped – just someone else to talk it through because it is a safe space, and you know you don't you don't go in there feeling like you're going to be judged (p17). It was nice knowing that there's someone there, (The GD psychologist, Dr Lindsay McMillan) really understands what on earth I'm going to be going through if I was struggling (p5).

You're being silly

I wouldn't have felt able to like go to my doctor or anything … I just thought they would be like, you're being silly (p6). The sonographer, you know, I mean, I didn't release my emotions in front of her with Ed, but it was so hard to contain (p39). People think you're just being a bit silly (p6), (and) you don't want to be told that your feelings aren't valid effectively (p18).

I'm not going to allow myself to spiral

There's a lot of mental health in my family … and I've always been very conscious that if it's in your family, you're more likely to get it (p22). You know, my mum died when I was 15, my dad tried to kill himself. We've lost our homes before and been homeless. My dad did die a

couple of years ago, so I'm quite young to have lost both my parents. And there's been a lot of things, and when I look back I'm like, I was my dad's carer for a while because he got hit by a car and was nearly paralysed. I've been through a lot, and at the time it almost doesn't seem as bad… you just get on with it (p25). I just kind of almost, like, not literally, but slapped myself around the face. I was like, this is what I've got; I don't want any more children. I don't think I could cope with any more children physically or financially. So, I just kind of almost like shook myself and was like, you're going to have to get on with it and accept it and make the best of it (p22). I was like I'm not going to allow myself to spiral and then not be there for the children that I do have. And it is very much a constant reminding myself that just because they're boys, doesn't mean they'll leave me when they're older. Just because they're boys, doesn't mean we can't be close and things like that (p23). I'm either gonna fall into the abyss or I need to buckle up and do something about it (p23). Daily, it's a conscious choice to not dwell on it and just enjoy the kids (p25). I very consciously talk to them about, like their feelings, and their emotions (p34). I can change my perception of what a relationship could be with the children in the future (p24).

Reflexive Pause: The Plot

Ottillie's journey was humbling; she had faced so much in her life but faced it with an inner strength, a strength that I am not sure that I would find time over like she did. I wanted to tell her that I thought she was an incredible woman, with such silent strength and kindness, and so I did.

It struck me that she had been through so much and come out the other side, but her maternal 'GD' was causing her to stumble and struggle in a different way. It seemed that maternal 'GD'; was an experience she perceived society to diminish and something she felt shameful for feeling, yet it was causing her so much distress. I wondered if it was the layer of disenfranchisement that appears to accompany the maternal 'GD' experience that was creating an additional level of complexity for Ottillie to navigate. It also made me question the depth of what having a daughter meant to Ottillie for it to be as impactful as it was for her given all that she had previously navigated. I wondered how much a daughter was intertwined with her sense of identity and purpose, her core sense of self and something fundamental about who she was. What it did tell me is that this phenomenon is not a mere 'disappointment'.

Second Listening – I Poems

Accordingly, for Ottilie's I Poem the multidimensional and layered distress that she experienced because of her maternal 'GD' experience stood out as the appropriate focus for her I Poem.

I find really hard to talk about
I don't know
I just fear judgment
I do find it hard to talk
I just
I feel like unless people are talking
I think people think
I wouldn't have ever thought, to go to, like ask a doctor
I was feeling really low
I went through a whole period
I couldn't
I had complete insomnia
I was crying every day
I felt really really low

Reflexive Pause: I Poem

Ottillie's I Poem starts with fear, a fear so significant it silences Ottillie. She is afraid to talk about her maternal 'GD' experience for fear of judgement despite the distress being so great. Ottillie's fear of judgement may stem from the socially perceived abhorrence that a mother of healthy children may hold a sex preference for a child; thus, vocalising this may lead Ottillie to be rejected by society which may impact her sense of self-worth, especially in relation to her mothering journey. Moreover, it highlights a link between fear and vulnerability. To overcome her fears, Ottillie would need to talk about her maternal 'GD' experience; however, this could create a sense of shame. However, Ottillie felt that she could not even allow herself to be vulnerable even in front of her doctor, despite the significant distress she was experiencing.

As a reader of Ottillie's I Poem, her avoidance of seeking help due to her fear of judgement is a concern to me as it has the potential to exacerbate her experience that is already preventing help-seeking. Without the support that a healthcare professional could offer, the intensity of the experience may increase for Ottillie, instigating further withdrawal, compounding an already-held sense of isolation and shame. The layering and compounding effects of the maternal 'GD' experience can clearly be seen in Ottillie's I Poem in.

Third listening – Contrapuntal voices

Ottillie's story appears to be one of a mother who seems to have moved through the 'rawness' of the maternal 'GD' experience. Even during the interview, I was struck by the forward-focused, progressive way Ottillie talked about and described her journey. When I first began to analyse Ottillie's contrapuntal voices, I knew this was a unique aspect of her journey, and so I sought voices that spoke to this in an attempt to identify the layers and tensions within. I initially heard what I called the voices of "I need to do something", and "worries about mental health". Yet, the more I immersed myself in Ottillie's transcript, the more I came to ask, "what is it about these two voices that is striking? What are they representing?" Thus, I sought the voices of vulnerability and resilience.

Voice of vulnerability
Voice of resilience
(my words to aid flow)

I need to be prepared because *there's...there's a lot of mental health issues in my family (p3), And I've always been very conscious that if it's in your family, you're more likely to get it (p22)* **I just kind of almost like, not literally, but slapped myself around the face (p22) you're going to have to get on with it and accept it and make the best of it (p22). I was like I'm not going to allow myself to spiral and** *then not be there for the children that I do have (p23),* **it is very much a constant reminding myself (p23) that** *you have to* (be conscious of your mental health vulnerabilities) *because otherwise I could just fall down this like hill where I keep getting more and more sad (p23).* **I was like, right, I've just got to, I've got to move forward now (p24). I can change my perception of what a relationship could be with the children in the future (p24). I put lots of energy into really spending time with them (p24)**

focusing on what I do have (p 24). Daily, it's a conscious choice to not dwell on it and just enjoy the kids (p25), you pick up and you move on because what's the other option (p 26)? *Everybody around me in my family has some kind of struggle with mental health, and I just didn't want that (p30).* **I can't let that be me (p30),** *if I let myself go down, then that's their childhood (gone) (p30).* **It was almost like a mantra that you tell yourself (p32).** *I am very aware that I could, if I let it open fully and submit to it, I know where it can lead into depression (p33).* **(So) I'm just making a conscious effort (p35).**

Reflexive Pause: Contrapuntal Voices

Throughout, Ottillie's voices of vulnerability and resilience are intertwined on a courageous journey attempting to banish her maternal 'GD' distress. The voice of resilience was often loud and purposeful, yet it did not entirely calm the voice of vulnerability and the fear it spoke about. Instead, the voices coexisted in a tension where the voice of resilience constantly strives for agency but remains haunted by the quieter, but persistent, voice of emotional vulnerability and fear. This intertwining of the voices of vulnerability and resilience can be seen when the voice of vulnerability talks of feared mental health problems that may arise if her maternal 'GD' remains unaddressed. This spurs the voice of resilience into conscious and deliberate decision-making, actively reframing and working to influence her future.

The voice of resilience sometimes spoke in brutal ways with metaphors of slapping. This prompted me to question the societal and familial expectations placed upon mothers to perform strength at all costs, prizing maternal sacrifice, especially when facing distress related to mothering. Something that I too experienced when on my own maternal 'GD' journey and preventing me from seeking the help that I knew I needed and wanted.

The reflection of possible wider social discomfort alongside psychological suffering, particularly for mothers, highlights how the interplay of Ottillie's two voices wants to both support her to move forward but at the suppression of genuine emotional expression, possibly creating layers of shame and isolation. Ottillie's emotional labour appears psychosocially layered: to cope with her fears, to conceal her vulnerabilities and to deal with them herself.

6.6 Nora's story

First listening: The Plot

Make sure they're not a chauvinist pig

I didn't think I wanted children (p19), (and if I did), I just assumed I'd have a boy and a girl (p19). It feels like as a mum of daughters, your role is just like, let them try everything, let them be themselves, let them, the world is their oyster. Empower them, go! And for the boys, it's like, make sure they're not a dick, make sure they're not a chauvinist pig, make sure that they know how to do all these things (p82).

What the fuck

People will constantly make comments about, about like, your desire for a certain sex or, you know, or haven't you got your hands full? (p30). I visited (my friend when she had) her second daughter when I already had both boys, she made like a joke about, I was like oh can I pick her up, she's like, "yeah, but don't steal her because I know you wanted a girl" (p30). (My other friend) said something like, "oh,I can't believe", like just joking, "oh I can't believe there's another penis inside you" (p69). We've got like a little small group of us at school and one of the mums she was like, "oh we should all go camping, oh I love having fun, let's camp, so we should all go camping" and I was like, "oh yeah, yeah" and then she went, oh but you've all got loads of boys and my daughter is gonna be really bored, so actually, maybe we won't do it and I was like "oh what the fuck just happened?" (p8).

She just didn't get it

I organised a phone call (for counselling through work) and just spoke to a lady who just didn't get it (p2). She was like, "well, I don't really understand what you're saying. Two boys is like, you know, the prize sort of thing", she just didn't get it (p22). I paid for extra counselling sessions and again I just still couldn't, there was still that kind of counsellor trying to find out for me what it was, and me just really not (p24) and because there's no reason because it's not like I could say, actually my, you know, my father was horrible to me when I was little or, or you know, I've only, I've grown up in a household and all I know is … like, none of that exists

(p44). But I just remember feeling very panicked during the counselling sessions, very panicked about would I say things that, that I got judged on (p42). I've never spoken to anyone about the gender disappointment apart from my friend really (p48). I'm just so scared of what they'll say or how they'll judge me (p84). My mum knows a bit about the gender disappointment, but she struggled to understand it … she tried to, but she, yeah, she couldn't (p46).

Termination

I got pregnant (unexpectedly after Luke) and then I was full of emotions of like actually not wanting three children … so then I explored termination … (we decided) if it's a girl then like... yeah, we shouldn't do it… and it was a boy … I went through with a termination which ..it's really hard… I didn't tell anybody until the morning before (when I phoned my mum) … I thought I was in time that you could use the tablets but you couldn't, I had to go for an operation my husband joined me at the hospital after I'd taken, (the tablets) and I remember him sort of going oh kind of, going kind of like, "oh I don't know (if we should), and I'm like, oh it's too late for this conversation" (p25). I had another unexpected pregnancy … I went to the scan and it had gone. it was like a miscarriage, and then I was just like heartbroken all over again because then I felt, I went through a big spiral of feeling like I'd basically been punished. And I just couldn't. I just couldn't cope (p26).

I'm grieving a loss

I remember finding out at the scan that it was a boy (with Luke) and just being absolutely heartbroken (p21). I was feeling really upset and trying not to cry and then just sobbing my heart out and just really, really struggling (p21). (I didn't know) how to process it and then just being, feeling very disconnected (p2). I just really wanted that relationship (like I had with my mum) (p22). I'm not like disappointed with their gender, it's more that I'm grieving a loss of a projected future (p39). They're still real to us in our mind (unborn daughters) (p34). I feel quite ashamed (p35) (and) I feel guilty, (p38) for my daughter preference (p38). Gender disappointment is an unhelpful term because it makes you feel like you're a shitty parent, it makes you feel that you're not blessed to have a healthy children (p39). It feels like it lands heavily on the children, and I don't think that's fair (p40). Because they're two boys, I feel like I've got something to prove (p60).

I was in a tunnel

In reflection, would I have been depressed but just not have called it depression? Yeah (p42). I felt, like I was in a tunnel experiencing all these emotions all the time, and (my husband) was at the other side, and he just couldn't understand why I was still in the tunnel (p47). My confidence has been shattered (p28), (and I wonder), will I ever essentially fully be fixed without (a daughter)? (p14). I absolutely love (my sons) to bits, but I'm still really sad (p23).

I want to move on

I can talk about it now, whereas before I literally couldn't talk without sobbing. I just couldn't move past it (p64). I've built my own defence mechanisms (p49). I want to move on (p66), I wanna make sure I'm interested in the things that interest them (p76).

Reflexive Pause: The Plot

What struck me about Nora's experience was that it starts with her not knowing if she wants children and evolves into an assumption about the sex of the children she would have. Her perception of boys, lead her to believe being a mum to only boys would be shrouded in negativity. Nora's experiences of being a mum to boys, compounded by her longing for a daughter, were so great that she chose to terminate her third pregnancy when she discovered it was another boy. This termination, followed by a miscarriage, appears to lead to intense feelings of shame and confusion for Nora. Nora did attempt to seek help for her distress but found this a challenging experience; however, she was now in a place where she could talk about her journey, which may be the first steps to hopefully moving out of the depths of the maternal 'GD' experience because it may help to reduce some of the layers of perceived isolation and shame.

Second listening - I Poems

Nora's experience of maternal 'GD' was unique in that she didn't know if she wanted children when she was growing up. Therefore, her sex preference and the depths of that preference shocked her. When Nora's second son was still a toddler, she found herself unexpectedly

pregnant. Upon discovering it was another boy, she and her husband decided to have a termination. A short time later Nora was unexpectedly pregnant again:

I had another unexpected pregnancy
I was like
I'm gonna
I'm gonna
I feel
I've told one friend
I was talking to him
I was like
I don't
I can't do it
I can't do a termination again
I can't do it
I'm gonna
I went to the scan and it had gone
It had gone

Reflexive Pause: I Poem

The familiar maternal 'GD' tug of war between love and logic appears in Nora's I Poem. It seems that this tussle instigated Nora to reach out for support and perhaps perspective too, interestingly, to a male friend. The poem highlights with firm clarity that she "can't" terminate again, but she then she concedes that "I'm gonna" terminate before the decision is taken from her hands as "it had gone".

Nora's I Poem creates the image of a mother who is stuck. Her heart may be acting in the hope that if she terminates a male pregnancy, the chance for her imagined daughter would remain. The confusion and desperation are tangible in Nora's I Poem and highlighted the confusion and sense of uncertainty, creating possible compounding layers of loneliness, guilt and shame.

Third listening – Contrapuntal Voices

Nora's voice, which was seeking support, was resounding during the interview and remained just as loud and poignant when I immersed myself in the transcript. In her quest for support, I identified two voices: the voice of seeking and the voice of fear. These voices are alive in Nora's search for both social support and professional support. The voice of fear appeared to work to protect the voice of seeking, which appeared vulnerable at times.

Voice of seeking
Voice of fear
(my words to aid flow)

*It would really help me to kind of hear, like (from you, the researcher), even if it's like a two-minute snapshot of kind of what you went through (p1).***I find myself subconsciously wondering if I can be better friends with someone if they've got only boys (p15)** *When I was really going through it, I would go on the forums, like search for gender forums dedicated to it (p8). (I had) some counselling (p10), (some) free counselling service through work. Yeah, I organised a phone call and just spoke to a lady* **who just didn't get it (p21)** *So I paid for extra counselling sessions,* **and again I just still couldn't; there was still that kind of counsellor trying to find out for me what it was, and me just really not (p24). (I was) feeling very panicked during the council sessions, very panicked about would I say things that, that I got judged on (p43) I didn't know how to do that. And I didn't want her, I thought she might call some council hotline and send me to prison, I thought she might take the children off me. I didn't know if it's okay to have a termination if I knew what the sex was like. I didn't know these things and I was so panicked and I was so scared.** *I told her and it was obviously okay* (p43). *My mum knows a bit about the gender disappointment (p46), I'm really close to her (p93)* **but she struggled to understand it (p 46) (and) won't tell her everything (p93) I don't think people are very open about it (p70).**

Reflexive Pause: Contrapuntal Voices

Although I identified Nora's voice of fear as loud, it did not stop her voice of seeking searching for support. It appeared that the voice of fear was upheld by layers of feared judgement, isolation and questioning the validity of her experience. Nora described how these layers led her to question her judgements and decisions about who she felt safe to seek social support from.

Nora's voice of seeking propelled her to seek support from a counsellor. In doing so the voice of seeking overrode the voice of fear. However, after finding a councillor, Nora's voice of fear began to rise again, but Nora's need for support was so great that her voice of seeking was triumphant in the end.

The conflict between the two voices in professional help-seeking highlights a perceived lack of professional understanding of maternal "GD," which negatively impacts Nora's sense of well-being and her help-seeking behaviour. The term "disappointment" perpetuates a misconception of disappointment in the children that have been birthed and may insinuate potential danger being caused by the mother to her birthed children, and perhaps this is what Nora fears. Reflecting on my own experience and that of the mothers who I have worked with, Nora is not alone in this fear. Moreover, this fear is strengthened by the taboo, shame, and lack of information about maternal "GD." But Nora's persistence in seeking support indicates how much she knew she needed help and at her inner strength in pursuing help even when it felt scary. When Nora's voice of fear is at its strongest, it seems to hinder her ability to seek wider social and professional support, which creates layers of isolation, fear, and judgement for Nora.

6.7 Kate's story

First listening: The Plot

I'd suddenly found my purpose

I knew I always wanted to be a mum, and then they (my boys) were born, and it was like I'd suddenly found my purpose in life (p25), but I was always quite honest about the fact that I always envisaged having a daughter and wanting a daughter … we ended up pregnant (again) and Robert died (in utero). We found out just before he died that he was actually a boy (p7). So, I am mum to three boys, two of which are here and no daughter (p7).

A son's yours until he's got a wife

(I get) worried about, you know, what does the future look like if I'm just a mum to boys? (p9) (Because) a daughter is your daughter for life, and a son is yours until he's got a wife … that is always just like, wiring away in the background (p25) (and I see) girls are all off to ballet classes and doing dance shows and, you know, crafting…. and (my boys are) really busy, and they're really typical sort of busy boys who love fighting and shooting and, you know, getting filthy (p1). Some days I find it easier to be like, everybody's just the same, and then other days it's glaringly obvious that we're not all the same. And then you feel almost tricked (p32); it frustrates me that the gender divide is there (p19).

Grieving the loss of a daughter

'GD' is a forbidden taboo (p30). (It has) felt like a roller coaster (p22), it felt at one point almost pathological (p23). It's been so hard that I couldn't even look at baby clothes in the supermarket of the opposite gender because that wasn't an experience that I was allowed to have (p17); there's always that like where's my little girl? (p8) I am kind of grieving the loss of a daughter and the opportunity for a daughter but I'm grieving my son who died as well and so I think there was also even more guilt from that side of things, like, did I feel almost less sad that I lost him because he was another boy versus if he'd been my chance of a daughter, you know, and trying to reconcile that has been very hard (p22).

That's horrifying

There is that sense of like, guilt or shame on (p7), how can I feel almost guilty or ungrateful for what I do have? (p7) My baby's here. I just grew a person. They're perfect, and they're fine, and it's amazing. But why do I feel disappointed? That's horrifying. It's a horrible feeling to have (p22). Those feelings of feeling guilty about it or wishing for something different. It's hard (p10), (and) I don't want to feel jealous of people, but I do (p42). It's made me feel very low at times (p41).

I felt like she'd stolen my life

(A friend had a little girl and) I felt like she'd stolen my life; why have you got what I'm supposed to have? Feeling like that towards people, it's horrible. I'm not like that as a person and I don't ever want to sort of feel ill about anybody. But it's really hard. And I couldn't see some of my friends for a while (p42). (The world of being a girl mum) definitely felt very forbidden (p19). (When my friend was having a daughter) I remember just going upstairs and like lying on my bedroom floor, just crying, why aren't there any boy mums? (p42). My entire life I've always been like a goal attainer (p32), but I can't excel at being a girl mum, and that is intensely frustrating (p33); that route is not available to me now, mainly because of my husband. It's really irritating that he's standing in the way of my future happiness (p34).

It's not a disappointment in them being boys

There's always so much from people, aren't they, like, two boys, you've got your hands full, and like, are you going to try again for a girl? (p13) (It's like they think that) I am disappointed in my sons (but) I feel like it's not a disappointment in them being boys. It's like a disappointment in the absence of something. Which I think is hard to communicate to people sometimes (p8). I've struggled for acknowledgement from (my husband) about how it's how important it feels to me, there's just been a lot of like well you should just be happy (p28). I don't ever want the boys to feel like I want them to be something different or that they're not wanted as they are, which I think is why I sort of really try to go over the top being a good boy mum (p3).

Am I normal?

I felt quite unsupported sometimes emotionally. I didn't really feel safe through some of what we've been through (p46). (So) I sought help from (The 'GD' Psychologist who) could just validate it in a way that somebody hadn't before; it felt like a really safe space, you know, there was no judgement. I could just say, hey, this feels really difficult for me. Am I normal? It was really reassuring and actually was sort of quite freeing for those feelings because I didn't have to feel ashamed of them (p30). (Sharing my feelings helped to) stop the spread of like shame and fear and guilt about it (p48).

I'm sort of evolving

So, I even have a letter that I wrote to my daughter who wasn't born. Just as a way to try and get some feelings on paper (p5). If I do let myself think about the fact (having a daughter) won't happen, then that's just not a very nice place to be, I don't want more grief (p39). (With my boys, I'm) trying to be as nurturing as I can with them and sort of build that really special relationship with them (p14). I want my boys to be in touch with their emotions and things because my husband really isn't (p15). I have a very open narrative with both of them, and you know I hope that I'm setting them up for sort of good emotional management when they're older (p26). I'm trying to put a positive spin on things instead, just so I'm not dwelling in that endless negative cycle (p23). I am trying to live gratefully now, I recognise that I'm sort of evolving (p41).

Reflexive Pause: The Plot

Kate's maternal 'GD' experience is intertwined with the loss of her third son. Her grief for Robert appears to be complicated by her infant sex preference. The absence of a daughter leaves Kate with a sense that she will be missing out on bonding experiences, but also appears to impact the relationship with her husband. Kate feels somewhat unsupported by her husband, and this appears to be compounded by a frustration that it was he who caused her maternal 'GD' in not producing a daughter. The way in which Kate is trying to find a way forward suggests that her goal-orientated approach may be enabling her to move forward out of the experience while at times, creating further layers of distress.

Second Listening - I Poem

The section of text that felt poignant for Kate was when she described her terror at not knowing what to do with a boy, something I had not heard from the other participants. Thus, I was keen to explore what was happening around this statement.

I'm a very girly girl
I'm very close to my mum
I was like
I really want to be able to replicate that
I think
I had boy cousins
I mean
I'm instinctively not like that... shouty and flighty and loud
I was really terrified when the boys came along
I was like
What do I do with a boy?
I always had
I was always much more comfortable in female company

Reflexive Pause: I Poem

Her use of "I mean" and "I think" while attempting to exert autonomy in rationalising her experience indicated how the maternal 'GD' experience may create a sense of uncertainly in one's own knowledge, which could create layers of self-doubt, loss of control and isolation, compounding an already confusing experience.

In trying to understand her maternal 'GD' experience, Kate appeared to be grappling with a fear of having boys. Kate is afraid that she will not know what to do with a boy as she does not associate with 'boy behaviour', compounded by her feelings that she is a 'girly girl'. The use of her word 'terrified' conveys a sense of overwhelming fear that is both emotional and embodied. This fear not only shapes her immediate emotional response, but it also has the potential to influence her future decision-making and action-taking.

Kate's I Poem shows how she attempted to use her autonomy to rationalise and understand her experience. In being able to validate and better understand her experience, perhaps Kate is more able to cope with her feelings of loneliness, isolation and shame. I wondered whether, if more information and support strategies around maternal 'GD' were available to mothers, if Kate's experience might have been different. Would she still be facing maternal 'GD' with the same level of distress?

Third listening – Contrapuntal Voices

As I searched for Kate's contrapuntal voices, I initially heard her voice of distress. Distress has been used as an umbrella term to describe a combination of emotions associated with psychological discomfort (Ridner, 2004), so I worked with the transcript to highlight all utterances or implied experiences of distress. Upon extracting the voices of distress and analysing them more closely, two distinct voices were identified. These were the voice of should and the voice of anxiety. Feelings of 'should' can lead to distress by creating internal conflict when individuals struggle to align with societal expectations (Brandt et al., 2022) with anxiety rising from the distress.

The voices of distress:
Voice of should
Voice of anxiety
(my words to aid flow)

There is that sense of like guilt or shame (p13) (but) *how can I feel almost ungrateful for what I do have* (my boys)*? (p13)* (There is this) *feeling guilty about it or wishing for something different. It's hard (p15)* **I kind of just felt like the world had gone out of my control (p23)** (and) **it'd be better for my own sanity (if I knew sex of sister's child) (p23) maybe I can get prepared and I can process some of those feelings before he's here (p24).** *I definitely had guilt (over wanting a daughter when I had my boys) (p33) how can I feel disappointed? (p33) It's horrifying. It's a horrible feeling to have when you're meant to be in this sort of really happy bubble (p34),* **why do I feel disappointed? (p34)** (I worry) **a trigger would come along (p34)** (and I'd be) **dwelling in that endless negative cycle (p35).** (All the time thinking,) *you should just be happy (p42) how can you possibly want something else when you've already got so much (p46). Why isn't that enough, and it absolutely is enough, but you know (p46). Feeling*

like that towards people like that, It's horrible. ***I'm not like that as a person and I don't ever want to sort of feel ill about anybody.*** *But it's really hard (p63).* **(It) sounds absolutely crazy when you voice it out loud (that you have two healthy sons and feel so desperate to have a daughter) (p74). People are going to think that I'm a bit crazy (p75) (especially because it's a) taboo subject (p76). (My feelings and what to do is still) unresolved, but I don't know how to resolve it (p76).**

Reflexive Pause: Contrapuntal Voices

Kate's voice of should seemed to have led her to question the validity of her emotions, initiating a layer of discord between what she was feeling and what she perceived as the societally acceptable emotions of a mum to healthy children. This discord appeared to give rise to the voice of anxiety. The voice of anxiety talks in a forward-focused way, fearful and wary of what could happen if her maternal 'GD' emotions are triggered.

Kate's voice of "should" continued to question the legitimacy of her emotions, but it went further in its apparent reprimanding. It seemed that the intensity of her self-blame, shaped by her perceived expected behaviour, causes her to see "triggers" and leads her to an "endless negative cycle."

The voice of should was loud for Kate. It seems to constantly remind her if you are a 'good mother', "you should just be happy". Due to this discord in her internal emotions and perceived expected emotions, Kate seems to have been led to a place of cognitive dissonance; she did not perceive herself to be an ungrateful or unkind person, yet she felt this is what society was telling her she was, which give rise, once again, to her voice of anxiety. Kate appeared to be stuck, and could not move away from the voices of should and anxiety.

Kate's voice of 'should' appeared to be a trigger for her voice of anxiety. When 'negative' emotions arose, her voice of should reprimanded her and seemed to try and invalidate them, reminding her that they are not socially acceptable emotions of a mother. This appeared to give rise to the forward-facing worry instigated by the voice of anxiety.

6.8 Chapter Summary

This chapter has presented six in-depth case studies. Each case study presents the mothers' journeys in their own words, an I Poem, and the identification of two contrapuntal voices. Each case study presents the participant's layered journey. Chapter 8 will present the themes that were identified through an amalgamation of stage 4 of the LG with reflexive thematic analysis.

Chapter 7: Across the Mother's Stories

Findings: Thematic Analysis

This chapter presents stage 4 of the LG analysis, which was created by drawing together the data in stages 1 to 3 of the LG and conducting a systematic reflexive TA. This enabled a gazing across the mother's stories to identify themes throughout the data set. Accordingly, two overarching themes were identified: Broken and Hope, and each overarching theme had a series of subthemes In combination, this analysis enabled a layered and reflexive exploration of the journeys of the mothers in my study. The six women gave brave and vulnerable accounts of their maternal 'GD' experience, which led to the generation of rich data about their emotional experiences, losses, and hopes associated with the phenomenon.

Theme 1 - Broken **"Will I Never Essentially Be Fully Fixed?" (Nora)**
1:1 The "Ugly" Emotions and Feelings of Maternal 'GD' *1:1:1 "I felt like she'd stolen my life" (Kate): Resentment Towards Mothers of Daughters* *1:1:2 The Mental Loop of Rumination* *1:1:3 "I've Not Achieved Something" (Anna)* *1:1:4 "I'm Deprived of Something" (Kate)*
1:2 The Intensity *1:2:1 The Fear Beneath the Longing* *1:2:2 It's Taking Me Over*
1:3 Is This Even Disappointment? *1:3:1 Is This Disappointment?* *1:3:2 Is This More than Disappointment?* *1:3:3 Am I "Disappointed" With My Child?*
1:4 In It with My Husband, Or Because of Him *1:4:1 "He Probably Thinks It's Not as Big a Deal" (Otillie)* *1:4:2 "It's My Husband That's The Failure" (Gorgie)*

1:5 Layers of Loss

1:5:1 "That Little Cord Pinafore" (Nora)

1:5:2 "It's More About the Future" (Anna)

1:5:3 "This is Grief" (Georgie)

1:5:4 "I Shouldn't Feel Like That" (Alba)

Theme 2 - Hope

"These Are the Last Hours That I'll Still Have That Hope" (Georgie)

2:1 The Seed of Hope: Assumptions and Expectations

2:1:1 I'd Always Have a Daughter

2:1:2 "I've Always Been Able to Achieve" (Georgie)

2:1:3 "Well Next Time it Will be a Girl" (Anna)

2:2 Hope in Motion

2:2:1 The Chances are Going, the Hope Diminishes, and the Difficult Feelings Amplify.

2:2:2 The Obsession with Finding Another Way

2:2:3 "I'll Always Just be the Mother-in-Law." (Georgie)

2:3 The Heart of the Longing

2:3:1 The Obsession with a Longing-for Emotional Connection

2:3:2 Idealised Shared Experiences

2:4 Relinquishment of Hope: Confronting "The Line"

2:4:1 Number of Children and "The Line"

2:4:2 Role of the Husband and "The Line"

2:4:3 My Body as a Limit

2:4:4 The Hope That Lingers

2:5 Letting Go

2:5:1 When Hope Becomes Harmful

2:5:2 I Have the Power to Reframe This

2:5:3 Choosing to Accept

7.1 Theme 1 - Broken

When talking about their maternal 'GD' experience, the mothers described uncomfortable and challenging emotions. The mothers described the intensity of their difficult emotions and how, in combination, this led the mothers to question if their lives were destined to be "crap."

1:1 The "Ugly" Emotions and Feelings of Maternal 'GD'

The mothers in my study experienced raw emotions and difficult feelings because of their maternal 'GD' experience. These included resentment, anger, jealousy, rumination and a sense of injustice. These "ugly" emotions are rarely voiced by mothers, but my participants experienced them deeply.

1:1:1 "I felt like she'd stolen my life" (Kate): Resentment Towards Mothers of Daughters

Anna described how her resentment was focused towards her friends, as they had all birthed daughters and she had not. Anna's resentment manifested itself in anger, which led her to write down a list of her friend's names to validate her resentment. However, she was repulsed by her actions:

> *"Every single one of my friends has a girl … I remember even writing down a list of all the people I knew who had girls and then, like the two people I knew who had boys. And I was just like, bloody hell, this feels really fucking ugly." (p29, Anna)*

For Georgie, her resentment at not having a daughter was experienced as anger as well as condemnation towards people who would offer input about the sex of her unborn baby, even when she actively asked for input:

> *I was like telling my friends, oh, it's another boy and they'd say, oh you don't know that, I think it's going to be a girl, and like all these people are like putting their opinion in it and they really wound me up to be honest. I was like, you don't have a clue, at least I've a nub picture, I was like, it absolutely does (work) if you've got a good picture of the nub. Mine wasn't the best picture of the nub but, I actually thought it was a girl when I did it, so I paid*

someone online to do it and they thought it was a boy. And I was like, you're wrong. They weren't wrong, obviously. But yeah, people putting their opinions in , like, don't try and tell me it's a girl when you have absolutely no idea what it is. And maybe they were trying to be helpful. I don't know. But it really, I just didn't want to know. I didn't. (p .35, Georgie)

All the mothers described receiving comments from friends, family and strangers about their assumed longing for a daughter. Alba explained how a seemingly innocent and often common question about her desire for a certain sex child could give rise to her resentment and incite deep levels of defensiveness:

people would say oh, did you want a girl? And because they're (my eldest two sons are) the closest in age, people would be like, oh, did you have a third because you wanted a girl and then you've got a boy? And I'm like, well, even if I did, what's it got to do with you? And think about it, if I did, and then you're saying that to me and I'm having a boy, do you think that's very helpful? (p20, Alba)

Anna described how her resentment was experienced as jealousy because she felt forbidden from being part of a social group of mothers who had daughters, a group she wanted to be part of:

I feel like I am not part of a gang that I want to be part of (p55, Anna)

Georgie explained how her jealousy was accompanied by frustration and injustice because her friend wanted a daughter, and she got that while Georgie did not:

And then my other friend, she's got two girls, and she wanted a girl both times, and we were pregnant at exactly the same time with my eldest and my middle, and she was getting what she wanted, and then I didn't" (Georgie, p47)

Kate explained how her resentment was so intense it led her to experience envy, displacement and lack of control over her own life:

I felt like she'd stolen my life. I was like, why have you got what I'm supposed to have? (p41, Kate)

Kate explained how her resentment impacted her action-taking. She was unable to see some of her friends as she could not bear to be near them. However, like Georgie, she did not condone her behaviour. Rather she "hated" herself for feeling and acting like she did:

I couldn't see some of my friends for a while. Because mainly, I think some of it was because they had a tiny newborn and I didn't have my newborn. But also, like, they've got my life. You know, and I'd never wish what happened to me to happen to anybody (termination and miscarriage), but I want what they have (a daughter) and that I hate, it's jealousy and I hate that. I hate, I don't want to feel jealous of people, but I do. And I think it's a really ugly emotion. I think. And then that's hard to navigate. Yeah, yeah cause I, you know, I don't, I try and live my life to be sort of kind and compassionate. And my job is all about having empathy for people. And it goes against all of that to sort of be so actively jealous of somebody that you can't even be in the room with them (p41, Kate)

Like Kate, Nora experienced uncomfortable self-reflection around her resentment of other mothers who had daughters. The use of "irrational" as a way to describe her experience is interesting, as it suggests that there was an alternative and rational response to the experience of maternal 'GD' but one she had no access to or knowledge of:

Well, not anger (when someone tells me they are having a girl), it's like, it's just like, massive jealousy. It's like a huge form of jealousy and being like, well, of course you got what you wanted, kind of an irrational thought process (p47, Nora)

The intense hostility from the others in my study towards 'girl mums' was also described by Anna. Anna experienced a fluidity between immediate anger, and a repeated sense of injustice that led to her deep-seated resentment and hostility. This intensity can be seen in Anna's use of swear words towards other mothers:

she's had another girl, and it's moments like that, I'm like how the hell did she get another girl? Like I get this immediate reaction of like, for fuck sake, how have you got another girl? (p20, Anna)

Nora repeatedly questioned how it was possible for other women to be mums of girls when she could not, yet it was something she so deeply desired. The intense frustration that Nora felt is seen in her repeated questioning:

like how did you do that? how did you do that? how did you get one of each, how? how did you? (p29, Nora)

1:1:2 The Mental Loop of Rumination

Rumination, as part of the 'ugly' feelings and emotions experienced by the mothers in my study. The women experienced times where they would continuously and repeatedly think about how to conceive a daughter and about their distress of not having a daughter, which led to the rise of difficult emotions.

Georgie experienced a repeated thought loop focused on her sense of injustice, loss and failed control at not having a daughter. Georgie's ruination is emotionally led, and she seemed stuck in this loop:

No, it could never have happened because you're gonna have a daughter right and I will have a daughter yeah everybody else gets a daughter. Why would it be different for me? There was no reason. Our family is definitely even with girls and boys, like, there was absolutely, I mean, I've tried all the methods (p32, Georgie)

Anna described how her resentment of 'girl mums' led her to a place of rumination with a focus on social comparison. Anna was able to articulate all the people, as far back as childhood, who had birthed daughters. Yet Anna went further than just sitting in mental rumination. Anna described how she wrote "down a list of all the people I knew who had girls". But upon reflection of her actions, she described them as "fucking ugly". Anna experienced a loop of thinking that amplified her emotional distress in what was missing:

Every single one of my friends has a girl. I have since made friends who have just got boys, but within my friendship group, and I'm talking like primary school friends, like there must be about eight of those, all have had a girl or two girls or girls and a boy. Like friends I've met since uni, they've all had girls (p27, Anna)

Nora's rumination created confusion, rooted in emotional confusion and the inability to quieten her internal conflict. Despite the time she spent thinking about her situation, she "still" could not find the answers, nor create a daughter; her mind was circling but without progress:

I still can't really put my finger on why (I feel like this) and that kind of grates quite a lot. That's hard. It is hard. (p23, Nora)

Nora's rumination led her to experience frustration, fear and 'craziness' at still not having answers or being able to birth a daughter. Nora experienced affective rumination**,** where the focus is not just on the situation but on the emotional distress itself:

I find myself thinking did it fix you? Like did having the girl fix the, actually, was that just, like will I never essentially fully be fixed without that? And that's kind of what my thought, my mind goes a little bit crazy (p14 Nora)

1:1:3 "I've Not Achieved Something" Anna

Despite having two healthy sons who she loves, Anna described feeling a failure in her life and in her role as a mother. This was compounded by comments of others and in contrast to her perception of how a 'mum of girls' would feel:

(Not having a daughter) I feel like I was less than or that I've not achieved something that I should have achieved or that somehow my life is destined to be crap because people were telling me that it was going to be crap. Yet, just generally feeling like, or you don't think this is as good. Whereas I think if you had two girls as a woman, it would just have been like "oh wow, you couldn't have had anything better" (p42, Anna)

Nora described having to go through all "that crap" because she had not birthed a daughter. She saw having a daughter as the answer to all of her struggles as she felt that she would have felt fulfilled and full of confidence:

I've worked through the counselling phase (to try andd help me with my 'GD'), but when I'm at a low, I'm like, if I'd just had a girl, I would have not had to go through all that crap Yeah,

I could have just been, and I feel like, you know, my confidence has been shattered (p28, Nora)

Kate felt, unlike her 'girl-mum' friends, her role as a Mum was going to be less worthy as she was going to be left without an active mothering role as her boys grew up This thought "frightened" her:

my girl-mum friends would not have quite the same experience (and) it frightens me thinking too far ahead at the moment because I do feel like they won't (my boys) be as active a presence in my life as they are now (p22, Kate)

Georgie also described a sense of loneliness, but in a different way to Kate. Georgie described how her frustration at not birthing a daughter led her to experience resentment and a sense of loneliness in her navigation of mothering:

oh, why is it only me that deals with this? (p88, Georgie)

Ottillie did not talk about her life being "crap" due to being a 'boy mum', and Alba hardly did. This may be because Ottillie and Alba are at a point in their maternal 'GD' experience where they live more in the present moment. A concept that is explored in Theme 2.

1:1:4 "I'm Deprived of Something" (Kate)

Georgie described experiencing injustice because of a perceived loss of choice, agency and hope. Georgie's imagined future may not be what she had imagined, and this created not only distress, but also a sense of "wrongness". Georgie's sense of injustice led to resentment. However, the sense of injustice appeared not to spur her into action, but rather there seemed to be a resignation to her situation causing her to feel "cross". Her 'crossness' was compounded by her perceived loss of control and the risk of striving to regain control being too great to take. This meant that she would be left without a daughter and seated in a sense of injustice:

I felt like that chance (for a daughter) had been taken away from me a bit, and I was cross about that. It felt like it wasn't my decision anymore, but this issue was so deep rooted, but

then I did want three. But then now I feel like maybe I want four, but then I just couldn't risk that (p21, Georgie)

Kate articulated her sense of injustice in not having birthed a daughter with direct clarity. Her use of the word "deprived" suggested that as a mother she had been prevented from having something considered a fundamental aspect of the mothering role. She described her role as a 'boy mum' as an injustice, as she felt she was experiencing the absence of basic and assumed maternal experience that could only be provided by a daughter:

because I don't have a daughter, I feel like I'm deprived of something (p37, Kate)

Ottillie described her sense of injustice in the form of unidentified information that could have changed the trajectory of her mothering role, providing her with a daughter. Online there are many forums detailing diets that will increase the chances of conceiving a girl. Ottillie described how she came across these forums after she had birthed her sons and felt it "thew me off" because if she had had this information before conceiving her boys, she would have had a greater chance of conceiving a daughter. This created a sense of injustice and frustration, seen in the multiple rhetorical questions:

the diet thing threw me off a bit because I felt really annoyed that if there had been something that I could have done and that I hadn't been doing it. Yeah. And that really annoyed me. Yeah. Because I was like, well, why did no one tell me? Why did I let myself down by not doing the research? Why didn't I realize that this was so important? All those kind of things (p80, Ottillie)

1:2 The Intensity

The intensity of the maternal 'GD' experience was vividly articulated by all the mothers in this study. They described an experience so emotionally intense that it pervaded every aspect of their lives, moreover, they felt the emotional distress was out of their control. Combined, this led to an intense experience of overwhelming emotions impacting the mother's daily lives and decision making.

1:2:1 The Fear Beneath the Longing

Ottillie talked about her fear of finding out the sex of her baby, impacting her physically and mentally. Ottillie placed great importance on the conception of a daughter, and ultimately, she questioned her ability to survive without a daughter:

in the run-up to finding out what he was, I just, I couldn't sleep I didn't eat very well. I just, I felt complete anxiety, like really, really stressed, like very, like almost like shaky in my body at times. Because I was so scared that if I don't have the girl, I wasn't sure if I was going to be all right. And I worried about how my mental health would be (p15, Ottillie)

Anna feared not being able to "fix" her "feelings", and without being able to fix them, she did not know how she was going to live her life and flourish. She feared that she did not know how to move forward in her life without stopping the distress because of her maternal 'GD'. However, she felt that this could not be "fixed" because without a daughter the longing and associated distress would keep coming. She described the consequence of this as harming her well-being and her ability to live a fulfilling and meaningful life:

I can't stop this feeling from coming (the desire for a daughter). And whilst most things can be fixed, this can't. So how do you sit with it not being fixed and having to live with it and be OK in it and still kind of flourish and have a nice life within it? (p49, Anna)

Georgie feared that she was not doing enough to try and conceive a daughter, which meant that she was stuck in her difficult emotions because, like Anna, she could not see a way of moving out of this experience without a daughter:

I don't think there's any way that I could get over it …. Maybe I should be more... Well, trying to do more, it's quite scary to give up the thought of having a daughter, petrifying, yeah, because that's part of me. (p43, Georgie)

1:2:2 It's Taking Me Over

Nora described how, even after the sonographer confirmed the sex of her unborn baby was male, she struggled to accept that she was carrying a son, so she went for a 3D scan. Here a

boy was also confirmed, and Nora described struggling to know how to process the news that she was carrying a son, leading to her feeling disconnected with the son she was carrying:

I went for a 3D scan and obviously, it's still a boy, yeah, yeah and then just kind of not knowing how to process it and then just being feeling very disconnected (with the pregnancy) (Nora p21)

Nora went on to birth this son. But when she fell pregnant with another son, this time she decided to terminate the pregnancy. Nora then unexpectedly fell pregnant again, but unfortunately, this pregnancy ended in a miscarriage. Nora described how this she felt like she had been "punished" leading to "problems in my brain like confusion":

and it was like a miscarriage and then I was just like heartbroken all over again because then I felt, I went through a big spiral of feeling like I'd basically been punished. And I just couldn't. I just couldn't cope with, I remember speaking to like a bereaved midwife and just saying "I've been punished", this is what you know, yeah, I just felt like everything I'd done (the termination) … and then I had a lot of problems in my brain because, problems in my brain like confusion (p27, Nora)

Ottillie highlighted how the intensity of her experience impacted her ability to function on a daily basis. Yet despite feeling completely overtaken by the experience, she didn't feel that she could seek professional help:

I went through a whole period where I couldn't, I had complete insomnia and I was crying every day and I felt really, really low about it but I wouldn't have felt able to like go to my doctor or anything… I think I just thought they would be like, you're being silly (p6, Ottillie)

Kate described how her maternal 'GD' experience took over her to the point it became "almost pathological" and unhealthy. It even prevented her from going into certain shops, or looking at baby clothes:

it felt at one point almost pathological, like I said, I couldn't even walk in the shop, I had to look the other way from the baby clothes and stuff…it's not healthy (p21, Kate)

1:3 Is This Even Disappointment?

The word disappointment is used in the label for this phenomenon and so it was no surprise that all the mothers discussed notions of disappointment. It appeared that disappointment was used by the mothers as a lens through which to try and understand their experience.

When gazing across the mother's stories, there appeared to be general confusion about notions of disappointment: "Is what I am feeling disappointment? In what am I feeling disappointed? Why am I having these feelings? What would it have been like with a daughter?"

1:3:1 Is This Disappointment?

Anna described disappointment as unquestionably part of her experience however she suggested a conflict between her expectations of motherhood and her reality, thus feeling "let down":

disappointment is absolutely what it is, because disappointment is feeling sad, feeling like you've not fulfilled something that you really hoped for, like feeling a little bit let down (p21, Anna)

The confusion around disappointment and the maternal 'GD' experience can also be seen in Nora's experience. Nora suggested that she felt disappointment, but despite her attempts, she remained unsure "why" her feelings were "so" intensely disappointing, maybe suggesting that what she was experiencing was something other than disappointment:

I just still don't know really why I'm so disappointed (p23, Nora)

The possible confusion around if her experience is one of 'disappointment' was articulated by Kate. Kate's account highlighted the multiple levels of confusion associated with the notions of disappointment in the experience. She seemed unable to align disappointment with what she was, or should, be feeling. This created a sense of self-loathing and self-questioning. This led to a sense of anxiety and emotional distancing which in turn led to self-resentment and uncertainty in her emotions:

why am I disappointed about this? Like, you know, when they've just been born or not long after they've been born and you're just like, how can I feel disappointed? Like, my baby's here. I just grew a person. They're perfect and they're fine and it's amazing. But why do I feel disappointed?... That's horrifying. It's a horrible feeling to have (p20, Kate)

1:3:2 Is This More than Disappointment?

The label for the phenomenon suggests that 'sufferers' will experience disappointment. However, the intensity of the experience led some of the women in my study to question if what they were experiencing was actually disappointment:

It's not a disappointment. That's something quite minimal to me. Whereas this hits me quite hard (p14, Ottillie)

For Anna, the feelings were so intense and overwhelming that she talked about her uncertainty in carrying on the pregnancy. Indicating that for Anna, the experience was far more than a disappointment. She reflected on how she perceived her thoughts about maintaining the pregnancy as "horrible", which may have led to layers of guilt and shame, raising further questions for Anna as to if her experience was that of disappointment:

I thought I just can't have this baby, or like, what would it be like if this baby just didn't make it? … All these horrible thoughts (p69, Anna)

Kate experienced terror and fear at the thought of being a mum to only boys because she was unsure of her capability to raise boys. This is interesting as is something that none of the other mothers talked about experiencing. The terror that Kate experienced suggested something far greater, more intense and overwhelming than a disappointment:

I was really terrified when the boys came along… what do I do with a boy?(p8, Kate)

1:3:3 Am I "Disappointed" With My Child?

The mother's stories highlighted consistent confusion around the focus of their 'disappointment'. As illustrated below, they questioned if they were disappointed in their birthed children as society assumes them to be, or in something else.

Ottillie's 'disappointment' was clocked in confusion, as is seen in her repeated use of "I don't think". She questioned herself but then proceeded to rebuff her initial self-question. Ottillie described deep love for her boys which she considered she would not feel if she were disappointed in them:

I don't think I'm disappointed with them at all. I don't think I would, I don't think I could love a girl anymore than I would love them. They're just awesome little kids and they're so loving. (p15, Ottillie)

I asked Georgie how the word disappointment aligned with her material 'GD' experience. Georgie's response was one of confusion. At points she was clear that she was not disappointed in her sons, but then was not so sure. However, her use of "the child" indicated a distancing from her sons which may indicate a level of unacknowledged disappointment:

More sadness in a way, like it is sort of disappointing like I don't know, I don't know what I'd call it as an alternative. I don't know if there is. I'm not disappointed with the child (p40, Georgie)

Kate was certain her disappointment was not in her boys. Rather, her disappointment was in the "absence of something", but this she found hard to explain:

I do feel like it's not a disappointment in them being boys. It's like a disappointment in the absence of something. Which I think is hard to communicate to people sometimes (p7, Kate)

Alba's disappointment was held alongside her gratitude. Her disappointment was not in her son; she was grateful that she had birthed a healthy child. But because he had been born, she so was disappointed that her imaged mothering experience of having a daughter would not become her reality:

I feel grateful and disappointed together. That you can hold two emotions at the same time grateful I've got a healthy baby, but disappointed that's not going to be quite how I imagined. So yeah, definitely something like the two feelings at the same time (p29, Alba)

Anna's experience highlighted the level of confusion because of possible and perceived disappointment in her sons. There was an assumption by Anna's husband that she was experiencing the difficult emotions of maternal 'GD' because she didn't want her unborn child due to him being a boy; an assumption she was disappointed with him being male. Despite her assured answer, Anna secretly questioned if her "awful" and "upsetting" disappointment aligned with the social assumption that the disappointment she was experiencing was in her sons. Her experience was filled with a layering of emotional confusion.

I just felt awful and upset (we were having another boy) and my husband was saying ... like "do you not want the baby anymore?" And I said "of course I do", but inwardly I was kind of thinking I don't know what I want now (p26, Anna)

Kate described feeling ostracised from the 'girl mum' experiences. This was compounded by her perception that not having a daughter had impacted her perceived purpose, indicating that her feelings went far deeper than disappointment:

I very much like you're on the outside of this world that, you know, being a mum was just everything to me. Like, that was the biggest part of my purpose. And then, then you don't get, and the thing - You don't get to be a mum in the way that you envisage (p57, Kate)

1:4 In It with My Husband, Or Because of Him

When gazing across the mother's stories, partner ambivalence was evident. All the mothers felt that their partners were trying to listen but with a lack of understanding and acknowledgement of their experience. This led to the mothers' oscillation between the desire to be vulnerable in their emotional experiences and the need to protect themselves emotionally. However, some mothers did not seem to experience ambivalence towards their partners, rather they talked of certain anger.

1:4:1 "He Probably Thinks It's Not as Big a Deal" (Otillie)

Ottillie felt validated when her husband tried to understand her experience. However, even when Ottillie seemed certain that her husband "understands my point of view", there was a sense that he was not able to fully relate and appreciate how difficult the experience was for her:

my husband, he understands my point of view, but even he's like, he doesn't feel it the same way. So he'll, he'll listen to me, but he doesn't really say a lot. I think he probably thinks it's not as big a deal as it is (p 18, Ottillie)

Alba reflected that this ambivalence impacted her decision-making in who she felt 'safe' to be emotionally vulnerable with as her experience developed. The experiences with her husband meant that she chose to no longer talk with him about her maternal 'GD', creating emotional distance, thus a reduction in her support network:

And I think probably that's why I spoke to her because I knew we (my husband and I) couldn't have that conversation (p13, Alba)

1:4:2 "It's My Husband That's The Failure" (Gorgie)

In Georgie's case ambivalence could sometimes be seen in feeling failed by her husband which surprisingly affected the setting of personal boundaries in unexpected ways. Georgie described feeling failed by her husband because she perceived him as the blocker to her pathway to fulfilment (the birth of a daughter). However, despite seeing him as a failure, she also described a need to go above and beyond to prove to him she was a capable mother in the hope that he would agree to have another child, and this child would be her long-imagined daughter. Georgie's experience reflects a possible loss of autonomy shaped by relational and reproductive power:

It's not my choice at the end of the day, it's my husband that's the failure (because he decides the sex of the child) (p51) I go into this like crazy mode where I'm like, I must do everything so then my husband will let me have another (a daughter) (p35, Georgie)

1:5 Layers of Loss

When gazing across the mothers' stories, I identified an experience steeped in a confusion of disenfranchised grief; this shaped the final sub-theme. The mothers described experiencing a forbidden grieving experience for a daughter that was real to them. Their long-imagined daughters had often been named, and their mother-daughter experiences had been created and envisioned in their minds. Yet, a lack of social recognition for their loss made the grieving process difficult to understand and navigate.

1:5:1 "That Little Cord Pinafore" (Nora)

Anna described that at her first scan, she was "so convinced" she had conceived a daughter that she expected the sonographer to confirm what she knew. Then, she and her husband would be free to make the final decision on a name which they had discussed many times already:

I think I just got so convinced, like this is the moment (at the scan) they'd say it's a girl and we can go and choose our girl's names, which we'd already kind of discussed many times, like you know, it would be Amelia or Amy (p27, Anna)

Alba had spent time thinking of, and creating in her mind, all the experiences she would have with her daughters. She talked of not just a daughter, but of her daughters, indicating how she had imagined being surrounded by her daughters and immersed in a female-dominated world. Alba had "even" selected their names. The use of "even" highlighted an extra level of commitment and assumed certainty about her daughter's existence. Alba's use of "all" illustrated how encompassing her imaged experiences with her daughters was, she had not had fleeting thoughts, she had thought about " all the things" they would do together. Her daughters were alive in her mind:

it was all the things that I had imagined of having daughters and even like what they would be called and, you know, all the things I imagine doing with them (p13, Alba)

George's daughter had become so 'real'to her she was no longer an infant but a "person". Moreover, so alive in her mind that she felt compelled to have another child to birth "this" specific daughter:

I can't not have another baby because this person is real (p4, Georgie)

Nora described her daughter's clothing as not just the garment type, but the exact colour too. Her use of "that" to describe the "little cord pinafore" suggested that this item of clothing was well known to Nora and her daughter. However, in reality, Nora's daughter and her items of carefully selected clothing only existed in her mind. Nora has clearly invested a lot of time and emotion in thinking about her daughter who was real to her:

I just really wanted to dress her in some mustard tights. I just really wanted to put her in that little cord pinafore (p35, Nora)

1:5:2 "It's More About the Future" (Anna)

The mothers illustrated how their loss was not of a past they had lived nor for the present within which they were living but for an imagined future and the lost connections without a daughter.

Ottillie highlighted a logical approach to her loss:

it's not a loss in life because I didn't have it in the first place (p14, Ottillie)

Anna reflected that her experience was not a loss in the present but "about the future" and the absence of something in that projected future:

I think for me it's more about the future than actually what's happening right now (p17, Anna)

Alba and Georgie highlighted that their loss was not focused on their birthed children, but rather it was a "mourning" for what they were certain their life would be like with their imagined daughter; the loss of their hopes, dreams and experiences:

it felt like a loss of the future I had imagined … it's like grief at the life I wasn't going to have, or grief that I wasn't going to have what I'd envisaged, not about him (p14, Alba)

As Anna and Kate illuminated, but discussed by all the participants, the loss was for a perceived meaningful and emotionally intelligent connection only possible with a daughter. Anna and Ottillie highlighted their desire for female connection and how that desired connection held central importance in their lives. Moreover, a connection that was not "fully" possible with boys. Thus, their grief was for the loss of perceived meaningful and fulfilling future connections. Kate's loss of connection is based on the mother son relationships she had experienced:

Alex (my husband) doesn't feel the need to like speak to his mum every day, or as I speak to my mum every day. You know, and I guess I just, it's that, I think it's that loss of connection (p22, Kate)

Anna elaborates upon this and describes a feeling discussed by all the mothers: that there is something special about being female and the connections that can be formed but are impossible with sons:

I think it is something to do with being a woman and there is something about having that connection with another female. And I don't think you, I don't think you can fully feel like you're going to have that connection with a male (p63, Anna)

Ottillie expands upon what Anna may be referring to with "connection":

I imagine that girls would stay with me a bit more, talk to me, be more open with me as they're growing up, whereas boys, my impression is that they sort of close themselves off (p13, Ottillie)

1:5:3 "This is Grief" (Georgie)

Although Ottillie experienced a "complete loss", she still only thought it was grief-like. In other words, she was unsure if she was experiencing grief:

for me it's a complete loss, it's like a grief (p14, Ottillie)

Alba is more sure, but still only reflected that she "thinks" her experience was likely grief:

I think it was grief if I look back. That's the best way I can describe it, I think that because it wasn't, like I said, I was weirdly fiercely protective of him, but feeling really sad about what I felt like that I was never going to be (p14, Alba)

Georgie, however, had greater certainty. She compared her experience to grief and justified it as such. Yet, she still questioned the validity of her experience, the disenfranchised aspect of her grief added a complex layer of emotional turmoil to her experience:

it's just there; it's part of me this is, this is grief isn't it essentially, it doesn't go away for me even though that person wasn't real. And then my friend's dad died, and I was like how can I be possibly grieving someone that never existed (p26, Georgie)

Anna gave a striking account of her grief experience which highlighted how distressing and unexpected the grief was. She described a visceral experience where her body was "overtaken by grief". Moreover, to a level that she had "never experienced" highlighting how distressing and unexpected the experience was:

it was just, is visceral the word? Just like the absolute, just my body overtaken by a grief that I have never experienced at that level (p48, Anna)

Kate reflected on how she had experienced such a significant level of grief that it was challenging to work through. Moreover, she feared the grief that may yet come and how she would work through that experience. There was also a sense of frustration and resentment that she has had to work "so hard on the other grief":

I don't want more grief. I don't want to allow sort of more grief when I've spent, so hard working on the other grief (p37, Kate)

1:5:4 "I shouldn't feel like that" (Alba)

When gazing across the mothers' stories, the women felt their emotions, sense of loss and grief were socially prohibited. Moreover, there were no social rituals in which they could engage in to understand distress. This compounded the taboo element of the maternal 'GD' experience, creating layers of "guilt" and "shame".

Georgie felt her grief was socially prohibited:

I'm mourning something that I thought would happen (a daughter)…people can't understand that, I'm sure. And when you get an actual death, you don't feel guilty or sad that someone's actually died. No, because they were actually a person (p86, Georgie)

Alba highlighted how significantly perceived social expectations can shape the maternal 'GD' experience. Alba discussed her experience of feeling guilt and shame due to the loss she encountered. She indicated how her socially unacceptable grief for the "loss of a future I had imagined" created "massive like shame and guilt" compounding her grief and shameful feelings further:

it felt like a loss of the future I had imagined …and a massive like shame and guilt that I felt like that, which then compounded that feeling because I felt like I shouldn't feel like that. (p14, Alba)

Kate also talked about the feared social judgement because of the emotions she was experiencing. She discussed wanting to process her experience but feared that she would be judged as "absolutely crazy" if others knew about it. However, Kate ended her reflection with a sense of self-validation. In reflecting on her experience, feelings and actions, she came to the understanding that if she is to move through her maternal 'GD' experience, she knew she must process her emotions in a way that was meaningful to her, even if not socially validated:

I make baby blankets and stuff for my friends when they have babies, and I have felt quite a strong urge to like, make her one, my imaginary daughter, a blanket and just have a little baby box for her that no one knows about apart from me. Like a little, you know, which sounds absolutely crazy when you voice it out loud. But it doesn't to me. I do feel like, you know, that would just be a way of me trying to like, put it in a box a little bit (p53, Kate)

Anna recounted how her mother made it clear that the social perception of maternal 'GD' meant that she should not talk to anyone about her "grief" (p48) due to certain social judgments:

(my mum said) to me, but this is it now you've just got to put it to bed, don't talk to anyone else about it … and don't tell anybody because they'll all, you know, when this baby comes, everyone will be thinking oh, she didn't want this (p23, Anna)

Theme 1, Broken, has considered the distress of the maternal 'GD' experience. This was discussed in seven sub-themes: 1:1 the ugly emotions and feelings of maternal 'GD'? 1:2 the intensity, 1:3 is this even disappointment, 1:4 in it with my husband, or because of him? 1:5 layers of loss, 1:6 "this is grief" (Georgie), and 1:7 "I shouldn't feel like that" (Alba). Theme 2 will explore the dynamic layers of hope in the maternal 'GD' experience.

7.2 Theme 2: Hope

2:1 The Seed of Hope: Assumptions and Expectations

Gazing across the mothers' stories, there was an assumption by the women that they would have a daughter. The mothers talked about how they had achieved goals in their lives, so a daughter could be achieved too, and when it was not, there was a feeling that the next child would be.

2:1:1 I'd Always Have a Daughter

Nora was the only mother who was initially not sure if she wanted to have children, but her 'motherly instinct' began to change that. The notion of a feeling from within implied that the feeling could not be argued with; it was innate. Moreover, it was not just a daughter that Nora longed for, but "my girl", which suggested a protected and special emotional connectedness:

I didn't think I wanted children .... I just kind of had, all of a sudden, I had, like Oh, I was like Oh, I kind of know, Oh, I felt, I felt that thing that women talk about feeling, and I'd have my girl (p 20, Nora)

Alba always wanted three children and talked of imagining her daughters, not one, but several. Alba had named them in her mind, indicating how sure she was that she would birth at least one girl:

I always wanted three children (p3) ... I had imagined having daughters and even like what they would be called (p13, Alba)

Anna "really fundamentally thought" she would have a daughter. Thus, for Anna, having a daughter was an essential, non-negotiable assumption of her "life story". She articulated how she "was going to have" which gave no room for movement away from that assumption; it appears to be a certainty in her mind, almost a planned 'truth':

I really fundamentally thought was going to be part of my life, that I was going to have a daughter, and it was going to be part of my life story (p 50, Anna)

Georgie articulated how she has "always" achieved what she "wanted" but now she could not because it was "out of my control":

I've always been able to achieve what I wanted in the past and now, it's (having a daughter is) out of my control (p17, Georgie)

Kate described herself as a "goal attainer", something that she has been for her "entire life" suggesting how intrinsically linked achieving her goals may have been with her sense of self. Kate reflected on how this trait may have impacted her maternal 'GD' journey; it made the relinquishment of the hope and acceptance that she may never realise her dream of a daughter a "struggle" because she came to realise that she has no "control":

I've always been like a goal attainder my entire life, which I think is why I struggled with this because I cannot control this (p32, Kate)

2:1:3 "Well Next Time it Will be a Girl" (Anna)

In their hope for a daughter, the mothers seemed to fall between possibility, plausibility and probability as a way to manage their hope expectations and convince themselves they would have a daughter. Alba talked about how her hope provided comfort amidst her distress, as while her hope remained, the possibility for her daughter did too. Alba always wanted three children, so the birth of two sons still meant there was the plausible chance of female conception:

Because I always felt that I would have three children, I didn't feel like, well, that's it, I'm never ever gonna have a girl when I had my second son, so there was a bit of like, well, it would have been nice if this one was a girl but there was still yeah, there was a sense of hope of like there still the possibility that I will have a girl in the future (p12, Alba)

Georgie felt the probability of having a daughter next time enabled her to manage her emotions when the sonographer told her she had conceived a son. Georgie's causal language "got another shot" and not having a daughter being viewed as "never an option" suggested that she believed

the probability of having a daughter was high; therefore, she need not worry, and her hope could remain intact. However, this was not realised, and at the time of the interview, she was receiving treatment for depression to help her manage what she described as her difficult maternal 'GD' emotions:

So when I got pregnant the first time we went for a scan and they said "oh, it's a boy" and I'd said, apparently I'd made some comment to my husband and I'd said, "oh", it was the long the lines of, "that's a shame because now we've only got another shot at having a daughter" and he picked up on that and he was like "oh, that's an odd thing to say". But it was obviously pressure I was putting on myself. Like, all my family have had like girl, boy, girl, boy. And then my husband's family had boy, girl. So yeah, it was never an option. I can laugh about it now, I'm on the drugs, that's why. No, yes, so there was never an option. It's like ingrained in me." (p3, Georgie)

Anna also kept her hope for a daughter alive by a movement through possibility, plausibility and probability. After her first son was born, she "boxed off" her distress because of the possibility of a daughter next time. When she became pregnant again, again this developed into plausibility; she was now pregnant, and this was her chance. By the time of her scan, the anxiety that Anna experienced indicated a movement towards probability, as she had emotionally invested in the news the sonographer would deliver. Her focus on the baby's sex, rather than health, illustrated how deep her hope was:

I kind of almost boxed it off in my head, "well next time it will be a girl and it won't be a problem". And then the second time, I remember just, I was so nervous before the scan and I kept saying to my husband, I feel terrible because I'm not nervous about if everything is OK, I was just like, I'm just so nervous about finding out if it is a boy or a girl. And we were both got quite convinced it was a girl (p2, Anna)

2:2 Hope in Motion

The mothers described a hope that was evolving and full of emotion. The women's hope was not fixed, but it changed dynamically with each pregnancy, and bringing the mothers ever closer to their perceived emotionally and socially reduced future role of the mother-in-law.

2:2:1 The Chances are Going, the Hope Diminishes, and the Difficult Feelings Amplify

As I gazed across the mothers' stories, I identified a continuum of hope running through the women's experiences. At one end of the continuum was high hope for the realisation of their long-imagined daughter, and at the other, the forced relinquishment of all hope for their longed-for daughter. The continuum of hope demonstrated that as the journey of maternal 'GD' progressed through the birth of subsequent sons, the mothers felt that their chances of conceiving and birthing their daughters were dissipating. Thus, the hope they held for their long-imagined daughter became more desperate, and the difficult emotions of the maternal 'GD' experience were intensified (explored in theme 1). As their chances of conceiving a daughter decreased, they felt increasing hopelessness, leading to helplessness, and they felt forced towards the relinquishment of hope.

As I drew the mother's stories together, it seemed that the intensity and desperation of their hopes were aligned with the number of children that they thought they would have when they embarked on their mothering journey. The number of children the mothers expected to birth, seemed to create their perceived 'chances', which they marked off as each son was born. The mothers talked about the birth of their first son as manageable, but with the birth of subsequent sons, the intensity of their difficult feelings increased, as did the desperation in their hope.

Kate described how her hope became more desperate the more sons she birthed. After the birth of her first son, the pressure held in the hope of having a daughter intensified:

> *the hope was always there and it felt more pressure on that hope after Henry. So I was like, I've missed my opportunity at the first go-round so I have hope for another one (p36, Kate)*

Ottillie experienced increasing distress as she gave birth to more sons. The feelings began with an intermittent "low" mood. But after becoming pregnant with her second son, as her chances of a daughter were evaporating, she began to "really struggle" due to her "diminishing hope" as her chances of having a daughter were decreasing with every son she birthed. Ottillie suggested how her "diminishing hope" was interwoven with the increase in the distress she was experiencing after the birth of each son:

I would say after having Robert, I started to have periods where I was low about it. But then when I got pregnant with Ed, that was when I was really struggling because I knew that was my, we only wanted three kids and I don't think I could cope with any more. So, I was very much like, that's the last chance… the hope was diminishing (p8, Ottillie)

Anna experienced increasing distress with the birth of each son, leading to on overwhelming embodied experience:

Just like the absolute, just body overtaken by a grief that I have never experienced at that level (p48, Anna)

Ottillie described how as she used up her 'chances' of having a daughter, the pressure to conceive a female became greater, ultimately leading her to experience anxiety over her well-being. In the build-up to this thought, Ottillie described the physiological impact the experience had on her ability to function. The repetition of "really" highlighted how intense this experience was. She attributes this to a fear that without a daughter she would significantly suffer and be unable to function in the "right" way. It was also interesting that Ottillie uses the term "the right way" as it suggests that she had formed ideas about the 'right' and 'wrong' way to cope:

when I was pregnant with Ed, in the run -up to finding out what he was, I just, I couldn't sleep I didn't eat very well. I just, I felt complete anxiety, like really, really stressed, like very, like almost like shaky in my body at times. Because I was so scared that if I don't have the girl, I wasn't sure if I was going to be all right (p15, Ottillie)

Georgie was fearful about how overpowering her difficult emotions would be during pregnancy if the sex of her unborn baby was confirmed as a boy. She feared her forced relinquishment of hope would lead her to depression. She explained that she did not want to know the baby's sex during pregnancy, because while she did not know the sex she still "had that hope" for her daughter. This demonstrates how important hope was in Georgie's journey, to the point of influencing her action-taking to preserve it and protect her from feared depression:

(I didn't find out the sex in pregnancy) … I didn't want to know for sure because I didn't want to have the depression in pregnancy again. I just wanted to have six months or five months where I just didn't know and had that hope still (of having a daughter) (p34, Georgie)

Even in the “last hours” of labour, Georgie held onto her hope. The hope that the baby would be a daughter. This showed how her hope, which was maintained by not knowing the sex, provided the “chance of having a daughter” and thus how resistant she was to be relinquishing that hope:

when I was in labour, I was like, these are the last hours that I'll still have that hope… These are the last few hours that I'll still have a chance of having a daughter (p35, Georgie)

2:2:2 The Obsession with Finding Another Way

All mothers, except for Kate, obsessed about possible alternative pathways available to conceive a daughter with. The data suggested that Georgie is the mother who is the most entrenched in her maternal ‘GD’ distress, and this continues to be evident in her description of the multitude of pathways she has become familiar with in her attempts to conceive a daughter. Collectively, these techniques are referred to as swaying:

So, there's swaying, there's eating certain food, there's certain positions, there's certain douche, like there's literally like... I did a diet, I lost a lot of weight, which is apparently good for a girl as well. Didn't work, did it. (p32, Georgie)

When Anna talked about feeling disconnected with her son during the pregnancy, she described how she reflected with frustration and anger at her ‘missed opportunity’ to increase her chances of having a daughter:

feeling really pissed off and then thinking “oh shit I've read about all these techniques to make sure you've had a girl and I decided let's not do that, you know let's not make a sway or anything”. Like I knew that that was a thing, like why did I not do that (p69, Anna)

Nora shared similar anger at missing one of her ‘chances’ of influencing the sex of her two sons. However, as she was contemplating having a third child, she tried the diet technique. However, it ‘failed’, and she conceived a son. This led to a termination:

all of a sudden then I was angry because I discovered all the things you can you can change the gender of your baby by what you eat … so I started changing my diet, cutting out the salt, God, it (the diet) was boring. So boring … but like, you know that obviously, that didn't work, and but then I was like oh well why didn't someone tell me about the diet thing before I had the boys because I could have yeah, choose the boys, but no, the other. So that's the termination, it was in Spring (p25, Nora)

Ottillie talked about her obsession with finding an alternative swaying technique; she tried timing intercourse to allow the female sperm to reach the egg first. However, this was unsuccessful:

I did do a lot of looking into it and apparently, girls sperm is slower but lives longer. Boy sperm is faster, but dies faster. So, you should have sex just before you're going to ovulate. So, we did try that, yeah, with Ed. I didn't try anything before because I was like, whatever happens, happens. Yeah. And obviously made no difference. (p21, Ottillie)

Georgie's obsession with conceiving a daughter meant that at the time of the interview she wasn't sure if she would try again for a daughter. However, she had begun researching two more techniques. These swaying techniques may be deemed socially extreme:

I still haven't ruled it out in my mind having another baby, but, it's not fair to expect my husband to agree to that. And obviously that comes with a whole different kind of where I'm like going for IVF and stuff, and that might not even work … Like I think at least then I could say I'd tried everything (p40, Georgie)

I mean I've thought about like, I've joked with him. I'm definitely joking. I hope. I'm gonna leave and go to the sperm bank, get IVF. Like it is joking but he probably doesn't see it like that sometimes, because he knows what this is. I wouldn't ever do that but I shouldn't really be joking about it either because that could ruin it if he starts believing it, if I say it enough. I don't know. I feel like he's gonna stick around. I don't know. I don't know. It's weird. (p 52, Georgie)

2:2:3 "I'll Always Just be the Mother-in-Law." (Georgie)

The mothers talked about their perceptions of becoming a mother-in-law which were situated in their own lived experiences and the experiences of others. The overwhelming sense from the mothers was that as the mother-in-law, they would be ostracised and not be as involved with any grandchildren as they would be if they were the mother of the mother.

Alba reflected that on her own mothering journey, her mum has been "much more involved" and projected this experience into her future. She suggested that when her sons "have children", she will not be as involved, meaning that she will miss opportunities and experiences because she will be the mother-in-law. Her stuttering and struggle to articulate her fears suggested how deep-rooted Alba's emotions around this were:

when they have children and stuff, like I know, like I've, my mum has been much more involved than my mother-in-law (p10, Alba)

Nora upheld this notion and articulated with clarity her expected banishment from supporting her grandchildren because of being the mother-in-law:

the percentage likelihood is, is that the the mother of said future grandchildren will use her mother, not me, for support. Because I use my mother-in-law for support, but not in the same way that I use my mum (p33, Nora)

Georgie feared abandonment by her sons because of being the mother-in-law. However, she countered this internal narrative with a lived experience which highlighted a tension between deeply entrenched social narratives and lived experiences:

I just feel like if I have all boys, they're going to go and leave me when they're older and I'll always just be the mother-in-law. Saying that, I've got a friend she is the best daughter-in-law, and I've told her, you restore my faith in having boys… she's closer with her other half's mum than she is her own (p11, Georgie)

2:3 The Heart of the Longing

The mothers in my study described deep longing for their imagined daughter due to perceived enduring, meaningful and emotionally rich relationships and shared experiences with their imagined daughters - relationships they did not believed were possible with their sons.

2:3:1 The Obsession with a Longing-for Emotional Connection

The mothers talked about an idealised hoped-for connection with their imagined daughters leading to a deep and meaningful bond between them. They talked about an instinctive bond that would be strengthened as they went through life together.

Kate talked about an idealised connection with her daughter as being "inherent", suggesting that she felt the relationship with her daughter would be permanent, fundamental and they would be inseparable. Moreover, because boys are a different "species", she would be able to understand her daughter in a way that was not possible with a son:

inherently because we're the same species, both being female, that we just understand each other a little bit more … I just think instinctively, maybe we just get each other a little bit more (p12, Kate)

Georgie developed the views of Ottillie and Kate in her assumption that a boy could not "relate" to her in the same way as a daughter. She described a deep, internalised emotional craving that was visceral but not fully understood. Georgie's obsession of her idealised relationship with her longed-for daughter holds important emotional and relational meaning for her:

I think about helping them go through life changes and stuff and kind of in a mentoring way, I, yeah and having someone that relates to me perhaps more than the boys do. Like it's quite selfish really isn't it? But I feel in a way that would be nice to have. I don't know what it is. It's so like, I just don't know. It's just in me. It's in me here. I don't know what it is. I just feel like my life would be more... which is sad because I shouldn't say that because my boys are everything (p42), Georgie)

However, Georgie questioned these assumptions and deemed her thoughts and desires as "selfish". Yet she carried on, seemingly trying to understand her own thinking and justify her emotions despite the way she described them as embodied and within her.

2:3:2 Idealised Shared Experiences

Although the perceived "ridiculously close bond" (p11, Ottillie) anticipated by the mother-daughter relationship is of central importance to all the mothers in my study, the women also talked about how a daughter would provide the opportunity for "shared experiences" (p63, Georgie).

Nora described about how a daughter would provide the "ability" to "share life experiences" that had become idealised and real in her mind. Nora's use of the word "ability" shows that she believes by having a daughter she would have the opportunity to flourish in the maternal experience of shared activities and caring, in a way that was not possible with her sons. Nora places a limitation upon her mothing role because she has not birthed a daughter. However, she reflected that her assumptions are situated in entrenched social narratives, but for her, her daughter, and all she represented was real in "our" mind. Nora's use of "our" may encompass all mothers who long for a daughter and draws attention to my role as an insider researcher:

the ability to share life experiences and, you know, like I'll never get that…I'm like, I'm never gonna be able to be the one that gives someone the hot water bottle that knows how they feel that when they're pregnant, if they're pregnant shares that experience of what pregnancy was like. Like there's that kind of that feminine bond of, assumed bond, like I know, like I've explored it all, like I know there's all the assumptions and they're all things that, but they're still real to us in our mind (p34, Nora)

With a daughter, Ottillie imagined consistent, lifelong experiences. Sadly, Ottillie did not have mother-daughter experiences to draw upon due to her mother's death, so she refers to her thoughts as "a bit fantasy". Ottillie had created the meaningful relationship with her longed-for daughter solely in her mind rather than being able to base it on lived experiences:

I just imagined going through life together and being there for each other and doing their hair and I don't know. It's a bit of a fantasy for me because I didn't have it … It's about the relationship, not so much anything else (p12, Ottillie)

Similarly, Anna described an imagined relationship that would be constant and continual, intersecting significant female experiences. Describing her hoped-for daughter as "the one" highlighted how her imagined daughter held a role that no other person could. Moreover, a relationship that was ever-present, unfaltering and reliable. Anna described how her hoped-for daughter would enable "those meaningful conversations" which are not yet real and so are idealised in her mind. Her daughter would be the one person with whom she would have those highly significant, personal and impactful conversations with. Anna's account of the experiences that only her hoped-for daughter could give her access to, indicated how meaningful this imagined relationship and experiences were to her, furthermore, how they are only possible with a "daughter":

the daughter would have been the one who would always talk to me and we would have those meaningful conversations and as they get older would maybe go for lunch or to a spa day or to the theatre together and like you know, if they got married would go wedding dress shopping (p 19, Anna)

Georgie felt that without her daughter she would feel incomplete, yet she felt helplessness in her quest for 'completeness', followed by self-judgement that created likely inner tension. Georgie was aware that her hoped-for relationship, connection, and shared experiences with her long-imagined daughter put pressure on her unborn daughter, and she recognised the unfairness of doing that, but it did not stop her hope and subsequent distress:

It's so hard, these boys are lovely, they're such lovely boys, I'm so proud of them. But I say to my husband I don't want to feel incomplete, but that's awful to put all that pressure on a future daughter (p5, Georgie)

2:4 The Relinquishment of Hope: Confronting "The Line" (Georgie)

All the mothers talked about reaching a point where they would have to face not having a daughter and reimagine their future without a daughter in it. Georgie described this point as "the line":

at what point do you just draw a line, and that's the bit I'll struggle with forever … while there's still a chance, I can't like let it (the hope) go (p55, Georgie)

For the mothers, “the line” represented the relinquishment of hope for their imagined daughter and an acceptance that a daughter would not be part of their mothering experience. Thus, reaching “the line” represented the relinquishment of hope that they had nurtured for their long-imagined daughter. Although some of the mothers talked about logically knowing that “the line” had likely been reached, their deep and enduring longing caused them to question the finite nature of “the line”.

2:4:1 Number of Children and “The Line”

Nora explained how she envisioned having two children, and now she had had two children. Thus, she felt her choice and chance of a daughter had gone, therefore she was being forced to relinquish her hope:

> *I was like, I'm only having two. So, I've lost my, to know I've lost my choice (p31, Nora)*

Alba described how the birth of her third son represented her last chance at conceiving a daughter. Therefore, with the birth of her third son, the hope that she held for her long-imagined daughter was now gone. The removal of her hope led to a realisation that her daughter would now not become a reality. Alba had been composed and very matter of fact until this point in our interview, and after this point she was again, but while recalling this moment she cried:

> *And I just remember crying, I can remember saying, like, I feel so fiercely protective of this little life in me and it's not that I don't want him, it's just that, that's it, I know I’m never gonna have a girl now. And I'm surprised, I'm crying now because I felt like I could talk about this (p8, Alba)*

For Alba, although there was the possibility of having a fourth child, her initial intent to have three children was preventing her from going on to try again. In her mind, her chances had all gone, and she had not birthed a daughter. Despite being biologically able, more children were not an option, leading Alba to relinquish her hope, meaning that she had reached the finality of ‘the line’. But significantly, she’s was still not sure, as seen in her use of “almost”:

I know that could still have been possible when I had my third because I could have had a fourth, but it never felt like that, I don't know why, it just never felt like a very, I'm not saying it's not something I've considered, and in all honesty considered until probably about a year ago on and off, it's something that I thought about. But it felt really different because in my head I'd only wanted three children… I think I just kind of felt very much like that's it a finality almost with the last one (p13, Alba)

Anna had two sons and was concerned about trying for another. Not only because three children might be "a lot" to manage, but because she had decided with her husband that they would have only two children. Yet, despite this, Anna still talked of a seed of hope which tested the finite nature of 'the line':

I was thinking oh, three sounds like a lot. Like, I don't know, especially at the moment, like my husband and I have just said absolutely no chance (to a third). But I think I still have that kind of hang onto "oh, but we could, and it might be, it might be a girl" (p13, Anna)

Despite the struggles of mothering, and her resistance to go back to a place that was "too hard", Anna still questioned if she was ready to relinquish her hope. This highlighted how important a daughter was to Anna and caused her to question her boundaries. Interestingly Anna frames this as "closing the door":

and just saying to my husband all of the time, I can't do this, it's too hard. So yeah, I just kind of think, "oh, do I want to go back to that again". But then that does really mean just closing the door … of, would I ever have a daughter? (p16, Anna)

Nora framed her internal battle with reaching 'the line' in a different light; she was more forward-focused. Instead of being fearful of going back to the early stages of mothering, Nora talked about her fear of losing the freedom her family had gained as her boys had got older. Nora talked as a "we", seeing herself as part of her family unit, and creating opportunities that they could all enjoy. It was the resistance to losing this freedom and these experiences as a family that, in part, led Nora to reach 'the line' and relinquish the hope for her long-imagined daughter. Nora appeared to be living in the present and not in her imagined future with her longed-for daughter. This shaped her ability to logically assess her yearning for a daughter and

the impact of her desired daughter on the family she had created. However, Nora still questioned herself:

we love going like down to the French Alps in the summer and going climbing and stuff with them and I know that if I had another child that would scupper all that stuff. Yeah, and I love the freedom that their age gives me. So, I don't, I know I don't want another child, but then at the same time I'm like, oh man, it could have worked out quite nicely, couldn't it?

(p38, Nora)

Ottillie logically reflected on the physical and financial implications of having another child. It seemed in that moment, Ottillie, like Nora, was able to make a logical assessment of a future child regardless of sex. This shaped her thinking as to whether she had reached 'the line' and was ready to accept that her daughter would not become a reality, thus relinquish her hope and move forward. However, her use of "I don't think" retains an element of doubt in the finality of her decision, something that is evident across all the mother's experiences:

I don't think I could cope with any more children physically or financially. So, I just kind of almost like shook myself and was like, you're going to have to get on with it and accept it and make the best of it. (p22, Ottillie)

2:4:2 Role of the Husband and "The Line"

Georgie could not reach 'the line' because she still held hope for the possibility of her long-imagined daughter. Georgie explained how she attempted to use the 'reality' of her husband's "hints", "even if it's not a hint", to uphold the desires and hopes of her heart alive. Georgie felt it was her husband who ultimately had the power to decide if she had reached 'the line'. In an attempt to avoid his confirmation of her suspicions that 'the line' had been reached and they would have no more children, she avoided asking him. However, Georgie was also aware of her own biological age. Yet despite this, she felt that there was always a way to achieve a daughter despite the obstacles. A notion upheld by all the mothers who felt that if they tried hard enough, they would be able to achieve their daughter:

I can't accept it because it's still a little bit unknown, but realistically, I need to accept it, I just can't. I can't let go. And so anything that my husband would say that would even hint,

even if it's not a hint, I would take it as a hint and be like, it's not ruled out yet. Like, when actually it probably is (p55, Georgie). He can't say no if I don't ask. So it's still there, isn't it, hope. But then I'm just very aware of how old I am. I didn't want to be having a baby at 40. But it's like I can achieve it, there's always a way (p83, Georgie)

Nora felt that her husband played a significant role in keeping her hope alive because he was the one who could give her a daughter. Thus, she asked her husband to have a vasectomy as a way to take away her hope, therefore her turmoil, because for Nora, while the possible hope for her daughter remained, she felt unable to move on and was stuck languishing in the torrent of difficult emotions that she so desperately wanted to be free from:

I'm like, can you just have a fucking vasectomy? And he doesn't want, well, he's not against it, but his thought process is like, well, he's not sure it's for him… But it would stop me hoping, stop me considering it (another child) as an option. Like there'd be no choice, because at the moment there's still choice … it would just take the hope away from me, and it would take away that horrible turmoil (p51, Nora)

This part of the interview took place as Nora and I climbed the final accent to a peak overlooking a beautiful valley in the spring sunlight. We stood shoulder to shoulder for several moments, looking at the view and both shedding a silent shared tear. The desperation in Nora to simultaneously keep the hope for her long-imagined daughter alive but also the need to have it removed to enable her to move forward was raw and tangible. It was exceptionally powerful and moving.

2:4:3 My Body as a Limit

The mothers talked about holding onto hope for their long-imagined daughters until their perceived choice to have a daughter was removed by a biological inability to conceive; thus, 'the line' would be drawn. But even this became a discussion of probability, plausibility and bargaining.

Although Nora was 40 and aware that her chances of conception were diminishing, she actively sought out examples of older mothers who had successfully given birth to a child to keep her hope alive:

there's still, oh well, I know I'm 40, but so-and-so had a baby at 43 and she's all right (p53, Nora)

Georgie explained that her age meant that having a daughter was unlikely and so she would be forced to "accept" that her daughter would not become a reality. This caused her panic and fear of depression:

I'm going to be 39 soon so it's getting to the point where it's probably not going to happen, At one point that was like, yeah, making me quite panicky. (p15, Georgie) ... Well, obviously we'll have to accept it at some point because I won't be able to have physically, I won't be able to have children. But then at the same time I'm like, I don't, that bothers me getting to menopause actually and being like, how will I feel then when it's physically not possible? That bothers me quite a bit. Like, is that going to send me into a depression? (p87, Georgie)

Kate also talked of a feared forced relinquishment of hope. Like Georgie, Kate feared this would instigate an emotional journey. For Kate, one of grief:

when I'm eventually at that stage where it's no longer an option (biological conception), then I'll probably have another grief journey to go on then (p38, Kate)

2:4:4 The Hope That Lingers

Some mothers felt that while any tiny speck of hope remained, and it would until there was a finality, they would never be free of the constant intrusion of maternal 'GD':

"I think when it's (the possibility of a daughter) not just associated with anyone's decision and it's taken out of my hands, then that's a different scenario. But I do still have, it's a tiny little grain of hope, but it is still there and it's always just niggling" (p37, Kate)

Not being able to relinquish her hope meant that Georgie experienced confirmation bias. Georgie described how mundane daily things became a sign that there was a chance that her wish for a daughter may come true. It seemed that hope was causing Georgie to distort incidents of chance to keep the hope for a daughter alive:

the registration on the car was SFS and I was like, "oh I would have called her Sarah, she would have had the middle name Florence. But like it was SFS would have been her initials – it's a sign. We've not finished yet" (p58, Georgie)

Unlike Georgie, who sought out incidences of chance, Kate attempted to use logic to keep her hope alive. She assessed how many children of each sex were born to her friends and drew on the statistical chance of a boy or girl being born next time to inform the probable chance of her having a daughter if she were to try again. Her use of "everyone" in her data collection suggested she was invested in this process and committed to ensuring that all data was collected so she could ascertain her chances. However, there would be possible impactful consequences if anyone did have a daughter:

I start playing like the odds game with everyone. I'm like, well, there's been three boys born now, so someone's due a daughter and then like, if they have a daughter, I'm never going to be able to speak to them again (p56, Kate)

2:5 Letting Go

2:5:1 When Hope Becomes Harmful

Some of the mothers talked about needing to let go of their hope because it their hope was becoming harmful in some way. Ottillie talked about a fear that holding on to hope for her long-imagined daughter could become detrimental to her and her family. She discussed "everybody" in her "family" having "some kind of struggle with mental health", and in her acknowledgement of this, there was a refusal to allow herself to follow this path. This highlighted how Ottillie was living in the present and that in the relinquishment of hope for her imagined daughter, she could avoid further mental health turmoil and instead create the future that she had imagined for her family.

everybody around me in my family has some kind of struggle with mental health, and I just didn't want that. I can't let that be me because it doesn't fit what I want for my future and my future is I want to have a wonderful family and a relatively happy life (p30, Ottillie)

Kate also described knowing she needed to relinquish her hope to be able to protect her mental well-being and move out of the maternal 'GD' distress. Kate talked about her hope as a "little grain" which suggested it held wonderful possibilities, but the wonderment of this hope was contrasted by the knowledge that having the hope she was at risk of being "destroyed again". Kate describes here a battle with wanting hope but not being able to let herself feel the hope because she would be "destroyed" if she allowed the hope to remain. This shows how deep her sense of feared emotional overwhelm was because of the maternal 'GD experience. Being "destroyed" indicates a sense of insurmountable personal destruction, highlighting the intensive and significant impact of the maternal 'GD' experience for Kate:

although that little grain of hope is still there, like, I almost can't let myself feel it because I don't want to feel that destroyed again (having another son) … Like, I just can't let myself. Yeah, I just can't now because it's very unlikely to happen (conception of a daughter) but also, if I do let myself think about the fact that it won't happen, then that's just not a very nice place to be (p38, Kate)

Nora, Georgie and Ottillie all described moments that suggest hope could become harmful as it had the ability to delay or disrupt emotional connection with their unborn child. During her last pregnancy, when the sonographer confirmed that she was having another son, the possibility of a daughter was taken away from Nora, and this created disconnection:

I went for a 3D scan and obviously, it's still a boy, yeah and yeah and then just kind of not knowing how to process it and then just being, feeling very disconnected with the pregnancy (p21, Nora)

Experiencing a difficult pregnancy after finding out the baby's sex was again male is something that Georgie also talked about. Georgie felt that she experienced postnatal depression with her first son due to maternal 'GD' and during her pregnancy with her second son because the hope for her daughter was taken away:

when I found out Jack was a boy, well, no, I had really severe postnatal depression after Tom. Yeah, and I don't know whether that was probably with gender disappointment. That's probably the main cause of it, I would have said. Yeah, so I was like, Well, next time, and then obviously next time it was a boy again. And I had really bad depression in my pregnancy

(p3, Georgie)

Ottillie described how the birth of her last son confirmed that her daughter would not become a reality. However, she did not 'blame' her son despite the role he unknowingly played in her maternal 'GD' experience. It is interesting that although Alba acknowledges "even though he's no different to them" (his younger two brothers), she also reflected that "he's the one" that has meant there will be no daughter, and she worried how she would bond with him knowing that her chances of a daughter were no more:

then I was worried, will I connect well with the last one? Because even though he's no different to them, he's, you know, he's the one that's gone and sealed it, there's no girl (p15, Ottillie)

2:5:2 I Have the Power to Reframe This

For those mothers who were moving closer to accepting that they would not be a mother to a daughter, there appeared to be a conscious choice to reframe their thinking around being a mother to only boys.

Anna described her process of doing this as a conscious confrontation of her thoughts and feelings about being a mother to "two boys" was going to be like. She went on to suggest that she felt she had some power in shaping her future:

I think having had two boys I've had to really address some of these things that go on in my head about being a parent. Yeah, like address all these kind of things I have in my head and what I expect from the future (p30, Anna)

Ottillie described her conscious and continual reassessment of her mothering experience and investment in her 'now' as a way to gain control over her maternal 'GD' experience and movement through it:

I just had to let go of everything I'd almost imagined because it probably wouldn't have come to fruition even if they were a girl, and get to know your children and love them for who they are and that's, and you just got to make the conscious choice to forget about what you've

imagined. Just take it day by day, day by day, and just, not that you wouldn't as a parent anyways, but just spend the time with your kids getting to know them and then you love them so much that you wouldn't wish them to be anyone else anyways.
(p26, Ottillie)

Alba appeared to be the furthest along in her journey of maternal "GD," beginning to emerge out of the other side of the experience. Her boys were slightly older at 10, 6 and 4 years old, and the passing of time as a mother of only boys had maybe helped her to process the experience, thus giving ger her a new perspective as a mother to sons without a daughter. Alba reflected on her imagined mothering experiences with a daughter and applied them to the experiences she had with her sons. Alba anticipated feeling sadness in having three boys, but through her experiences with them, she had found that the sadness she expected did not materialise in the way she had anticipated. In fact, she has had experiences she expected only a daughter would provide but were actually being fulfilled by her boys:

the things I guess I thought I would feel sad about having three boys, I don't as they get older (p11, Alba) … I've had to learn fairly recently to French plait because it was never something I thought I was going to be doing (p4, Alba)

Like Alba, Nora talked about how the passing of time and movement away from parenting small children had created memories and experiences that she could reflect on. The experiences with her sons did not always conform with her expected 'boy mum' experiences which enabled her to create a more accurately and personally informed narrative of being a mother to only boys:

because of the boy's age and because of the benefit that as they get older, that brings the experiences we have, because when the kids are little you're like in the trenches of parenthood (p65, Nora)

Ottillie reflected on a conscious awareness she had developed to counter the 'boy mum' narratives she held. Ottillie explained that because her children were boys, she feared "they'll leave me" and they be distant emotionally. But Ottillie described how she actively countered these narratives. She did this to take control of her maternal experience and shape it in a meaningful way. As part of this process, Ottillie acknowledged the reality of her situation, and

so she had the option of "not sitting and dwelling in" and she did that by being in the present moment and not looking to the future and grieving what she would not have, rather living in the present with them:

it is very much a constant reminding myself that just because they're boys, doesn't mean they'll leave me when they're older. Just because they're boys, doesn't mean we can't be close and things like that. But I just I want to be there for them … I've got to move forward now and be there for them in the best way that I can be. And that is by not sitting and dwelling in what I can't change (Ottillie p23)

2:5:3 Choosing to Accept

The data analysis process led to indications that Alba was furthest along in her maternal 'GD' journey, perhaps having reached a level of acceptance, followed by Anna, Ottillie, Kate, Nora and finally Georgie, who appeared completely stuck, not able or wanting to consider relinquishing her hope for a daughter, thus stuck in tumultuous distress. For those mothers who seemed to be nearing a place of acceptance, they seemed to be making a conscious choice to do so. These mothers appeared to be frank with themselves about their reality, while drawing on strategies to prevent them from falling into the depths of the difficult feelings that they had experienced during their maternal 'GD' experience.

Kate, who sits in the middle of the mothers in terms of her place of acceptance and relinquishment of hope, did not talk of discrete strategies she could draw upon to support her on her road to acceptance. However, she did acknowledge that the 'power' is within her to move to a place of acceptance. Yet, she felt that she did not yet know how to access that power. Despite knowing that finding acceptance would help, she was not yet ready to do that and perhaps will not know how to until she is facing 'the line', at which point acceptance will have to be considered:

you end up just coping don't you with whatever life throws at you and you find that sort of inherent strength and that inherent sort of way through. But I don't quite know how to access them at the moment and I don't know until I'm fully in that situation whether I would (Kate p39)

Ottillie feared spiralling back into the depths of her maternal 'GD' experience, and this, she worried, would prevent her from being present and able to mother her boys. Thus, she was making a conscious effort to accept that she would be a mother to only boys:

I just kind of almost like, not literally, but slapped myself around the face. I was like, this is what I've got. I don't want any more children … I'm not going to allow myself to spiral and then not be there for the children that I do have … I feel like you have to be (conscious about it) because otherwise I could just fall down this like hill where I keep getting more and more sad about it and I can't change it (p24, Ottillie)

Alba and Anna were the mothers who appeared furthest along in their maternal 'GD' experience.

Anna employed a conscious strategy to pull herself away from longing and into the present moment with her boys. The lengths that she went to, to remain in the present and not slip into her difficult emotions of the maternal 'GD' experience showed how much Anna was struggling with the chasm in her imagined mothering experience and her reality. She had developed a mantra to focus her mind on what she knew she had to do. Anna's mantra had the purpose of focusing her on her reality and in what ways this aligned with her hoped-for mothering experience:

like a mantra that you tell yourself. Like, I wanted three kids, I've got three kids, they're all boys, but I'm happy I've got three kids, they're healthy (p32, Anna)

Alba, who appeared furthest along on the journey to acceptance and with the oldest children, described how her maternal 'GD' experience had dissipated "it just feels less of a thing", not completely but "in a way" as "they've got older". Although Alba appears to have reached acceptance and relinquished her hopes for a daughter, there is an air of deflation, "I don't know" and "in a way" indicates the longevity and possible lifelong nature of maternal 'GD' :

as they've got older, I don't know, it just feels less of a thing to me in a way (p5, Alba)

Alba described being brutally honest with herself about her reality as a strategy in her quest for acceptance:

I'm never going to have a little girl (p8, Alba)

In this chapter I have drawn together the themes that I identified through gazing across the mothers' stories and conducting a reflexive thematic analysis. Theme 1, Broken, explored the multifaceted and layered emotional experience of maternal 'GD'. This theme raises questions of whether the maternal 'GD' experience is one of "disappointment" or something more intense, distressing, and complex. Layers of difficult and intense feelings due to the loss of an imagined maternal future are identified and are marked by individual and societal silencing.

The theme 2, Hope, weaves through each mother's story, creating layers of longing and distress. Rooted in societal narratives about motherhood and parenting, the mothers created a hoped-for mothering experience. However, the dark side of hope created distress, and despite the intensifying distress, some mothers struggled to let go of the deeply held hope for a daughter. However, some of the mothers were beginning to make conscious decisions and continued efforts to accept their reality. This analysis has identified hope as a dynamic, layered, and complex process. The interweaving of hope, loss, and meaning making gives form to the emotional journey of the mothers in my study.

7.3 Chapter Summary

This chapter presented the final stage of analysis, which was a combination of stage 4 of the LG and reflexive thematic analysis. This combined analytical approached allowed for the identification of themes across the data set. Two overarching themes were identified: Broken and Hope. These themes do not sit in opposition, but rather they represent a dynamic and evolving relationship that will be explored in Chapter 8, Discussion.

The aim of this study was to develop a more informed conceptual understanding of maternal 'GD'. In Chapters 6 and 7, multiple themes were identified, including guilt, shame, pity, imagined futures and relationships, the role of sex and gender. These are all consistent with themes reported in the existing empirical literature on maternal 'GD'. Thus, to fulfil the study's aim of developing understanding beyond what is already known, the discussion that follows in Chapter 8 focuses on themes that emerged as novel or theoretically generative within my data. Specifically, limerence, hope, biographical disruption, and disenfranchisement. These

constructs offered new conceptual lenses through which to make sense of and better understand the experience of maternal 'GD'. Consequently, extending current theoretical understandings of maternal emotion and experience.

The decision to centre limerence and disenfranchisement in particular, reflects their analytical significance across participants' narratives. Both constructs captured recurring patterns of experience that had not previously been identified in the maternal 'GD' literature, while also allowing existing findings to be situated within richer theoretical contexts. Through the lens of limerence, I extend existing knowledge on mother's imagined futures and long hoped-for relationships. Similarly, disenfranchisement encompasses and helps to contextualise the shame, guilt, pity, and isolation that have been asserted in earlier research, enabling these emotions to be understood as responses to the social invalidation of maternal 'GD'. Thus, these theoretical lenses are not used in isolation from existing evidence but are instead employed to situate and deepen our understanding of what is already known, helping us to better understand how emotional and social dimensions of maternal 'GD' intersect and are reinforced.

Chapter 8: Discussion

8.1 Introduction

This study aimed to develop a more informed conceptual understanding of the maternal experience of a phenomenon currently known as 'GD'. To develop this understanding, my study explored the impact of this experience on a mother's perception of her emotions, sense of well-being, and help-seeking behaviour. This chapter will reflect on, analyse, and interpret the new insights found by this study. The novel findings asserted by this thesis reveal significant new layers of complexity in the journey of maternal 'GD' for women living in the UK. Consequently, as these layers had not previously been discussed or theorised, they raised questions beyond the scope of the existing literature review. Theoretical approaches that had not been discussed in the literature review were applied to explore their implications and enhance our understanding of the maternal 'GD' journey.

I draw on a combination of four theoretical and conceptual approaches to reflect on and evaluate the findings: i) hope theory; ii) the concept of limerence; iii) the theory of biographical disruption, and iv) grief theory. I demonstrate how these theories and concepts help us to better understand the findings and, how, when combined, they facilitate a more informed conceptual understanding of the maternal 'GD' journey for the population in my study. In this process, I have drawn parallels with bodies of research about other types of distressing lived experience, including IVF, infertility, parenting children who suffer from serious chronic medical conditions, and maternal grief (Copp et al., 2020; Mattingly, 2010; Peddie et al., 2005). I recognise the possible tensions and sensitivities around making such connections; however, to further understand the experience of maternal 'GD' and develop a more informed and nuanced conceptual understanding, these bodies of work needed to be drawn upon.

I begin this discussion chapter by presenting a summary of the key findings. The discussion is then presented in three overarching themes which illustrate the maternal 'GD' journey for the mothers in my study: i) Hope; ii) Silent Ruptures, and iii) Acceptance in Action. Next, I will argue that the current label of 'GD' is inappropriate and arguably harmful, and I will therefore propose a more appropriate way of labelling the experience of this population. Following this,

I introduce a novel model illustrating the negatively compounding cycles of distress that define the journey of this population. Finally, I make suggestions for future research.

In drawing this chapter to a close, I will argue that my study develops our conceptual understanding of maternal 'GD' in two distinctive ways. First, it proposes a more appropriate label that addresses misconnections and confusions that arise from the current terminology. Second, I present a novel model of the maternal 'GD' journey for the mothers in my study. These original contributions to knowledge were enabled by the innovative methods that I adopted and by my partial insider status.

8.2 Hope

8.2.1 The Longing

A Hoped-for Infant Sex Before Conception

For the mothers in my study, the maternal 'GD' experience began before conception with hopes for a daughter that they imagined and idealised. For most of the mothers, their daughter was imagined for as long as they could remember, but for Nora, it was not until adulthood that she knew she wanted to be a mother, and specifically a mother of a daughter. The commonality is, that before conception, all the women hoped for a daughter. Kane (2009) conducted a study in which she carried out 42 in-depth interviews from a socially and culturally diverse sample, including 24 mothers and 18 fathers, to ascertain if the parents held a son or daughter preference for before becoming parents. Kane (2009) found that even before conception, parents can hold an infant sex preference. Moreover, the sex of the parent's imagined child impacted their perceived relationship and anticipated experiences with the child, consequently shaping their identity as a parent. Kane (2009) reported a relatively even split for a son or daughter preference, to which McMillan's (2012) findings concur. McMillan (2012) analysed data collected from online 'GD' forums, and she found that parents have preferences for both sons and daughters. Notably, McMillan (2012) asserted that parental sex preference should not be regarded as fixed. Thus, infant sex preferences can exist before birth and may shape a parent's identity, but those preferences may evolve and change over time.

Longing for a Daughter

The mothers in my study all held an exceptionally strong preference for a female child, as can be seen by the level of distress they experienced when their hopes were not realised and a daughter was not conceived. Kane's (2009) study can help us to understand why a child of certain sex child may be longed for. Her participants reported that their infant sex preference was based upon expected parenting relationships and experiences and that these could be pre-determined based on the child's sex. Kane (2009) also found that prior to birth, the parents would imagine themselves sharing these important experiences, creating an anticipatory vision of both themselves and their children. Kane (2009) thus reported that the preconceived gender experience parents anticipate having with their child "contributes to the social reproduction of gender" (p378). The social reproduction of gender is reinforced by the persistence of gender essentialist views, which reinforce the notion of inherent and fixed differences between girls and boys, women and men (Baron-Cohen, 2004; Hendl and Browne, 2019; Mckay, 2018; Risman, 2004). It has been suggested that these embedded gender essentialist views are corroborated by the parents' lived reality (Groenewald, 2016; Saccio, 2025; Young et al., 2021).

The mothers in my study all talked about idealised bonds with their hoped-for daughters that would be special and enduring. They felt this hoped-for emotionally meaningful relationship was something that their sons would not be capable of, in part, because that is what society was telling them. In the context of maternal infant sex preferences, it has been suggested that the aforementioned gender essentialist views may be influencing the longing for daughters, as mothers anticipate that daughters innately possess the skills and desire to create fulfilling, emotionally rich and lasting mother-daughter relationships in ways that boys are simply not capable of (Eliot, 2009; Fine, 2010; Young et al., 2021). However, McMillan (2012) argues that the intricacies of sex preference are more nuanced than a sociological focus allows for as in isolation it fails to illuminate individual parental preferences and the nuanced meanings attached to them. Whether the desire for a child of a certain sex is individually or sociologically situated, Kane (2009) cautions that a parent's imagined experiences and anticipated relationships with their children did not guarantee that was the relationship they would eventually have, highlighting a possible emotional vulnerability for parents.

The participants that I recruited for this study, and all who enquired about taking part, were all mothers to only sons who longed for a daughter and significantly this was not a result of the study design. Interestingly, two recent qualitative studies which had a focus on maternal 'GD'

also recruited only mothers to sons and again, this was not due to the study designs (Young et al., 2021; Saccio, 2025). Notably, Kolk and Jebari (2022) highlight the "widely observed daughter preferences in many high-income countries" (p1619). A recent study conducted by Jensen and Jorgensen-Wells (2025) analysed data from 30 studies with samples in the Global North to look at predictors of parental differential treatment and found that "parents tended to report favouring daughters" (p39). In Jayarajah's (2023) paper, she also states that "the literature suggests that in Western culture there is a notable daughter preference, due to strong inherited beliefs that girls are innately more empathetic, emotionally aware, nurturing and closer to the family" (p3) although Jayarajah does not reference specific studies to support her claim. It is striking therefore, that in combination these studies suggest that female infant sex preference is the more dominant preference in the Global North.

It is important to note that notwithstanding their overwhelming longing for a daughter, the mothers in my study expressed their profound love for, and pride in, their sons. Similarly, Groenewald's (2016) study found that mothers who had sons and experienced maternal ''GD' wanted to impress on her the love they had for their sons. Young et al's. (2021) study found the same sentiments. Interestingly, McMillan (2012) argued that a strong positive preference for one sex does not necessarily translate into a negative preference for the opposite sex. She asserts that an infant sex preference should not be interpreted as a binary opposition between a positive and negative preference; that is, to actively want a daughter does not necessarily represent a rejection of a son, arguing also that the strength of a parent's sex preference and push away from the other sex may vary along a continuum. This suggests that the term "disappointment" may be misleading, as it suggests that the mothers are "disappointed" in their birthed child, whereas this is not what the women in my study experienced.

Applicability of Hope Theory

All the mothers in my study talked about hope for their imaged daughter: hope that one day she would be realised, and hope for an enduring and deeply meaningful relationship. Hope theory asserts that hope requires two elements; a sense of agency and a pathway, and in combination these elements facilitate the achievement of the goal upon which the hope is focused (Snyder, 2000). Thus, in turning to hope theory to help us to better understand the experience of maternal 'GD', the conception and birth of the mothers' longed-for daughter must represent a goal. Therefore, it was important to first establish if for the mothers in my

study, their longed-for daughter represented a goal or simply an assumption. A goal has been defined as "the object or aim of an action" (Locke and Latham 2002, p705), while an assumption is a fundamental belief that something is "true" without proof, and to fundamentally believe something is to assume that a particular outcome is inevitable (Newman and Rosenfield, 2018).

All the mothers in my study "*fundamentally*" (Anna) believed that they would have a daughter, rather than framing the conception and birth of their long-imagined daughter as their goal. Locke and Latham's (2002) review of goal-setting theory asserts that assumptions about a desired outcome can evolve into a goal. Expanding on this, several studies have investigated how individuals modify their skills and knowledge to achieve their goals (Gardner et al., 2016; Chiaburu and Marinova, 2005). In this way, an assumption can become a goal when the individual actively invests in making the goal happen rather than just expecting it to. Accordingly, as the mothers in my study gave birth to successive sons, they began to invest increasing amounts of time and energy in swaying techniques and eventually medical techniques to achieve their desired outcome of a daughter. Swaying is the use of natural techniques that aim to support female conception by aiding female sperm to reach the egg before the male sperm. Swaying techniques include timing of sex to align with ovulation and lifestyle and dietary alternations (Gouda, 2012; Philips, 1998; Shettles and Rorvik, 2006). Medical techniques are the use of PGT IVF to determine the embryos biological sex prior to implantation (Strange and Cesagen, 2010). Thus, due to the participants in my study shifting from passive to active investment in realising their fundamentally assumed daughter, the longed-for daughter may be conceptualised as a goal.

While the first element of hope theory is pursuing a goal, the second element is having a sense of agency (Snyder, 2000). Most of the mothers in this study described themselves as successful goal-achievers, even when the desired outcome seemed unlikely. This highlighted their perceived ability to act intentionally and with success. The mothers' sense of purposeful action reflected the concept of agency, which has been defined as an individual's ability to act and to make choices and decisions about their own lives (Cook and Cuervo, 2019). However, in the context of maternal 'GD', a woman's agency operates, in part, within her biological limits (Duncan, 2019; Foster, 2010) and within the paradigm of motherhood, feminists have described one facet of agency as a mother's ability to make reproductive choices (Neyer and Bernardi, 2011). Typically, reproductive choices refer to the decision about whether to have a child.

However, in the context of my study, agency takes on a more complex form, as it extends to women who have proven their reproductive capabilities but long for a child of the sex they have not given birth to, which in my study is a daughter. This means that for the mothers in my study who have already successfully proven their reproductive capabilities, their sense of agency extends beyond simply having children. For my population, their agency relates to a child of a specific sex, which is something they cannot directly control, perhaps bringing their sense of maternal agency into question and creating distress (Boyer, 2018).

Thus, there is a tension between the mothers successfully achieved reproductive choices and their inability to achieve the conception of a daughter. Women have been led to believe that their place of "power" is in motherhood (Szekeres et al., 2023; Harding, 2004b). But this perspective is not only flawed due to of biological constraints, but the mothers' availability of choice is further shaped by a myriad of social, relational, and structural influences that are often largely out of the mother's control (Duncan, 2019; Foster, 2010). The mothers in my study do not appear to be able to accept these constraints and they continue to employ their agency in seeking swaying techniques to help them conceive a daughter. Accordingly, these mothers struggled to let go of the hope they held for their long-imagined daughter. It has been argued that disengagement from parenting hopes is particularly challenging because parenthood often forms a central part of an individual's identity, making it difficult for parents to relinquish their psychologically and socially imagined parenting futures (Franklin, 1997). As a result, the inability of a mother to realise her imagined parenting experiences can create an emotional vulnerability (Wrigley et al., 2023).

All the mothers hoped for a daughter (their goal) but they also spoke about their need for hope to keep them going when they were enduring all-encompassing levels of distress, especially as their journey progressed and the mothers came to see that their daughter may never be conceived. Mattingly's (2010) ethnographic study of parents with chronically ill or disabled children sought to explore the hope that kept the parents going, even when there was no "cure" for their child, just as without a daughter the women in my study saw no "cure" for their maternal 'GD'. Although Mattingly's (2010) participants were managing their hopes for their ill children, the alignment with my study is that for both populations, their imagined future as a parent was being changed by their current reality. Mattingly (2010) expands Snyder's (2000) theory of hope in her assertion that hope is not intrinsically tied to an attainable goal. For Mattingly (2010), hope represents coping, providing resilience to individuals and the strength

to navigate a situation even when the desired goal cannot be achieved. The finding highlights that hope can be a positive force helping parents to cope in times of distress.

It has also been argued that it is optimism, rather than hope, that drives women to continue in their conception attempts. Copp et al., (2020) sought to establish the factors that contribute to the decision to continue or stop IVF cycles after multiple attempts. Twenty-two participants at one Australian fertility clinic were interviewed, and the transcripts were analysed using framework analysis. External and internal factors were identified as contributing to their decision making. The study found that the participants tended to overestimate the likelihood of successful subsequent IVF cycles despite having experienced multiple failed cycles, which was seen as "illustrating their optimism" (p6). Optimism is a general belief that good things will happen, even without investment (Segerstrom et al., 2017). Copp et al. (2020) attributed the participants' continued attempts at conception, despite multiple failed attempts, to their sense of optimism. However, I attribute the continued female conception attempts by the mothers in my study to conceive a female child to hope rather than optimism. Although optimism and hope are both positive states, however, there are key differences. Hope is a goal-directed and action-driven process that requires both the belief that success is possible and the active participation of the individual in pursuing their identified pathways (Snyder, 2000). Evidence suggested that for the population of mothers in this study, it is hope that drives their continued conception attempts, not optimism. Therefore, hope theory provides a useful framework for interpreting the findings of my study.

Accordingly, I argue that hope is central to the maternal 'GD' journey for my population. It is the hope for the long-imagined daughter that drives them to actively seek out pathways to achieve their daughter while using their agency to do so. They frame hope as a protective mechanism that keeps them going whilst preventing them from becoming overwhelmed with distress. Socially, hope is regarded as positive (Snyder, 2000) but paradoxically, it has a darker side (Brown, 2003; Nabi and Prestin, 2016; Rettig et al., 2007; Snyder, 2000).

8.2.2 The Dark Side of Hope

Maladaptive Hope

It has been argued that hope has the potential to keep individuals striving for their goal, even when the desired outcome may no longer be realistically achievable (Mattingly, 2010). This has been called false hope, and it is the point at which hope becomes maladaptive (Mattingly, 2010). The mothers in my study start their journey with high hopes for their long-imagined daughter, perhaps because the daughter is assumed to be inevitable, so there is no element of doubt to dampen their hopes of one day realising their daughter. However, despite repeated failed attempts at conceiving a female child, the mothers' hopes for their daughters keep them searching for alternative ways to successfully achieve the female conception that has thus far alluded them. Consequently, a mother's hope can move from a healthy motivator into something damaging, as the mother may continue to believe that her goal of a daughter is still attainable (Cook, 2018; Copp et al., 2020; Peddie et al., 2005).Thus, instead of seeking help and support as the distress and sense of loss of not having a daughter increase, the mother's false hope may fuel denial, obsessive rumination, and the seeking of uncertain pathways to success. Paradoxically, this false hope can prevent acceptance and increase hopelessness (Demirtas, 2020), which can detrimentally impact an individual's sense of well-being (Castelfranchi and Miceli, 2011; Snyder et al., 2002).

It could therefore be argued that false hope is what fuelled the mothers' continued attempts at female conception and their seeking of possible alternative pathways to support the conception of a daughter (Cook, 2018; Copp et al., 2020; Peddie et al., 2005), potentially contributing to a state of denial. In my study, denial is seen in the mothers' subtle, indirect behaviours, social interactions, and thought patterns. They rationalise or try and justify signs; they deny that they may never conceive a daughter; they appear to obsess over alternative conception methods (swaying and PGT IVF), or they incongruous emotional reactions (laughing off hurtful comments) that minimise the extent to which they reveal their distress to others. As part of false hope (Wrigley et al., 2023), the mother's denial appeared to sustain hope by allowing her to avoid the finality of knowing that she may never have a daughter. The concept of denial originated in the work of Sigmund Freud (Cramer, 2006) and has been described as a defence mechanism used to mitigate psychological distress and anxiety by rejecting or disregarding an undesirable reality (Ogden and Biebers, 2010). However, this coping mechanism has also been framed as maladaptive as it can prevent individuals from confronting and accepting their reality, and although this may appear to help, it is only a short-term solution (Boden and Boden, 2007). This is a significant assertion of my study as it shows that although denial might feel protective for the mothers in the short term, it has the possibility of prolonging distress.

The Role of a Sonographer

All the mothers in my study discuss the role of the sonographer in their maternal 'GD' journeys. They often found out the sex of their unborn baby as a way to manage their anticipated distress if they were told they were having a son. However, some mothers decided to wait and find out at birth as a way to prolong their hope. On the occasions when the mother's decided to find out their baby's sex during a scan, they all described how the anticipated experience with the sonographer held both fear and hope. Identifying the role of the sonographer and the ultrasound scan during the maternal 'GD' experience is a novel contribution to knowledge made by my study. The mother's interaction with the sonographer represents the point at which her long-held hopes will either be realised or revealed as fallacious, and thus it creates a point of increased emotional vulnerability (Da Silva et al., 2012). When applying the lens of hope theory, the sonographer's news that the mothers were carrying a son represents a defining moment; the women's hope that they had conceived a daughter is taken from them. Businelli et al., (2021) conducted a quantitative study of 285 pregnant women and found that anxiety is heightened before every ultrasound scan, but particularly at the first-trimester ultrasound scan, moreover, the level of anxiety felt by the mothers is likely underestimated. Businelli et al., (2021) also reported that most expectant mothers prioritise the detection of abnormalities at a scan over all else, yet, the mothers in my study were most anxious about learning their baby's sex; which they found difficult to accept and vocalise. This difference in concerns at the ultrasound scan highlights that for the population in my study, their baby's sex and the assumed gendered traits carry significant personal importance. Consequently, it suggests that for mothers who experience maternal 'GD', their longing for a child of a particular sex can shape their pregnancy experience, impacting their emotional state and levels of anxiety during routine scans.

Although sonographers are expected to deliver unexpected news around abnormalities during routine scans, it has been found that sonographers themselves often feel insufficiently trained for this difficult task (Tomlin et al., 2020). Given that the prevailing social narrative in the Global North is that a healthy baby is what parents should be most concerned about (Huppatz and Goodwin, 2010), the sonographer may not anticipate the disclosure of the sex of the foetus as a potential cause of significant distress, especially if the baby is healthy. Given the assertion that sonographers may already feel underprepared to deliver, although not uncommon, what

may still be unexpected or distressing new, the challenge becomes even more complex when the reason for the distress may not even be recognised by the sonographer. These findings highlight the need for improved training and an awareness among sonographers to ensure maternal well-being is upheld.

Maternal Emotional Disconnection

Some of the mothers in my study spoke about struggles bonding with their baby during pregnancy and fear about future bonding because he was a boy. Emotional disconnection with the infant during pregnancy is often experienced by the mother as a distressing, complex, and individually unique experience (Copeland and Harbaugh, 2019) with possible implications for maternal identity, mental health, and mother-child bonding (O'Dea et al., 2023). Embedded social narratives posit pregnancy as a positive bonding experience with the unborn child filled with emotional closeness, leaving little room for maternal ambivalence or uncertainty (Khalid and Hirst-Winthrop, 2020; Pollack, 2021). These normative expectations can make emotional disconnection difficult to understand or name, which can lead to guilt, shame, and perceived maternal inadequacy (Raphael-Leff, 2018). Creating a bond with the infant before birth has been said to support the mother's preparation for birth and longer-term parenting, so a disruption to this can be problematic (Stern, 1995). Within a hope theory framework (Snyder, 2000), the mothers' emotional disconnection with the unborn baby, maybe because the conceived son is the "blocker" to the mother's hoped-for daughter, as he has taken up one of her chances of female conception, resulting in the mother experiencing distress. Or, if that pregnancy represented the mother's last chance at female conception, she may feel hopeless (Marchetti et al., 2023). Thus, my data identified a layering of reasons as to why a mother may be experiencing a sense of disconnection with her unborn baby, highlighting the complexity of the maternal 'GD' phenomenon.

Some of the mothers in my study compared their sons' behaviours to the ways in which they imagined a daughter might behave, suggesting a possible disconnection or emotional distancing from their sons. McMillan's (2012) asserts that the longing for a child of a certain sex does not necessarily lead to negative feelings towards or rejection of children of the opposite sex, indicating that an infant sex preference can coexist with love for the birthed child of a different sex. However, negative feelings towards the birthed child cannot be ruled out for all mothers, as the data from my study and other studies do not allow for such assertions to be

made about the impact of infant sex preference on early bonding when there are possibly unresolved feelings of loss and distress. If a mother experiences disconnection with her child, there can be developmental implications for that infant (Branjerdporn et al., 2017). According to Bowlby's attachment theory, a secure emotional bond between mother and infant is imperative for the child's development (Bowlby, 1952; Bowlby, 1982). However, feminist and sociological perspectives highlight that attachment bonds posited by Bowlby are too narrow; moreover, Bowlby's approach attributes harmful levels of emotional and moral responsibility on mothers (Phoenix et al., 1991; Burman, 2007). However, this does highlight that it is essential for maternal and infant well-being and development to support mothers who may be at risk of experiencing emotional disconnection with their baby or who express difficulties in bonding, is essential for maternal and infant well-being and development (De Waal et al., 2023; Branjerdporn et al., 2017) thus, for mother's experiencing maternal 'GD' this implication should not be ruled out as a possibility.

High-Hopers

All the mothers in this study searched for multiple possible pathways, other than just sexual intercourse, in an attempt to conceive their long hoped-for daughter. Snyder et al.'s (1991) asserts that people hold varying levels of hope, with high-hopers being identifiable through their maintenance of a strong sense of agency in their generation of multiple potential pathways to achieve their goal (Corn et al., 2020). When high-hopers face an obstacle in obtaining their goal, they are not deterred; rather, they actively and persistently seek out creative alternative pathways to ensure success (Snyder, 2000). The mothers in this study appear to be high-hopers, as can be seen through their varied and continued explorations and implementation of pathways to support female conception, even when they may go against the assumed socially embedded narratives of the 'good' mother.

For the mothers in my study, as their maternal 'GD' journey progresses and they gave birth to more sons, the pathways they seek to try and conceive a daughter become more socially extreme (Hall et al., 2006). One mother, albeit half in jest, discussed the possible use of a sperm bank to secure a daughter. Several of the mothers talked about not knowing if they could continue with a pregnancy, while one mother had a termination due to having conceived a boy. The termination appeared to be carried out because if the pregnancy was continued with, Nora was "one chance down" in her female conception attempts, but with no more planned

conception attempts, that pregnancy represented her last possible chance, and she could not bear the thought of not having a daughter and so took the only option that would "free up" another female conception attempt. These experiences illustrate that the women in my study were becoming desperate, and in their desperation to conceive their long imagined and hoped-for daughter, they either considered or undertook pathways that may be viewed socially as extreme pathways. However, the women also described how these thoughts and actions were incongruent with who they believed themselves to be. This finding highlights the complex layers of distress, despair, and pathway seeking experienced by some mothers and how this led them to seek pathways that they may not ordinarily have considered.

Another example of a more socially extreme pathway that was either known about by the mothers' or was being actively considered was non-medical sex selection in the form of PGT IVF (Abassi et al., 2018; Hall et al., 2006; Shahvisi, 2018; Sharp et al., 2010; Strange and Cesagen, 2010). However, Snyder and Feldman (2000) have suggested that high-hopers are unlikely to choose socially risky pathways because they consider the implications of their goal and pathways within a social context, particularly in terms of whether their goal is working toward or against a greater social good. Sharp et al. (2010) used semi-structured interviews to explore the moral attitudes, beliefs, and social implications of 30 couples who had undergone PGD for non-medical sex selection. It was found that couples who held high hopes of conceiving a child of their longed-for sex rationalised their decision as morally acceptable and were prepared to defy societal norms and navigate complex ethical considerations and potential condemnation to pursue the hope of conceiving their long-imagined child. The participants in in the study by Sharp et al. (2010) acknowledged the social and ethical stigma attached to PGD for non-medical sex selection, but they justified their decision as a personal choice based on reproductive agency and a sense of empowerment. This illustrates another dark side of hope; as a parent's obsession with their goal of conceiving a child of a certain sex intensifies, they may rationalise or disregard ethical considerations in the pursuit of the outcome (Hall et al., 2006; Sharp et al., 2010; Strange and Cesagen, 2010), which highlights the importance for them of achieving this goal. However, parents who experience distress due to an unrealised infant sex preference following the birth of healthy children often already feel a sense of social isolation (Young et al., 2021). Thus, crossing socially established ethical boundaries may create further layers of isolation and possible shame for mothers (Wilcock et al., 2009). Such negative impacts can include cognitive dissonance (Festinger, 1957), acute emotional distress exacerbating negative impact on well-being (Lazarus and Folkman, 1984) and possible social

isolation (Page, 1984). Nevertheless, there is a scarcity of literature examining the psychosociological processes of parents who are contemplating or pursuing PGT IVF for non-medical sex selection and specifically looking at how these processes relate to the experience of maternal 'GD'.

High-hopers and their Vulnerability to Exploitation

A range of reproductive industries are undergoing rapid transformations (Hudson, 2019), and it has been acknowledged that sex selection for non-medical reasons is rapidly becoming an industry where the mothers' can be exploited by money-making businesses promoting PGT IVF as a "fix" to 'GD' (Hendl and Browne, 2019; Monson and Donaghue, 2015). However, my study extends this assertion by identifying that it is the paradox of hope that makes the mother's particularly vulnerable to exploitation. Moreover, at a certain point in their maternal 'GD' journey – when their chances of a daughter are diminishing which is seen as more sons are given birth to. IVF has been described as a "hope technology" (Franklin, 1997) and accordingly, Copp et al. (2020) argued that so long as IVF patients believe there is a possibility of attaining their hoped-for child, no matter how small the possibility, their hope leads them to continue with treatment, leaving them open to possible exploitation (Wrigley et al., 2023; Perrotta and Hamper, 2021).

Wrigley et al. (2023) and Perrotta and Hamper (2021) explore the roles of hope, vulnerability, and possible exploitation in ART. Wrigley et al. (2023) evaluated current thinking around how ART providers, for whom there is limited regulation, may exploit patients' emotional distress. They further argue that women embarking on a PGT IVF journey are already in an emotionally vulnerable position, making them susceptible to further emotional exploitation. This vulnerability is compounded by the financial strain of PGT IVF, in the context where non-medical sex selection is portrayed as a mean to achieve their hoped-for child. Perrotta and Hamper (2021) extend Wrigley et al.'s (2023) findings by asserting that hope is not only driven by the providers of ART, but hope is also socially reinforced through the Global North's socially perceived need "to try everything" approach, and by the notion that we always have a choice in our lives. Perrotta and Hamper (2021) use a sociological approach, and they assert that embedded social narratives create internal pressure on patients to continue ART treatment, even when they have experienced repeated failures and are dealing with the resulting increase in emotional and financial burdens. Their study revealed that hope is not passive; rather, it

actively drives women to continue with expensive ART treatments even in the absence of success. They argue that this combination leads to an experience where each failed conception attempt intensifies the patient's distress, making the woman even more vulnerable. Unlike Wrigley et al.'s (2023) theoretical discussion, Perrotta and Hamper's (2021) study gives voice to the experience of patients, providing rich, nuanced data for analysis. Although Perrotta and Hamper's (2021) empirical study explored the use of IVF for infertility, not sex selection for non-medical reasons, both studies concur with wider literature, that argues when patients continue conception attempts for their hoped-for child despite multiple unsuccessful attempts, and a declining likelihood of success, it leads to hope becoming false. Thus, women can become vulnerable to emotional and financial exploitation (Hendl and Browne, 2019; Jayarajah, 2024). For mothers experiencing maternal 'GD' this finding highlights that when hope remains unmet, it can become harmful, leaving women vulnerable to emotional and financial exploitation.

When Reproductive Hopes Remain Unmet

For all the mothers in my study, their hopes for a daughter remained unmet. Boden and Boden (2007) conducted 35 in-depth interviews with women and their partners to explore how patients cope when IVF treatment fails and the patient's reproductive hopes are not realised. It was found that when attempts finally ceased, the patients experienced distress and confusion. Höpfner and Keith's (2021) study, which explored goal-failure broadly, argued that repeated failures of a hoped-for goal have an undermining and compounding effect on well-being that remains for as long as that goal remains unmet. However, unlike IVF patients where the goal of conceiving a child is externally facilitated, the women in my study have "proven" their reproductive capabilities and are now employing their maternal agency to implement self-supported female conception techniques. Notably, there is no literature exploring how hope impacts well-being in this specific context. However, the findings of my study highlight the possible harmful impact of unmet yet deeply held hope in the context of maternal 'GD' is a novel contribution to knowledge because it challenges the social assumption that hope is always beneficial. Rather, hope in this context, after the birth of multiple children who are not of the longed-for sex, hope may prolong a mother's emotional distress rather than offering comfort, and this highlights an important risk to maternal mental health.

8.2.3 Limerence

At multiple times on their maternal 'GD' journey, all the mothers in my study imagined and created an idealised image of what their hoped-for daughter would be like. Furthermore, they experienced obsessive thoughts about how to conceive her and ruminated about their experience of maternal 'GD'. These characteristics mean that the concept of limerence can help us to better understand the maternal 'GD' phenomenon. Limerence is defined as having involuntary obsessive thoughts about an idealised romantic love object, called the limerent object, which leads to persistent rumination (Tennov, 1979). Smith and Alloy (2009) assert that rumination comprises of negative thought patterns that are repetitive, intrusive, and obsessive. However, there is a limited number of research studies on the experience of limerence outside romantic attraction, and the application of limerence to the maternal experience of 'GD' is an original contribution to knowledge.

Idealisation

Idealisation has been defined as holding unrealistic beliefs about others (Hague, 1994). In the context of maternal 'GD' the idealisation is that of an imagined daughter, a limerent object that does not exist in reality (Willmott and Bentley, 2015). In her study exploring maternal 'GD', Groenewald (2016) found that mothers idealise their imagined daughters. Groenewald (2016) argues that idealisation of the imagined child is not simply about the child's biological sex, but is it deeply tied to embedded social narratives about what it means to have a child of a certain sex and the subsequent relationship. This assignment of expected gender characteristics based on a child's sex has been identified in wider research (Agarwal and Kumar, 2023; Chase and Rogers, 2001; Eliot, 2009; Lawler, 2000). To this end, Groenewald asserts that the women's idealised daughters are constructed by the pervasive social narratives that denigrate boys and exalt girls. Groenewald (2016) expands on these assertions, reporting that the mothers in her study believed a daughter would give access to shared feminine rituals such as shopping, beauty routines and chatting as well as a close feminine bond, meaning that the mothers idealised daughter represented the "whole package" (p95).

In my study, some of the women wanted to recreate the relationship that they had had with their mother; others wanted to create an improved version of that mother-daughter relationship with their own daughter, while one mother who had never had a mother-daughter due to her

mother sadly passing away, wanted to create and experience her perceived special mother-daughter bond. This highlights how embedded social narratives, even when they do not necessarily align with what has been experienced, shape the idealisation of the mother's hoped-for daughter. Even before conception, my population created idealised relationships, thus us was not just the individual daughter that was idealised, but she was a conduit for fulfilling hoped-for emotionally rich relationships that had been created, in part, though deeply embedded social narratives about the strength of a mother-daughter relationship. These findings, that highlight the impotence of the idealised mother-daughter relationship, align with those of Duckett (2008), Groenewald (2016), Young et al. (2021) and Saccio's (2024) who all explored 'GD'. All these studies were empirical and gathered rich data, however, none of them explored in depth how the idealisation of the mother-daughter relationship it in a way that enabled deeper understanding of how idealisation fits within the broader maternal 'GD' journey. My study extends these findings by illuminating how the element of idealisation fits within the process of non-romantic limerence. Nonetheless, this group of studies throws light on how societies in the Global North portray girls as providing deep, enduring, mother-daughter relationships and this contributes to an obsessive idealisation of the imagined child.

Obsession

The mothers in this study experienced obsessive thinking about their imagined daughter and about what pathways could be taken to conceive her. Within the context of limerence, obsession is often linked with idealisation (Tennov, 1979) and while limerence was originally conceptualised within the context of romantic longing (Tennov, 1979), Willmott and Bentley (2015) suggest that limerence can be experienced outside of a romantic of sexual obsession and often reflects an individual's internal needs, past experiences, and psychological state. Regardless of the context and purpose, obsession remains the defining feature of limerence, which centres on an the obsession with a desired person and the inability to stop focusing on that individual (Wakin and Vo, 2008). Limerent obsession involves persistent thoughts (Tennov, 1979) to the extent of being unable to think about things other than the limerent object, moreover, the emotional intimacy associated with this obsession (Willmott and Bentley, 2015). In the context of my study, the limerent object is not associated with romantic love but with the connection to an imagined child. Moreover, the obsession was not just their individual psychological issue, but one that was socially shaped by embedded social narratives about boys and girls. These narratives assert what it means to be a "girl mum" or '"boy mum", constructing

sex and the associated gendered characteristics as a way to predict child behaviours and maternal experiences (Fine, 2010) shaping the obsession.

Rumination

All the mothers in my study experienced a variety of ruminative states; they imagined, in detail, their hoped-for daughters and the relationship and activities they would share. The women ruminated over what would happen if they remained "only" a boy mum. They also experienced angry rumination; anger and frustration at the unfairness of being able to reproduce but not conceive a daughter, anger at those mothers who had daughters, and worries about what they were experiencing and why.

Tennov's (1979) seminal literature on limerence suggests that individuals in a state of limerence experience ruminative thinking; re-playing past encounters with the limerent object or imagining future interactions. The distinguishing element for my population is that the rumination is only about future imaginings. Willmott and Bentley (2015) state that ruminative imaginings about the limerent object can produce significant emotional distress for the individual. Supporting these findings, a scoping review by Bradbury et al. (2024) explored rumination within the context of limerence, emphasising that rumination in a state of limerence is focused on an unobtainable limerent object, which for the women in this study is a daughter. Moreover, Bradbury et al. (2024) assert that rumination sustains the obsession with the limerent object. Supporting this view, McCracken (2024) suggests that a ruminative state due to limerence can last for years, mirroring how the mothers in my study describe prolonged ruminative states that they feel unable to repel, and that they fear may last for as long as they are seeking to conceive a daughter, which could be until they are biologically no longer able to conceive. For all my participants, this state had existed for many years at the point of my interview and had led to increasing desperation. This finding is important as the enduring rumination experienced by the mothers in my study led to persistent negative thoughts that increase emotional distress and stall a movement towards acceptance. A new contribution to knowledge is the length of time that mother's may be in a state of rumination, thus continuing to experience the distress of maternal 'GD'.

Angry Rumination

While rumination has been positioned as a core feature of limerence (Wyant, 2021), the paucity of research examining the limerent object beyond romantic contexts means that there is a gap in understanding rumination in the context of non-romantic limerent objects. Accordingly, in non-romantic contexts, the intensity and impact of the rumination may vary in a way that is not yet understood. The mothers in my study described a ruminative state focused on their limerent object, their imagined daughter, which produced anger and resentment towards mothers who had daughters, their husbands who some of the mothers perceive to be failing to provide them with a daughter, and towards themselves for perhaps not having tried everything possible to conceive a girl. Anger has been documented as an element of rumination (Anestis et al., 2009; Denson, 2013), and resentment often underlies anger (Fantini et al., 2013; Salmela and Szanto, 2024) and gives rise to angry rumination (Denson, 2013). Denson (2013) conducted a multidisciplinary review on angry rumination and conceptualises it as "perseverative thinking about a personally meaningful anger-inducing event" (p103). Anestis et al. (2009) argue that angry rumination can lead to the development of hostility and not just physical aggression (Denson, 2013). Hostility was reported by my population and appeared to impact the mothers' relationships with friends and husbands.

In her qualitative study, Groenewald (2016) found that mothers experiencing maternal 'GD' have what they call "disgusting" and repetitive resentful and angry thoughts due to not having a daughter while other mothers do. However, Young et al. (2021) present a different cause of angry rumination, arguing that the resentment and anger may arise when mothers to only sons perceive themselves as social failures. A divergence in disciplinary viewpoints may explain the differing perspectives; Groenewald's (2016) study is situated in the field of psychology, while the study by Young et al. (2021) has a more sociological orientation. My study extends these findings by situating the angry rumination as part of a repeating process that is experienced and intensified with the birth of each child that is not of the hoped-for sex. Furthermore, my findings show that angry rumination can also be directed at friends and the mother's husband, not only strangers, which could lead to relational struggles and consequently a breakdown in the mothers' support network.

Goal-Directed Rumination

All the mothers in my study spent time, energy and money ruminating on their unmet goal of conceiving a daughter. Which, in remaining unmet, lead to distress, the emergence of false

hope, and difficulty in moving towards the acceptance that they may never have a daughter. Goal-directed rumination has been found to be constructive where a goal is likely to be obtainable and unconstructive where it is not (Thomsen et al., 2011). Where rumination on a goal is unconstructive, this can lead to a negative impact on well-being (Siriapaipant, 2021).

By extending hope theory and combining it with the widened concept of limerence, my study has found that mothers who experience maternal 'GD' may encounter intensifying idealisation, obsession and rumination as their maternal 'GD' journey progresses. For the population in my study, the longing for a daughter begins as a seemingly simple assumption, but when not realised, it evolves into a complex emotional and cognitive set of experiences that combines gendered expectations, goal-directed agency, and intense obsessive idealised longing, culminating in a limerent rumination on the non-romantic connection with a daughter and how that hoped-for daughter may be realised. I assert that the non-romantic limerence that is experienced by the population in my study and helps to illuminate the reasons behind the mothers' persistent idealisation, obsession, multiple forms of rumination, and investment in goal-orientated natural and medical swaying techniques.

8.3 Silent Rupture

8.3.1 The Rupture of an Assumed Future

All the mothers in my study imagined themselves as mother of a daughter, but for all the mothers, this hoped-for, idealised, and imagined future remained unrealised. Bury's concept of biographical disruption (Bury, 1982) offers a theory for better understanding this experience. The theory of biographical disruption originated in studies on chronic illness, where it was found that the onset of illness disrupted the future that individual imagined for themselves, forcing a re-evaluation of their identity and future. The experience of biographical disruption necessitates a fundamental rethinking of the self, as the foundations that underpin knowledge of everyday structures and notions of self-identity are disrupted (Locock and Ziebland, 2015). Beyond chronic illness, the framework of biographical disruption has been applied to a wide range of contexts, including frailty, loneliness, critical illness and life transitions (Cluley et al., 2021; Morgan and Burholt, 2020; Tembo, 2017; Wedgwood et al., 2020). I argue that the rupture between the future assumed by the mothers in my study and their lived reality, evident by the absence of their imagined daughter, disrupts their existential equilibrium and thus their

identities, perceived agency, and sense of control (Tillich, 1944). Using biographical disruption theory to aid understanding of this maternal experience is novel.

In my study, having a daughter formed a core part of the future identity that the women imagined for themselves. The mothers described not having a daughter as a deviation from their anticipated maternal experiences. Ussher and Perz's (2018) study is pertinent as it explored the threat of biographical disruption in women and men whose anticipated parenting experiences were threatened due to infertility following cancer. They found that parenthood is central to adulthood for many, and that threats to parenthood were problematic as they negatively impacted well-being and necesitated the need for the parents to reconstruct their future selves. It is not clear how many of the participants shared their fears about the possible disruption to their imagined parenting future with their partner or a healthcare professional, yet we do know that for those that did share their concerns, it was beneficial. Moreover, in sharing their fears, these individuals was "more likely to report identity reconstruction" (p12); they felt better understood, as sharing normalised their experience in an inclusive way. Due to the data being collected via surveys, probing follow-up questions were not facilitated; thus, we have no further understanding of the psychosocial factors that might have influenced their decision to disclose their fears, the types of responses or support they received, or how this support shaped their long-term identity reconstruction. Ussher and Perz (2018) used an existing clinical population for recruitment to their study, something that is currently not possible with maternal 'GD' because women experiencing the phenomenon perceive their struggles to be largely invisible in healthcare settings and do not share their maternal 'GD' experience with health-care professionals (Young et al., 2021). Thus, recruiting a clinical population to study the phenomenon of maternal 'GD' would not be currently feasible. We are therefore unable to explore help-seeking in professional health-care settings or potential support processes, which limits our current understanding to self-identified experiences rather than those gathered in a clinical setting. Thus, because maternal 'GD' is perceived to be less recognised in health-care settings, the experience of biographical disruption may be compounded by stigma and shame (Dunford and Granger, 2017; Page, 1984), potentially undermining mothers' sense of self, making identity reconstruction problematic, and creating further layers of distress to the already difficult emotional experience (Dickson et al., 2008; Johnston-Ataata et al., 2020).

Although biographical disruption is widely framed as distressing, Locock and Ziebland (2015) posit that disruption can also lead to biographical reinforcement, inspiring growth where new

meaning and identity can be constructed, thus positively impacting perceived well-being. An individual can therefore emerge with a strengthened sense of purpose, values and beliefs form an experience of biographical disruption (Carricabuuru and Pierret, 1995; Wilson, 2007). In the context of maternal 'GD', the strengthening and re-framing of self could include reimagining what it means to be a mother to only sons and finding purpose and value outside of the mother-child relationship (Green, 2015; Toronto, 2024). Two of the mothers in my study talked about finding new meaning in their life without a daughter and how this helped them to begin to move out of their maternal 'GD' distress which they had been experiencing before actively investing in a life they had not imagined, as a mother to only sons. Studies on post-traumatic growth support this perspective, suggesting that meaning and identity can be developed after a traumatic experience (Calhoun and Tedeschi, 2014; Dell'Osso et al., 2022). However, such meaning-making is not certain, especially in contexts where the depth of distress is not acknowledged, because in this instance, an individual can become more susceptible to being stuck in distress (Park, 2010). Moreover, for meaning-making and growth to take place, there must be space for the disrupted identity to be socially acknowledged (Muldoon, 2020) because this determines whether the disruption and associated emotional distress are seen as socially legitimate (Butler, 1990). However, this is currently problematic for those experiencing maternal 'GD', as the absence of social validation for the experience may prevent the full activation of this adaptive potential. In this way, the biographical disruption when experienced due to maternal 'GD' may become not only chronic, but also stagnant, worsening its psychological impact and the effects of social isolation.

Applying the concept of biographical disruption to the phenomenon of maternal 'GD' reveals several novel findings. In particular, I argue that maternal 'GD' as experienced by the mothers in my study, constitutes a form of biographical disruption with psychosocial implications. Distress is compounded by the social taboo and lack of societal validation of the maternal 'GD' experience, in part evidenced using the term "disappointment", which does not acknowledge the significant distress that is experienced by the mothers. While the application of biographical disruption to maternal 'GD' is theoretically promising, studies of biographical disruption have predominantly focused on medically and socially recognised loss and disruptions, whereas maternal 'GD' is viewed by the mothers who experience it as a stigmatised and socially taboo experience. Nonetheless, the concept of biographical disruption supports the development of a deeper understanding of the disruption experienced by mothers affected by maternal 'GD'.

8.3.2 The Loss

Current Theories of Grief and Maternal 'GD'

All the mothers in my study experienced the five different facets of grief outlined in traditional loss literature: denial, anger, bargaining, depression and acceptance (Kubler-Ross and Kessler, 2005). The five stages of grief were developed to describe the experiences of terminally ill patients confronting their mortality, not to understand how a bereaved individual may be experiencing loss. This distinction is crucial, as although the framework developed by Kubler-Ross and Kessler (2005) framework has enabled a broad understanding of loss, applying the model that is presented in stages may not enable the nuances of the loss to be fully captured. It has been argued that the Kubler-Ross and Kessler model (2005) oversimplifies the individual and complex nature of grief, which is influenced by psychological, social and cultural elements that cannot be neatly organised into five stages (Neimeyer, 2001). Moreover, in challenging the notion of a universal grieving process, some research has suggested that grief is not a linear process where individual progresses through distinct stages (Stroebe et al., 2017). However, through the integration of multiple grief theories, more recent literature has furthered our understanding of grief, enabling a greater appreciation of its nuances (Black, 2020). Empirical research into 'GD' has reported that parents can experience a "deeply personal grief" (Groenewald 2016, p123) as a "continual mourning" (Duckett 2008, p107) and it has been asserted that the intensity of the loss experienced by the individual is linked to the level of investment given in achieving the child of the longed-for sex (McMillan, 2012). Until my study, the qualitative study by Saccio (2025), using semi-structured interviews of 12 biologically female participants, provided the most comprehensive insight into the relationship between maternal 'GD' and grief until my study. Saccio (2025) illuminated the alignment between the loss experienced due to 'GD' and the framework depicting the five stages of grief (Kubler-Ross and Kessler, 2005) drew attention to the notion of disenfranchised grief (Doka, 2002). Disenfranchised grief is a loss that is not socially recognised or accepted, and has no social mourning rituals, which can lead to the individual feeling invisible or unrecognised (Doka, 2002; Reynolds, 2002). Furthermore, it has been argued that when a loss is disenfranchised, the grief experience is exacerbated (Boss, 1999b; Layne, 2000; Mitchell, 2018). Although Saccio (2025) highlights an element of disenfranchised grief in relation to maternal 'GD', this is only discussed in relation to the second stage of grief: anger. Consequently, Saccio's (2025) findings could therefore be extended as they do not illustrate how the entirety of the loss experience as part of maternal 'GD' is shrouded in

disenfranchisement as my findings assert. Furthermore, my findings posit that disenfranchisement encompasses the entire maternal 'GD' experience. It penetrates and compounds the mothers' loss and suffering multi-dimensionally, persistently, and more intensely with the birth of each subsequent child who is not of the hoped-for sex. This is important, as failing to recognise the significance of the disenfranchisement on the broader maternal 'GD' experience, maternal help-seeking and well-being cannot be fully understood (Cassidy, 2023).

The mothers in my study spoke about struggling to frame their loss as grief as their daughter did not exist despite that being what they thought they were feeling. This aspect of maternal 'GD' could be understood as ambiguous loss which occurs when there is the absence of a tangible loss which creates a lack of certainty about the loss being experienced (Boss, 1999a). It has been reported that an ambiguous loss can be experienced in cases of missing persons, dementia, or foster siblings who move on to an adoptive parent's home (Tatton, 2023; Testoni et al., 2023; Yehene et al., 2024). Accordingly, the inability to obtain closure that makes the loss difficult to process, which may lead to prolonged emotional distress (Lang et al., 2011). Kirui and Lister (2021) asserted that when their participants had experienced a perinatal loss, they found emotional comfort by engaging in rituals and receiving social support. The findings of my study highlight that mothers who experience 'GD' often grieve in isolation, with no socially acknowledged rituals or vocabulary, and without the words to describe what is being experienced shame is perpetuated (Brown, 2012). In the context of maternal 'GD', the emotional burden of the loss is prolonged and complicated by the lack of social legitimacy (Butler, 1990). Consequently, without permission to grieve, mothers may experience a recursive cycle of shame, sadness, and secrecy (Duckett, 2008), leading to the erosion of emotional well-being (Caldwell et al., 2021).

My findings build upon the way in which 'GD' loss has been framed as disenfranchised and ambiguous and I assert that both these types of grief are evident in the maternal 'GD' experience. But significantly, a distinguishing factor of the disenfranchised and ambiguous loss my population experienced is the way in which the mothers describe how a 'good mother' would not be feeling the grief and distress that they were, as their grief conflicts with socially embedded master narratives of 'good' maternal behaviour (Kerrick and Henry, 2017). Mothers experiencing 'GD' perceive their grief to be socially inappropriate, and although they believe that sharing this profound sense of loss would be helpful (Young et al., 2021), it can only be

shared with other ‘GD’ sufferers who understand its complexity (Duckett, 2008) as my population recounts that grief and difficult emotions that they are experiencing go against the good mother model (Doonan, 2022; Kerrick and Henry, 2017). These findings are important as they highlight that maternal ‘GD’ is a multi-dimensional.

The Trauma of Parental Grief

The analysis of the data in my study found that with the birth of each son, the mothers grieve their imagined daughter more intensely, as the hopes that they will conceive the daughter they have long-imagined increasingly diminish. The intricacies of this intensifying emotional distress due to increasing grief and diminishing hope are not currently reflected in the literature and are a novel finding of my study. Current research illuminates the significant, enduring, and life-altering emotional consequences that parents face when navigating the grief of perinatal loss, and although the mothers in my population do not experience a death loss, they do experience a form of loss, and so the effects of perinatal loss is important to help better understand the experience of maternal ‘GD’ for the women in my study. Kirui and Lister's (2021) interpretative phenomenological study aimed to explore the lived experiences of mothers following a perinatal loss, their findings show significant emotional impacts, including confusion, emotional pain, denial, and anger that create a “traumatising experience” (p1). Importantly, Berry et al. (2021) expand on this and reported that these emotionally difficult experiences are not isolated or temporary. Their study was an interpretive meta-synthesis of 14 qualitative studies that included diverse geographical and cultural contexts and focused on losses that occurred from conception until the neonatal phase; thus, all the losses were of conceived infants. Berry et al. (2021) synthesised the emotional experiences of parents following perinatal loss and found that intense emotional turmoil, marked by complex and intense heartbreak, helplessness, and emotional pain are endured when parents experience a perinatal loss. Significantly, these are all emotions that my population also described experiencing. A critical finding of Berry et al's. (2021) meta-synthesis was that grief arising from parental loss is complex and multifaceted and is felt as a “traumatic and life-altering experience for parents” (p28). Their findings posit that the psychosocial complexities of parental loss mean that healthcare interactions with parents are crucial, as they can either exacerbate or alleviate the parents’ emotional distress. Sensitive and knowledgeable communication is an important protective factor, which is a widely supported (Raine et al., 2010). However, there is a notable difference between the population in Berry et al's. (2021)

meta-synthesis and my study; the women in my study are mourning the loss of an imagined child, they are not grieving for a child that has been conceived, meaning that the ambiguous and disenfranchised elements of loss endured by the mothers in my study are not captured in the meta-synthesis, and thus remain unknown. However, the significance of this finding is that maternal loss is a traumatic life event, and further research is required to understand the nuances of this trauma, and the impact of mothers who experience maternal 'GD'.

The Physical Experience of Grief

The analysis of the findings of my study have identified that for some of the mothers their grief, which was intensified by the compounding sense of lost hope for their long-imagined daughter, led to physical symptoms, sometimes acute and often chronic. The physical impact of grief is a well-documented phenomenon, with studies consistently showing that the emotional stress of grief can lead to a range of symptoms including fatigue, insomnia, headaches and gastrointestinal issues (Chirinos et al., 2019; Kowalski and Bondmass, 2008). A study by Testoni et al. (2023) analysed quantitative data of 185 bereaved individuals compared to 4,041 non-bereaved men and women and showed that bereaved people reported higher levels of somatic symptoms, such as headaches, chest pain, and dizziness. Crucially, the study identified that these physical manifestations were significantly mediated by heightened levels of anxiety and depression associated with grief. In the context of ambiguous or disenfranchised grief, the potential to experience increased anxiety is notable (Testoni et al., 2023). While Konkolÿ Thege et al. (2012) do not discretely explore ambiguous or disenfranchised grief, their study suggests that where grief is socially unrecognised or unsupported, individuals may experience heightened anxiety, thereby increasing the likelihood of physical impacts. This highlights the importance of acknowledging and conducting research into all forms of grief, including maternal 'GD'. This would enable better understanding of the possible relationship between the grief experienced and the mother's experience of difficult emotions, such as anxiety, as found by my study.

Guarding Against Grief

Possibly in an attempt to alleviate emotional, relational and physical symptoms of grief (Baker et al., 2017), the women in my study made conscious avoidant logistical choices when going about their daily lives, such as where they would shop and who they would be friends with.

Maternal grief following perinatal loss has been found to significantly influence a mother's daily decisions, including the choice of support groups and friendships, particularly so in the face of ambiguous maternal loss (Gold et al., 2016; Kavanaugh et al., 2004). In Cassidy's (2023) synthesis of parental grief literature, women who had experienced stillbirth or neonatal death reported avoiding places where there might be pregnant women or babies because they felt that these encounters would be emotionally challenging and too difficult to manage. Cassidy's (2023) study illustrates how grief can impact women's decision-making in their daily life. My study has added to this body of literature by identifying that in the context of maternal 'GD', women actively chose to avoid certain shops and groups of mothers as these become reminders of what is missing, intensifying their grief.

Similarly, Berry et al.'s (2021) meta-synthesis identified the theme of "transversing the social sphere" (p25) where they found that parents' "social interactions and social networks changed (…) and continued to change" (p25) when grief is experienced by parents, creating a sense of isolation (Hu and Wang, 2023). The mothers in my study reported changes in their social interactions that, like Berry et al.'s (2021) findings, changed as their maternal 'GD' journey evolved, with all the mothers experiencing perceived isolation during their maternal 'GD' experience. The population in my study described an evolution of their social interactions that were shaped by proactive decisions they made because of the grief they experienced. For example, some of the mothers chose not to see friends who had daughters because it reminded them of the loss they felt at not having a daughter while others felt ostracised by "girl mums". Research has found that shame, sadness and anxiety (something all the mothers in my study experienced) may influence where a mother feels emotionally safe when grieving, which highlights how logistical decisions come to be made not for convenience, but as an emotionally protective mechanism (Anderson et al., 2005; Cacciatore et al., 2009;Smith et al., 2020). Berry et al. (2021) reported that parents experiencing grief "felt others neither understood nor acknowledged their emotional pain" (p25), which can cause a change of routine to avoid places where these "others" may be (Baker et al., 2017). This can lead to the restructuring of daily life routines, an adaptive mechanism illustrated in the dual process of grief model (Stroebe and Schut, 1999). Furthermore, Berry et al.'s (2021) meta-synthesis posits a "continued change" (p25) in decision making, suggesting that logistical disruption is not a one-time shift, but an ongoing dynamic process where grieving parents continually reassess what they are emotionally able to withstand and adjust their logistical decisions accordingly (Khosravi, 2021). The possible implications of this are deepened when considering the ambiguity,

disenfranchisement and taboo shrouding maternal 'GD' (Groenewald, 2016; Saccio, 2025; Young et al., 2021). With no tangible loss to mourn and with the phenomenon of maternal 'GD' currently being viewed by the mothers who experience it as socially inappropriate, mothers experiencing 'GD' may not have their grief socially recognised or validated, making their logistical self-protection even more isolating (Tatton, 2023). Moreover, their withdrawal from potentially supportive spaces could impact their access to both formal and informal support (Smith et al., 2020) impacting their help-seeking behaviours.

Partner Relationships and the Grief of Maternal 'GD'

From a psychosocial perspective, grief affects not only the mother on a personal level but also her relationship with her partner, who for every participant in my study was the woman's husband. All my participants talked about their relationship with their husbands as being impacted by their maternal 'GD' experience. Grief can strain relationships by triggering misunderstandings, social withdrawal, or conflict (Dayton, 2023). Furthermore, the relational impact can be compounded when the loss is ambiguous or disenfranchised, as individuals may struggle to communicate their grief, leading to shame (Brown, 2012), causing them to feel unsupported (Kudeva, 2015; Reynolds, 2002). I argue that in cases of maternal 'GD', the grief experienced due to not conceiving the hoed-for daughter can cause relational strain between the mother and her husband (or partner); importantly, this strain that is amplified by the societal taboo surrounding the grief associated with the loss of an imagined child.

The women in this study initially found their husbands to be supportive of their emotional turmoil caused in part by her grief, but they reported feeling that this support waned as they gave birth to more sons and their grief and hopelessness became more distressing and enduring. The mothers began to feel unheard, which led some of them to feel resentment and anger towards their husbands. Studies indicate that mothers experience intense and enduring grief following a perinatal loss (Kersting and Wagner, 2012) and Stinson and Lasker (1992) found that at two months, one year and two years following pregnancy loss, women experienced grief more intensely than the "man". However, the limited studies with even longer longitudinal methodologies make it challenging to ascertain the significance of this finding for the mothers and fathers in my study, as the relational impact of the mothers' enduring grief had been accumulating for several years, usually since the birth of their first son. A novel finding of my

study is that the grief begins when the mothers find out that she has not conceived a daughter, and this grief is compounded by the birth of each son thereafter.

The assertion in existing literature that fathers may experience grief differently from mothers (Stinson and Lasker 1992) due to the social expectations of manhood and masculinity (McNeil et al., 2021) is of interest in the context of maternal 'GD'. Where the mother longs for a daughter due to a desired connection that is perceived as being possible only with a female child, relational problems arising from different grief experiences may serve to reinforce her belief that men and boys are not capable of meaningful emotional relationships, as is posited by this study and upheld by wider research on 'GD' (Groenewald, 2016; Young et al., 2021). Through confirmation bias, this may then compound the mothers distress and grief at not having a daughter (Peters, 2022). Although there is a growing corpus of literature exploring parental loss that offers initial insights into the relational effects of grief, it is not sufficient to provide an in-depth understanding of the phenomenon of maternal 'GD'. Until now, the impact of this grief on the mother's reported relationship with her husband, which was outlined in the findings of this study, has remained unacknowledged, as has the possibility that the perceived lack of support from the mother's husband/partner could serve to confirm the gendered assumptions that underpin of her longing for a daughter.

Intersecting Grief Theories

While the five stages of grief model (Kubler-Ross and Kessler, 2005) has provided a simple and accessible framework for understanding a specific process of grief, making it influential in both clinical and research contexts, the model has been widely critiqued for its lack of breadth and depth. Particularly when it is compounded by ambiguous and disenfranchised loss, as I argue is the case for maternal 'GD', grief can significantly and detrimentally impact the emotional, relational, physical, and logistical dimensions of an individual's daily life. While studies that explore ambiguous and disenfranchised grief provide valuable insights, there is a need for studies that explore the intersection of these forms of grief in the context of maternal 'GD'. By addressing these gaps, we can better understand the wider scope of grief's impact on women who experience disenfranchised or ambiguous loss of a longed-for, yet imagined, child. The findings of my study offer a valuable addition to the field of maternal grief by identifying dimensions that lie beyond its traditional focus.

8.4 Acceptance in Action

8.4.1 Barriers to Acceptance

The Deferral of Acceptance

One significant barrier to finding acceptance for my population is that they have proved their reproductive capabilities; thus, they "just" need to conceive a daughter. Without external barriers to their conception attempts, the mothers seem to defer their acceptance and keep trying to conceive a daughter. There is a dearth of literature exploring reproductive attempts when women in question have given birth to multiple healthy children. However, the study by Abramov et al. (2022) illustrates that when external constraints, such as financial ones, are removed, as seen in Israel's unlimited IVF funding model, women often persist in undergoing IVF treatment far beyond the point of realistic success. The study by Abramov et al. (2022) showed that women's conception attempts appeared to be sustained by unrealistic optimism, suggesting that financial barriers can serve as a defined stopping point that prompts parents-to-be to relinquish their hope for their imagined child and turn towards acceptance. However, in the absence of such barriers, women may not experience the external imposition of goal disengagement and thus defer their acceptance, which can lead to maladaptive hope (Wrigley et al., 2023). This finding suggests that for the population in my study, while the possibility of female conception remains, hope is sustained. Although the study by Abramov et al. (2022) used a quantitative methodology, which, it has been argued, can curtail the collection of in-depth data that would facilitate a more nuanced understanding of the women's decision-making (Blaikie, 2009), their findings are of particular interest to this study as, unusually for research studies exploring repeated IVF conception attempts, in Abramov et al.'s. (2022) study the financial barriers to the mothers' conception hopes are removed. The population in my study can conceive children without medical intervention; thus, they too have no external financial barriers to conception attempts. The intersection between my population and that of the study by Abramov et al. (2022) is crucial, as it helps us to better understand the process that mothers who experience maternal 'GD' may experience before feeling able to relinquish their hopes for a daughter. Abramov et al.'s (2022) study asserts that the exhaustion of all conception options is central to the process of hope relinquishment and acceptance. Thus, for mothers who experience 'GD', without clear stopping points such as financial constraints, perceived parenting capacity and partner reluctance (Gameiro et al., 2012; McDowell and Murray, 2011), there may be no perceived stopping point in their goal pursuit of a daughter. Conversely, in research exploring the letting go of conception hopes during IVF, where payment was required,

women were reported to reluctantly relinquish their hopes for a child sooner than they might otherwise have done (Domar et al., 2018; McDowell and Murray, 2011). Thus, the need for the women to in my population to feel they have tried everything possible to conceive a daughter becomes a self-imposed requirement, which may lead to the paradoxical persistence of hope (Snyder, 2000). This would explain why the mothers in my study continued to have children even though their distress increased with the birth of each son. Due to the lack of external barriers, other than no longer being able to conceive owing to menopause, the mothers are able to keep deferring their acceptance indefinitely. This is a significant and novel finding as it highlights that the absence of external limitations can intensify unresolved grief and enable the avoidance of acceptance.

All Pathways Must Be Explored

For this reason, it has been argued that relinquishment of hope is an adaptive mechanism that is beneficial to emotional well-being, achievable through goal disengagement (Boden and Boden, 2007; Wrosch et al., 2010). Consequently, goal disengagement may be achieved through an "I've tried everything approach". However, existing research does not adequately explain how an individual knows that they have tried everything. Hope theory asserts that when there is an element of possibility, probability, or plausibility (which my population reports feeling will remain until menopause is reached), the individual may unrealistically perceive their goal to be obtainable (Snyder, 2000). Therefore, no matter how small a chance of success, mothers who experience 'GD' may continue to pursue their goal by deferring their acceptance that they may never have a daughter, thereby adding additional layers of distress to their journey.

The Challenge of Goal Disengagement

A novel assertion of my study is that for the women in my population, there is a point in the maternal 'GD' experience where hope becomes maladaptive. For the mothers to be able to move away from maladaptive hope to adaptive hope, they must disengage from their hoped-for goal of a daughter. This may be achieved through the withdrawal of both effort and commitment to the goal and through the pursuit of a different, yet meaningful, goal (Wrosch et al., 2003). However, this assertion by Wrosch et al's., (2003) needs to be approached with care in relation to the population in my study, as these findings may have limited applicability

to socially taboo and stigmatised hopes. In the paper by Wrosch et al., (2003) there is an assumption that the original hoped-for goal is socially legitimate and validated. However, when their findings are applied to goals that are socially taboo, they may not be applicable. If the individual did not receive social support to fully engage in attaining the goal initially, this makes goal disengagement problematic, as they may feel they have not yet had the opportunity to "try everything". Also, without social validation, which has been found to support the adaptive coping required for the relinquishment of hope (Cook, 2018; Van Baar et al., 2025) the women in my study face a double silencing: one for the initial hope, and again for grieving the loss of that hope. Accordingly, this may complicate goal reengagement (Doka, 2002; Kudeva, 2015; Snyder, 2000) and increase the women's sense of defeat, which has been associated with depression, anxiety, feelings of helplessness, and impaired cognitive flexibility (Griffiths et al., 2014; Murata et al., 2019).

Furthermore, Wrosch et al.'s (2010) assertions seem to overlook the impact of goal disengagement in cases where hope is closely tied to an individual's sense of identity, as has been described in the case of motherhood (Christopher, 2012). When a goal that is linked to an individual's sense of identity is removed, it can lead to a loss of purpose, adding another complex layer of distress (Boreham and Schutte, 2023; Feldman and Snyder, 2005) to the already taboo and disenfranchised experience of maternal 'GD'. Moreover, Wrosch et al. (2010) suggests that goal disengagement is most beneficial when accompanied by re-engagement in a different yet meaningful goal. However, as Wrosch et al. (2010) themselves identify, if no alternative goal is available, the result of disengagement is not adaptive; rather, it can create an additional layer of distress. The mothers in my study struggled to see any possible alternative goal to having a daughter, which makes engagement in a repositioned goal challenging for them. Thus, while Wrosch et al.'s (2010) study offers valuable insights and illuminates the potential emotional benefit of goal disengagement, these findings cannot be extrapolated to all populations. A more nuanced approach that considers social influences and complexities is essential to support populations such as the mothers in my study.

8.4.2 Moving Towards Acceptance

Agency in Acceptance

The mothers in my study who appeared to be moving towards acceptance described taking a proactive approach and adopting a daily conscious mindset to enable them to let go of their

hopes and to find acceptance as a mother to only sons. Peddie et al.'s (2005) qualitative study explored 25 women's decision-making at the end of IVF treatment and found that the reason why the women kept trying to conceive when they should have stopped treatment was false hope. Moreover, that their false hope delayed the inevitability of having to "admit defeat" (p1945), and at the point of accepting they would remain childless, they were "forced" (p1949) to face issues they had previously ignored. Throsby (2002) draws attention to the notion of being defeated and forced; she argues that if a hopeful parent can instead interpret the decision to relinquish hope for their imagined child as a conscious choice, this will strengthen the legitimacy of their decision-making process and reduce their distress by enabling them to retain some sense of agency and control. However, Thorsby (2002) makes an implicit assumption that the hopeful parents can publicly acknowledge their hopes for a child and the loss felt when their child is not realised. This assumption may be largely accurate for patients undergoing IVF in the Global North, yet for mothers in the same geographical region who long for a child of a certain sex after birthing healthy children of the opposite sex, such social validation is felt to be largely absent (McMillan, 2012; Young et al., 2021).

The mothers in my study who had started to move towards acceptance described it as an engaged, proactive process that they had to consciously choose, even though they would rather not have. It has been asserted that repositioning hopeful goals is most effective when an individual perceives themselves to have agency (Malovicki-Yaffe et al., 2023). Giving up hopes for a child by deciding to cease IVF treatment has been described as a process requiring "constant maintenance through repetition" (Throsby, 2002, p237). Literature exploring the role of maternal agency in the repositioning of taboo parenting hopes is limited, but the findings of my study indicate that the mothers may feel that the disenfranchised and taboo elements of their experience restrict their agency, which makes goal repositioning more complex. These new insights fill a gap in our understanding of maternal 'GD' as they highlight that the narratives around the relinquishment of hope for mothers who have longed for a child of a certain sex can either support women and their well-being by igniting their sense of agency or potentially hinder their ability to find acceptance, causing additional distress.

Action Crisis and Maternal 'GD'

Although the mothers in my study did not want to give up hope for a daughter, some began to feel that holding onto their hope was causing them significant levels of distress; therefore, they

reluctantly acknowledged that they must begin to find acceptance. The intricacies of the multi-dimensional experience of letting go of hope can be understood as a complex and phased experience that emerges from persistent goal failure and the realisation that goal pursuit is causing increasing levels of distress (Franklin, 1997; Perrotta and Hamper, 2021; Snyder, 2000; Wrigley et al., 2023). This is both a cognitive and emotional process (Brandstätter et al., 2013; Dufault and Martocchio, 1985) which can be conceptualised as a phase of action crisis (Brandstätter et al., 2013). An action crisis phase represents the point at which hope can become maladaptive unless the mother engages in a process of goal disengagement and identity reconstruction. The systematic review by Gameiro et al. (2012) explored the reasons why patients stop IVF treatment. It was reported that repeated failed IVF attempts created increasing emotional distress, and this distress, which was being fuelled by the continued goal pursuit, was a defining reason for stopping conception attempts; this could be conceptualised as a phase of action crisis (Brandstätter et al., 2013). The relinquishment of hope alleviates the distress, marking a movement from a maladaptive to adaptive process (Brandstätter et al., 2013; Wrosch et al., 2010). The two mothers in my study who appeared to be moving into acceptance also seemed to have experienced a phase of action crisis, and although the grief for their imagined daughter remained, they reported that their level of distress had decreased when they began to relinquish their hopes and, importantly, their pursuits aimed at conceiving their longed-for daughter but they talked about how they felt that their grief would always remain. The concept of action crisis to the experience of maternal 'GD' provides an additional tool to expand our understanding of the maternal 'GD' experience. It helps us to better understand what may prompt mothers to move away from their state of intense distress and towards acceptance.

Finding New Meaning

Continuing the discussion of acceptance in relation to grief, the seminal literature on disenfranchised grief (Doka, 1999; Doka, 2002) deepens our understanding of the loss experienced by the women in my study experienced, but the later sixth stage of grief that focuses on meaning-making can further our understanding of the proactive process of acceptance (Kessler, 2019). Kessler (2019) concurs with Throsby (2002) in positing that proactive engagement in finding new meaning allows individuals to move beyond acceptance and to build a new future more purposely, effectively and with meaning. The concept of meaning-making aligns with literature that emphasises the need for meaning and purpose to uphold an individual's sense of well-being (Aftab et al., 2019). Yet, while meaning making

may be beneficial, some research has cautioned against its universal applicability. Not all individuals benefit from seeking new meaning, as these attempts can exacerbate distress, especially when an individual is not able to find meaning in new hopes (Annison and Davidson, 2023). A review of three papers exploring meaning-making in grief found that the meaning-making process is not restricted to internal processes but is shaped by "cultural meaning systems" (Valentine, 2019, p42). The first and third of the studies that Valentine (2019) reviewed are particularly pertinent to my study, as they highlight that meaning-making associated specifically with disenfranchised loss specifically, is a complex interplay of the cultural and social dimensions of loss (Boss, 1999a; Davies, 2004; Doka, 2002). The first study that Valentine reviewed explored meaning-making following drug-related death; the second was a paper that explored sense-making in the wake of the death of a young father and the final study was about death by suicide. Valentine's (2019) work is significant as it highlights that new meaning-making associated with potentially stigmatised losses is complex and so requires an individualised and nuanced approach to support (Delgado et al., 2023; McNeil et al., 2021; Pitman et al., 2018; Postavaru et al., 2023; Loyal et al., 2023). While Kessler's (2019) sixth stage of grief is helpful in the value it places on building a new future with meaning as a means to find acceptance, it risks invalidating the nuances of cultural and personal coping mechanisms in meaning-making (Valentine, 2019). Thus, my findings highlight how the sixth stage of grief must be applied with sensitivity to experiences where there are socially disenfranchised and taboo facets such as in the journey of maternal 'GD', but the value it brings is important for the population in my study.

8.5 Introducing a New Term

When commencing my study, I used the term 'GD' as the label for the phenomenon under exploration, as that is the term used in both academic research and in online parenting forums. However, in taking a novel approach, I began to refer to what I was researching as maternal 'GD' as a way of making to highlight that while 'GD' could be experienced by a range of populations, including fathers, grandparents, and the hoped-for child's siblings, amongst others, and the experience explored within my study that was focused exclusively on the experience of mothers. However, since the analysis of my findings I am led by my data to argue that the term 'GD' is inherently flawed. I assert that this term is not only problematic but that is is actively damaging to the mothers. The experience of the population in my study is not one of disappointment, but something so intense that it causes complex grief, despair, vulnerability,

and relational struggles. Furthermore, the incorrect usage of the terms "sex" and "gender" is also unhelpful as this phenomenon does not appear to be about gender, which is a socially constructed notion, but rather the sex of the child because of the assumed gendered characteristics and expectations of that sex.

Across Chapters 6 and 7, a number of emotional and relational dimensions of maternal 'GD' were identified, many of which, such as guilt, shame, imagined futures, and pity, uphold the findings of existing empirical research focused on maternal 'GD'. However, the analytic process of my study also identified new and underexplored aspects of the maternal 'GD' experience. By engaging with limerence and disenfranchisement as interpretive lenses to better understand the phenomenon, I sought not to move away from what is already known, but to embed it within a more layered understanding.

Limerence provided a means of situating mothers' imagined futures, longing, hope, idealisation, obsession and rumination, while disenfranchisement illuminated how shame, guilt, pity, and isolation can be understood societally and not just as an individual psychological experience. In this way, the discussion of this thesis has demonstrated how these theoretical constructs can extend, connect, and reframe existing knowledge. Thus, moving further towards a conceptual understanding of how maternal 'GD' is experienced, sustained, and shaped through the interweaving of psychological experience and social context.

Together, these interpretations informed the development of the term "maternal disenfranchised limerence" ('MDL'), which consolidates these insights and offers a conceptual springboard for new language in the articulation the complex interplay between hope, loss, longing, and identity within the maternal 'GD' experience.

Therefore, for the population in my study, I argue that the term 'MDL' more accurately reflects the experience of the phenomenon than the current term of 'GD'. The proposed new terminology moves beyond the current conceptualisation of the phenomenon, which my study has shown is grounded in an imagined, enduring mother-daughter relationship, a desired maternal identity, shaped by cultural constructions of sex and the societal gendered assumptions attached to biological sex and shrouded in disenfranchisement, leading to complex and nuanced layers of enduring distress. I am therefore proposing the term 'MDL', as it highlights that through limerence, the mothers experience agonising distress which is compounded by disenfranchisement multidimensionally. While limerence has traditionally

been understood as a state of romantic infatuation, this study extends the concept to include maternal limerence, which is an intense emotional fixation on a hoped-for imagined child and an idealised relational future. It was important that in proposing a more appropriate term, I also drew on existing 'GD' research. I did this to acknowledge the value of prior research and to demonstrate that my terminological contribution is evidence-based and not decontextualised.

I acknowledge that the new term I am asserting may not be immediately understood, and the terms "disenfranchised" and "limerence" may initially seem too academic. However, research shows that new, and challenging vocabulary can be acquired by adults (Smejkalova and Chetail, 2023). Furthermore, the use of accurate terminology encourages higher-level thinking (McKeown, 2019), which advances and supports understanding of an experience, and this is especially important in a healthcare setting (Nickel et al., 2017). In the context of this study, the use of 'MDL' describes an experience that does not yet have an appropriate label, therefore introducing this novel term allows for a more accurate understanding of the experience by mothers, wider society, health-care professionals, and academics (Mugweni et al., 2021). Choosing appropriate language around mental health challenges has been shown to reduce stigma, (Volkow et al., 2021) and empower patients because they are able to better understand their experience, therefore supporting help-seeking and help-giving (Smith et al., 2023). However, the newly proposed term 'MDL' is intended as an interpretive tool rather than definitive label. The asserted term aims to provide a starting point for discussion and conceptualisation of maternal 'GD' through the situating of both existing knowledge and novel insights from this study. Importantly, the term proposed by this study is positioned as a springboard for further exploration of terminology, encouraging refinement, debate, and adaptation in future research, rather than suggesting that the term should be treated as fixed.

What follows is a synthesis of the findings which led to a modelling of the 'MDL' journey. Although the dimensions of the model are presented linearly for the purpose of presentation, the dimensions are overlapping and dynamic, and together, they give form to the broader experience of 'MDL' as experienced by the population in this study.

8.6 Modelling the Journey of 'MDL'

In this study, I propose a provisional model of 'MDL' as a conceptual framework for better understanding this maternal phenomenon. The model is developed from the mothers' case

studies and reflexive thematic analysis. It is intended to capture key processes such as limerence, disenfranchisement, hope, and biographical disruption.

It is important to emphasise that the 'MDL' model is provisional and exploratory. It is not presented as a definitive or universally generalisable framework, but rather as an interpretive tool that situates both existing knowledge and new insights uncovered by this study. The model provides a foundation for future conceptual development and offers a springboard for further exploration of the maternal 'GD' experience, including the refinement of terminology and the investigation of additional dimensions of the experience. Any future research using 'MDL' as both a term and the model should treat this as a flexible and contingent framework that is open to adaptation and extension.

The analysis of the findings led me to model the journey of the mothers in my study into a negatively compounding cycle, which repeated and intensified with each son that was given birth to, until acceptance could be turned towards. The model maps the women's journeys onto distinct yet overlapping dimensions, which illustrate a nuanced, forward-moving, dynamic process through which 'MDL' is experienced. Rather than fixed phases, the mothers moved fluidly, and with varying levels of intensity through and between the dimensions in a way that does not represent a linear journey or universal sequence; rather, they reflect the emotional, cognitive, and relational aspects of the experience, shaped by individual, social, and contextual factors. This model is not intended to impose a rigid structure, but it offers a representation of the multidimensional and complex journey that the population in my study experienced. Consequently, it creates a more informed conceptual understanding of the phenomenon. My findings suggest that there are 7 dimensions to my population's experiences of 'MDL', and my data represents women experiencing different dimensions of this process and at different points along the overarching journey.

With each dimension I offer a descriptive narrative rooted in the analysis of the findings. The model begins before conception, and each dimension is shrouded in disenfranchisement. Beneath each description, relevant theoretical perspectives are integrated to contextualise and deepen understanding of these experiences. This presentation allows theoretical perspectives to illuminate the psychological, sociological, and relational processes the women in my study were living through. In a different population an alternative model might be identified. These theoretical insights serve not as explanations but as interpretive tools illuminating how hope,

loss, identity, and acceptance interact within this complex and nuanced disenfranchised experience.

Dimension 1: The imagined and hoped-for maternal experience. 'MDL' dimension 1 represents the mother's imagined maternal experience before giving birth. For this population, the birth of a daughter was often assumed to be inevitable. The women's longing was shaped by the perception that only a daughter could provide a deeply emotional, enduring, intuitive relationship and certain maternal experiences, something that a son was perceived to be incapable of.

Theoretical underpinnings: hope, limerence: idealisation.

Dimension 2: Preoccupation. Dimension 2 was not always experienced before the first conceived son. However, after the first-born son, the mother's preoccupation with how to conceive her longed-for sex begins and it intensifies after the birth of each child that is not the longed-for sex.

Theoretical underpinnings: hope, disenfranchisement, maladaptive hope, limerence: obsession, and rumination.

Dimension 3: Finding out the sex of the foetus. Finding out the sex of the conceived child when being shared before birth, represents a spike in distress for the mothers. It is the moment when the mothers' hope for their longed-for child is taken away and when intense distress, and disenfranchised grief is experienced.

Theoretical underpinnings: disenfranchisement, biographical disruption.

Dimension 4: Loss. When the women learn that they have not conceived a child of their hoped-for sex they experience disenfranchised grief for their long-imagined child. However, the women feel that even if acceptance is reached, their grief for their imagined daughters may never disappear (Boss, 1999a; Doka, 2002).

Theoretical underpinnings: disenfranchised grief, biographical disruption.

Dimension 5: Distress. With the birth of each son, the mothers' distress and difficult emotions become layered, compounded, and intensified. This has multi-faceted harmful impacts on the mothers, affecting their daily lives and producing detrimental effects on their relationships, decision-making and well-being.

Theoretical underpinnings: maladaptive hope, limerence: idealisation, obsession, rumination, disenfranchised grief, biographical disruption.

Dimension 6: Birth of child. This represents a significant moment, because it seems that after this point, for the mothers in my study, there is temporary relief from the distress of 'MDL'. I assert this as none of the women describe their difficult emotions as taking place at this point in time. However, my study is not able to expand on this dimension.
Theoretical underpinnings: *not known.*

Dimension 7: Reaching "the line" and moving towards acceptance. This dimension encompasses the way in which some of the mothers began to draw a line under the negatively compounding cycle illustrated below. The women reach this dimension in a yet undetermined period-of- time or after having given birth to a certain number of children. It is characterised by relinquishment of hope for a longed-for daughter and nascent acceptance that they may never conceive and birth a daughter. This required the women to reposition and reinvest in their imagined mothering experiences. It also involved re-evaluating perceived social narratives of what it means to be a mother to sons. When "the line" is reached, the mothers begin to find a level of acceptance of not being able to mother their hoped-for and long-imagined daughter. This entails relinquishing all hope for their daughters and, importantly, the ceasing of seeking pathways to conceive her. Ceasing to seek pathways to conceive a daughter appeared to be a definitive aspect of this dimension, as it denoted the beginnings of acceptance for the mothers. However, even when "the line" is reached, the mothers sometimes revisited the possibility of trying again for their long-imagined daughter. The combination of relinquishing hope and ceasing to seek pathways appeared to enable the women to live their lives as mothers to only boys. It began to bring an end to the enduring and multi-dimensional distress that they experienced and enabled them to seek the positives in their lived reality as mothers to only sons.
Theoretical underpinnings: adaptive hope, biographical disruption, and action crisis.

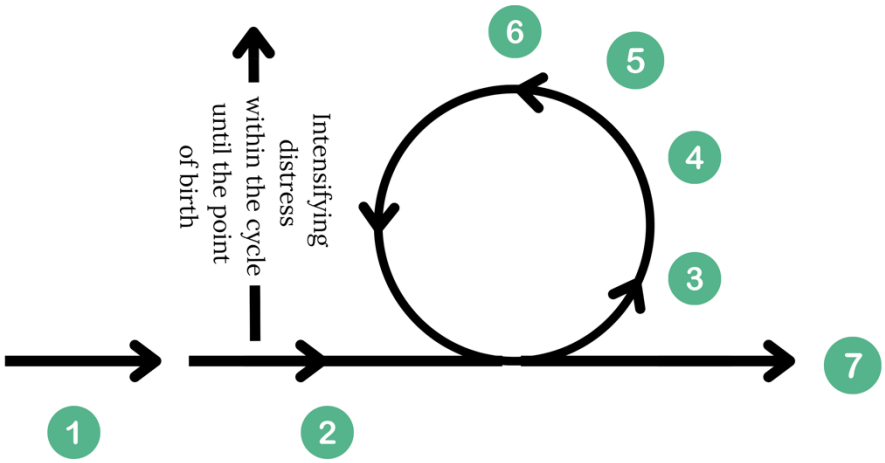
Oscillation Between the Dimensions. The analysis of the data suggested that oscillation between the dimensions is frequent. The findings identified that the hope held by the mothers for their longed-for daughter, and the imagined maternal experiences that the women believed only a girl could bring are incredibly deep. Therefore, to relinquish their hope and reimagine

their future without their imagined daughter is a profound, emotionally painful, complex, and multi-faceted experience that creates oscillations between the different dimensions.

Limitations of the model. Not all my data supports an understanding of dimensions 6 and 7. Dimension 6 represents the birth of a child; however, this dimension remains little understood. Some of the mothers in my study (Georgie particularly) remained stuck in dimensions 2, 4 and 5, and I was unable to ascertain when or if they would reach dimension 7, or what might happen if they remained stuck and unable to accept. Thus, these dimensions require further attention, as addressed below in the future research section.

Below, I present two novel visual models to represent the experience of 'MDL' for the mothers in my study. The first representation is of one cycle, which is experienced once for each child born that is not the deeply hoped-for sex. In contrast, the second model represents a zoomed-out perspective, illustrating the broader negatively compounding cyclical journey of 'MDL' which is experienced as multiped children that are not the longed-for sex are given birth to. The numbered dimensions reflect the key elements of the cycle for my population; however, the gaps between the numbers do not delineate the passage of time between the dimensions. For the mothers in my study, the birth of a child represented a temporary reduction in the level of distress they were experiencing before the cycle began again.

8:6:1 The Negatively Compounding Cycle of 'MDL'



1. The journey begins with **imagined & hoped-for maternal** experiences shaped by personal hopes and social experiences.

2. **Preoccupation** with how to conceive the sex of the longed-for child pre-conception.

3. **Finding out the sex** – a spike in distress is often experienced when the sex of the feotus is confirmed.

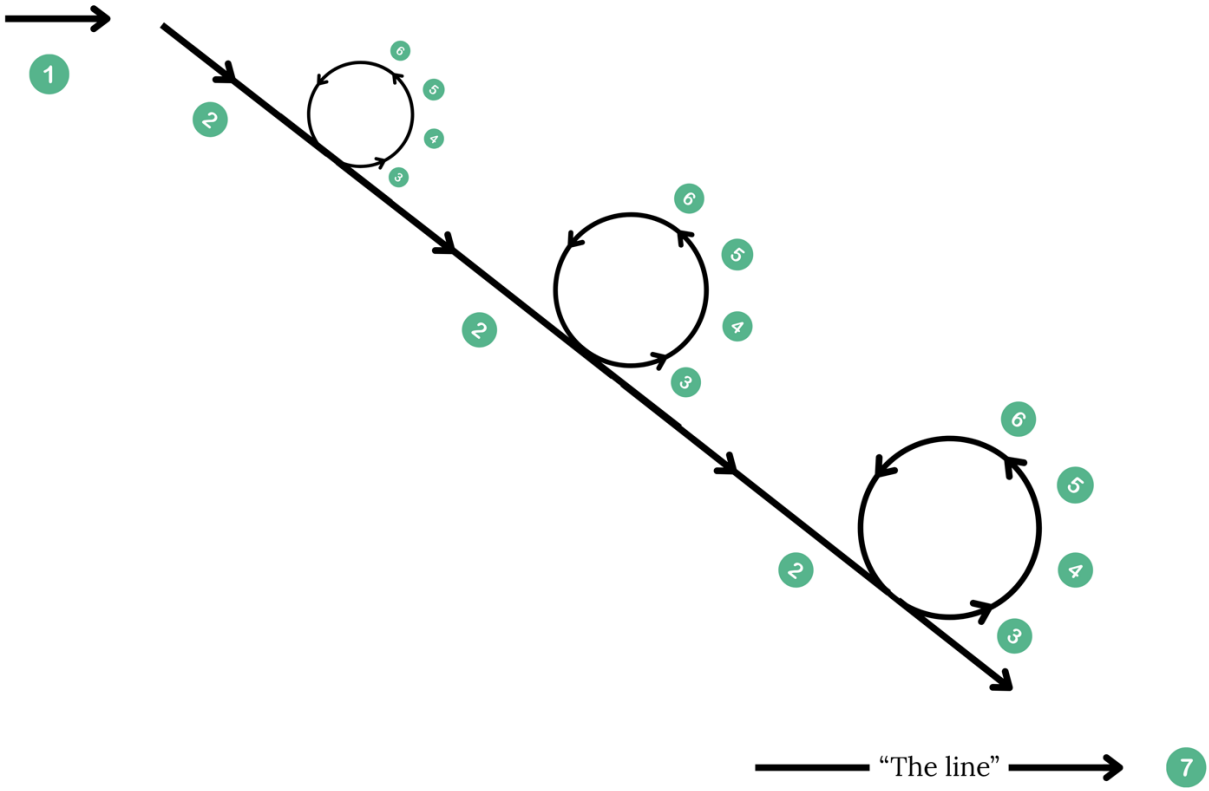
4. **Loss** – disenfranchised grief for the los of the longed-for child.

5. **Distress** – multifaceted and intense distress, including rumination, shame, helplessness and confusion.

6. **Birth of the child.**

7. **Reaching "the line" and moving towards acceptance.**

Although presented linearly for the purpose of presentation, the dimensions are overlapping and dynamic. Dimension 2 is usually experienced less intensively for the first conceived child and sometimes not at all. Together, they illustrate the journey of MDL as experienced by the population in this study



"The line" is reached, and there is a movement towards acceptance

A cycle is experienced for each child that is not the longed-for sex, until "the line" is reached, and then there is a movement towards acceptance.

With each repeating cycle there is:

- Increasing preoccupation
- Increasing distress
- Hope becomes increasingly maladaptive

8.7 Limitations

This research provides detailed and layered insights into 'MDL' as experienced by six mothers. While the study provides rich, nuanced data, it is important to acknowledge the scope-related limitations. The sample size was appropriate for the methods employed, allowing for in-depth, iterative analysis. Yet the homogeneity of the sample (all British mothers with only sons) limits the range of experiences that were captured. Greater diversity could be obtained in terms of ethnicity, sexuality, socio-economic status, or family structure and would provide additional perspectives and extend understanding of 'MDL' in broader populations. Likewise, limitations in time and resources precluded co-production of the research with participants, which might have enhanced the study through greater depth, accountability, and collaborative insight.

However, these limitations reflect the practical constraints of the study, rather than any shortcomings in its design or the application of the chosen methods. The study remains methodologically robust, providing a strong foundation for future research to explore the additional dimensions found by this research.

8.8 Future Research

Multiple aspects of the data presented here warrant future research.

8.8.1 The Dimensions of the 'MDL' Journey and Terminology

Whilst my study has developed a novel model of the 'MDL' journey for the women in my study, future research should seek to explore these dimensions in greater depth as these provide a springboard to further develop our understanding of 'MDL'. Consequently, the terminology used and the model being developed should be kept under review as our understanding of the phenomenon develops.

8.8.2 The Variations of 'MDL'

Thus far, empirical studies have explored 'MDL' from the perspective of mothers or have used online data. Consequently, there is a need to widen the research scope to include the

experiences of heteronormative parents, as well as parents from all sex and gender orientations, siblings and extended family.

8.8.3 Fear and Trauma in The Development of 'MDL'

The nuanced and complex ways in which social elements may shape and impact early life experiences for the mothers that may have led to 'MDL' require further research. The mothers all long for a daughter to provide them with a specific mother-daughter relationship, and in relinquishing their hopes, they may be faced with feelings and experiences that they have avoided (Peddie et al., 2005). But the scope of my study did not allow for the uncovering of what it is about these mothers' own experiences that led them to become so desperate for this type of relationship.

8.8.4 Healthcare Providers' Understanding of 'MDL'

There is a need for future research to understand healthcare providers' understanding of 'MDL'. While many mothers wanted to share their mental health struggles with professionals to gain support, this was problematic for some. Effective maternal mental health support requires healthcare professionals' ability to recognise and effectively support women (Baldisserotto et al., 2019; Hadfield et al., 2019). However, currently there is no data identifying healthcare professionals' knowledge of 'MDL'. Addressing this gap is imperative for improving mental health outcomes for mothers.

8.9 Reflexive Pause

My suggestions for future research are situated in the knowledge generated by this study; however, I am also aware that they are likely shaped by my work outside of this thesis. Working as a coach with women who experience 'MDL', I can meet with women over a period of time and explore in even more depth their experience of 'MDL'.

Furthermore, Dr McMillian and I have been approached by specialist midwife groups across the UK to deliver training and information on 'MDL'. From the data gathered at each session, it has become apparent thar there is a significant lack of knowledge around 'MDL' among healthcare providers is apparent, but healthcare professionals are motivated to learn about this

phenomenon. Although we have been able to gather a snapshot of data, it is not in-depth. To further support mothers who experience 'MDL' through training, policy developments, and support pathways, we must first better understand the knowledge position of healthcare providers.

8.10 Chapter Summary

My study advances our conceptual understanding of 'MDL' in two keyways; firstly, by proposing a more accurately informed term for the phenomenon that addresses current misconceptions while acknowledging that disenfranchisement and distress are central to this maternal experience. Secondly, I present a novel model of the phenomenon as experienced by the mothers in my study. The seven dimensions either build on our existing knowledge or have until this study not been identified in the literature in this way. These original contributions to knowledge were made possible through innovative data collection and analysis methods that I approached as a partial insider.

Chapter 9: Conclusion

In this chapter I illustrate the specific and novel contributions that my study makes to the literature on 'MDL', alongside a summary of my findings. I conclude by offering my final reflections.

My aim for this thesis was to explore the phenomenon known as 'GD' to develop a more informed conceptual understanding from the perspective of mothers. My objectives were i) to explore the emotional impact of maternal 'GD', focusing on the range, depth, and expression of the emotions experienced; ii) to examine the impact of maternal 'GD' on the mothers' sense of mental and relational well-being; and iii) to investigate the processes of help-seeking by examining how the mothers talk about seeking support, understand their experience, and feel validated in their maternal 'GD' experiences. Six mothers who self-identified as having experienced maternal 'GD' took part in walking interviews, and the data was analysed using the four stages of the LG, with the final stage being integrated with reflexive thematic analysis. From the novel methods used and the layered analysis carried out as a partial insider, new insights were gained, more appropriate terminology was proposed, and a model of the journey experienced by the mothers in my study was presented.

9.1 The Specific Contribution to the Literature on 'MDL'

9.1.1 Methods

A unique contribution of my study lies in the innovative use of walking interviews to collect data on a maternal mental health experience within the domain of health sciences. This represents an original approach to data collection in this field, creating an embodied experience for both participant and researcher, moreover, where a reduction of power dynamics could take place. As a result, the mothers appeared relaxed and open, sharing some very traumatic events with me. This approach not only facilitated the generation of rich data, but it also demonstrated the value of walking interviews in qualitative health science research.

The richness of the data collected through the walking interviews enabled the full potential of the LG to be used. The multiple levels of analysis allowed by the LG made it possible to identify the layered and often conflicting voices within each mother's story. Stage 1 enabled

me to ground myself in the women's stories. I felt a weight of responsibility telling the mother's story using only her words, but it was an incredibly powerful way to understand each mother's unique experience. Stage 2, I Poems, enabled me to see previously unnoticed contradictions in the mothers' experiences while creating a powerful and engaging form of data that I hope will draw readers into wanting to engage in the research. Stage 3, contrapuntal voices, was particularly important to me as it resonated with my philosophical orientation: that human experience is not flat or one-dimensional but is multi-dimensional and complex. Accordingly, through the analysis of the mother's contrapuntal voices, I was able to present these findings. Stage 4 of the LG enabled me to gaze across all the mothers' stories to identify themes across the data set. The integration of reflexive thematic analysis with stage 4 of the LG, a structured, multilayered analytical approach was supported,

My positionality as a partial insider (Hayfield and Huxley, 2015) enriched the entirety of the research process. I remained alert to my lived experience being different from that of the mothers in my study, but I held such respect for them because of their bravery in sharing their story and such empathy for all that they had been through, mainly in silence. During the interview, when the mothers shared something particularly personal or challenging, I would say how hard that must have been, or how brave I thought they must have been. I think this genuine empathy built meaningful, and sometimes almost tangible, rapport. When asked, I was open in sharing appropriate aspects of my own 'MDL' experience, and all the mothers thanked me sincerely for this and for conducting the research. I continually embedded reflexivity into my research, and this supported the credibility, transparency, and accountability of the research process.

I will now outline the specific contributions to knowledge my thesis makes.

9.1.2 Terminology

In orienting my study to pay attention to the emotional, well-being and help-seeking behaviours of the mothers who experience this phenomenon, I have been able to argue that the current term 'GD' is inherently damaging. I argue that the term 'MDL' is more appropriate for the mothers in my study. The term 'MDL' not only deepens our conceptual understanding of the phenomenon by questioning the notions of "gender" and "disappointment" but also disrupts dominant narratives about socially acceptable maternal emotion and experience in the UK. In

doing so, the terminology I am proposing fills a significant gap by providing more accurate language that better captures the nuanced complexity of the phenomenon experienced by the women in my study, thereby validating the experience for mothers and healthcare providers who might support them.

9.1.3 Modelling the Journey of 'MDL'

Through the combination of my philosophical orientation, innovative methods, the analysis of my findings, and the application of new theories and concepts to the data, I developed a model of the journey of 'MDL' for the mothers in my study. Prior to my thesis, no overview of the 'MDL' experience had been presented. The negatively compounding cycle that I present encompasses facets of the 'MDL' experience that have been previously documented: distress, grief, and shame (Young et al., 2021; Groenewald, 2016; McMillan, 2012; Duckett, 2008). However, my research extends and deepens this understanding by offering an overview model that illustrates the interconnected, dynamic, and nuanced dimensions of the 'MDL' journey of my population, some dimensions of which had not been previously identified in existing literature. My model brings together the different facets of the experience – emotional, relational, and social, while positioning all the dimensions as being shrouded in disenfranchisement. This novel contribution is significant, as it offers the first comprehensive overview of the journey of 'MDL' that some mothers may experience. In doing so, it meets the aim of this study: to develop a more informed conceptual understanding of the phenomenon, thereby filling a gap in the current conceptual understanding of the phenomenon. It also offers healthcare professionals the first overview of the experience that may be applicable to some women, which could impact the support that mothers are offered, both in terms of timing and type of support (Bäckström et al., 2016; Collins et al., 1993; Cust, 2016).

The findings of the study, the reimagining of the term used, and the negatively compounding cycle model of the journey of my population bring further legitimacy to the experience of 'MDL', hopefully opening future research opportunities, stimulating policy development, and supporting clinical practice advancements.

9.2 Concluding Thoughts

Maternal 'GD' is an under researched area of maternal mental health for mothers in the UK. Until my study, maternal 'GD' was understood in fragmented parts that include distress, shame,

loss, and a lack of social support. Moreover, a perception by "sufferers" that the phenomenon is widely misunderstood on a societal level as a disappointment in the children they have given birth to.

The novel method of walking interviews was used for data collection and enhanced by my partial insider status. The layered analytical approach of the LG was integrated with reflexive thematic analysis and enabled new insights into the phenomenon to be gained. Existing theories and concepts were used to refine and deepen our conceptual understanding of the experience. The terminology being used, 'GD', was argued as problematic, possibly causing well-being and help-seeking harm to the mothers; thus, a more appropriate term was asserted: 'MDL'. By identifying themes across the data set, multiple dimensions of the mother's journey were captured and brought together to create a model of the journey for the women in my study, the first of its kind. This dual knowledge contribution (terminology and model) represents an original contribution to knowledge made by this study alongside the novel use of walking interviews to collect the data as a partial insider.

My study represents several significant original contributions to our conceptual understanding of 'MDL'. My study advances both theory and knowledge of this maternal phenomenon. My study brings greater validity and recognition to the distress experienced by mothers and positions it as a legitimate, complex, and nuanced maternal phenomenon that is experienced as a negatively compounding cycle of distress that is worthy of further research and the women who experience 'MDL', support.

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Appendices

Appendix 1: Ethics Form

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH
Email: FMHS-ResearchEthics@nottingham.ac.uk

09 January 2024

Nina Young
PhD Student
Health Studies
School of Health Sciences
B Floor, Medical School
QMC Campus
Nottingham University Hospitals
Nottingham, NG2 2UH

Dear Ms Young

Ethics Reference No: FMHS 61-1123 **– please always quote**	
Study Title: A Qualitative Exploration of 'Maternal Gender Disappointment'	
Principal Investigator/Supervisor: Dr Alison Edgley, Associate Professor of Social Sciences in Health/Researcher in Residence Researcher Academy, School of Health Sciences	
Lead Investigators/student: Nina Young, PhD student in Health Studies, School of Health Sciences	
Other Key investigators: Sara Borelli, Associate Professor, Maternal Health and Wellbeing research Group, Midwifery, School of Health Sciences	
Proposed Start Date: 01/02/2024	**Proposed End Date:** 31.12.2024

Thank you for responding to the comments made by the Committee at its meeting on 21 November 2023 and the following documents were received:

- FMHS REC Application form and supporting documents version 3.0: 27.10.2023
- FMHS REC Application form and supporting documents version 4.0: 08.01.2024

These have been reviewed and are satisfactory and the project is given a favourable research ethics opinion.

A favourable research ethics opinion is given on the understanding that:

1. All gatekeeper permissions are checked if required and are in place before recruitment starts.
2. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
3. The Chair is informed of any serious or unexpected event.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lawrence

Dr John Williams, Associate Professor in Anaesthesia and Pain Medicine
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 2: Study Advert

Mums ...
have you always wanted a son or daughter?

The University of Nottingham

Research participants wanted

What is the study about?

Although it is not often openly discussed, some Mums (new Mums and Mums that are now Grandmas too) have always imagined having a child of a certain sex, but it just hasn't happened for them. This study is all about exploring that experience, no matter how long ago you had your children.

Who can take part?

- Biological Mothers
- Over 18 years with no upper age limit
- Lives in England
- At least two children (from young children or adult children) of the same sex who are both over the age of 12 months
- Longed for, or longs for, a child of the opposite sex to those birthed

What does it involve?

Participation will include a call to discuss and arrange an informal interview.

Please visit the webpage or send an email for more information.

nottingham.study.gd@gmail.com
www.nottinghamstudygd.wixsite.com/nsgd

Appendix 3: PIS

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences

Dr. Alison Edgley, Associate Professor
Alison.edgley@nottingham.ac.uk
Dr. Sara Borrelli, Associate Professor
Sara.borrelli@nottingham.ac.uk
Nina Young,
PhD student
nina.young@nottingham.ac.uk

Study Title:

A Qualitative Exploration of the Emerging Phenomenon Maternal 'Gender Disappointment'

PARTICIPANT INFORMATION SHEET

Research Ethics Reference: FMHS 61-1123
Version 4.0 Date: 07.01.24

I would like to invite you to take part in this research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish. Ask me if there is anything that is not clear or if you would like further information. My contact details are at the bottom of this document.

What is the purpose of the research?

Although research around maternal infant sex preference has taken place within Eastern cultures, it is little understood in the Western world. Researchers have explored how religion, culture, and government policy may have influenced maternal infant sex preference, but at this moment, there is limited research outside of this context. I aim to explore the experience of 'gender disappointment' from the perspective of mothers who have multiple birth children of the same sex, and desire, or desired, the opposite sex. I would like to explore how the experience of 'gender disappointment' may have impacted maternal well-being, feelings, emotions, and the impact on help-seeking.

Why have I been invited to take part?

You have been invited to take part in this research because you are a biological mother of two or more children of the same sex and long for, or longed for, a child of the opposite sex. There is no upper age limit for the mothers who take part in this study. I will be exploring 'gender disappointment' from the perspective of mothers, regardless of the mother's current age.

You are eligible to take part if you:

- Are a biological mother

- Are over 18 years old
- Live in England
- Have two or more biological children of the same sex
- Your children are over 12 months old
- Longs or longed for a child of the opposite sex

Mothers will be excluded from the study if:

- You are pregnant with a child of the desired sex
- You have had a miscarriage, stillbirth or live death where the child was the desired sex
- You have a diagnosed mental health condition

We anticipate up to 20 participants will be recruited for this study.

Do I have to take part?

It is up to you to decide if you want to take part in this research. I will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, I will ask you to sign a consent form and will give you a copy to keep. However, you would still be free to withdraw from the study at any time without reason up to 24 hours postinterview, simply let me know. With consent, your contact details will stored for the purpose of being invited to participate in future research studies.

What will happen to me if I take part?

I will contact you to go over the information sheet, explain what will happen during the walking interview and go through inclusion and exclusion criteria to check that you are able to participate. If you agree to take part in the study, you will be invited to take part in a walking interview. You will need to read an informed consent form, sign and return it. On this form will be some demographic information; your age, number of children, sex of children etc.

When we meet for the walking interview, I will again talk you through the study procedures and give you a chance to ask any questions that you may have.

For this type of interview, you will be asked to choose a place of significance to you, particularly in relation to your experience of maternal 'gender disappointment'. This could be an inside or outside location for example, a place you might have gone to walk when you were going through your experience or maybe a shopping centre. Here we will 'walk and talk' (the interview). The interview will be recorded by a small wireless blue-tooth microphone, one clipped onto your top and one onto mine. A small device, about the size of a phone, will be in my pocket collecting our recordings. You

can choose somewhere to stop, sit and talk if you'd like. If you choose somewhere outside and on the day we are due to meet there are adverse weather conditions, we will delay the interview until the next convenient time. It is anticipated that the interview will last approximately 60 minutes.

Are there any risks in taking part?

There are a few risks involved in walking interview research.

- **Confidentiality**: We may see people you know, or people may overhear. However, from the point of transcription, every place and name will be given a pseudonym.
- **Emotions**: The sensitive nature of the interview topic may cause unexpected distress. When you plan where you'd like the interview to take place, we can plan some stops or quiet spaces for peace of mind and provide time to re-balance if needed.
- **Physical safety** –To prepare for the interview sensible footwear should be worn, along with layers of clothing. Taking a drink and some snacks is also encouraged. The interview will take place in daylight and unless you choose your home for example, the interview will take place in public, unrestricted areas. If outside, weather conditions may change during the interview and impact our ability to continue with the walking interview at that time. If this happens, we will stop the interview and re-arrange.

In order to reduce any potential risks, I will discuss in advance what you would like to say if we meet someone you know, and they ask what you are doing. We can also pre-designate a place to sit and talk about more sensitive topics if you'd like. I will keep monitoring the weather prior to the walking interview, if there are indicators prior to the walking interview that unfavourable weather is expected we will postpone the interview. If rain or wind for example is possible but not likely, suitable clothing should be brought along to the walking interview.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research, however, the walking interview will provide a chance for you to reflect upon and explore your experience of 'gender disappointment' with a non-

judgemental researcher, Nina Young. Your contribution to this piece of research may impact both societal and healthcare understanding around the experience of 'gender disappointment' and so may support help-seeking pathways for other mothers.

Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study.

What happens to the data provided?

The digital blue-tooth recording will be downloaded and stored on a secure password-protected device and folder within 24 hours of the interview having taken place. The interview will be transcribed by the researcher, Nina Young, within 48 hours. The recording will then be permanently deleted.

The research data will be stored confidentially using a pseudonym. To help ensure your privacy, you will be assigned a pseudonym and this will be used instead of your name from the point of transcription. The initial data you will give; your name, date of birth, details of your children's sex and age etc, the transcripts and data analysis documents will all be stored in separate folders within a passwordprotected folder and password-protected device. Each data set will be sorted under your pseudonym, your real name will not be used. There will be no identifiable information within the transcript data or analysis data sets. Your name and information about you will not be shared outside of this study. Only myself the researcher and my supervisors will have access to the raw research data. All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

I would like your permission to use anonymised data in future studies, in articles, blogs, books and to share my research data with other researchers in

other Universities and organisations both inside and outside the European Union. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study without giving any reason. You are able to withdraw from the study up to 24 hours post-interview, after this time withdrawal will not be possible. If you do withdraw all data collected so far to be permanently deleted and not recoverable, this may include both participant demographic information and interview data

Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. All digital audio recordings and electronic data will be anonymised with a pseudonym as detailed above. Electronic storage devices will be encrypted while transferring and saving of all sensitive data generated during the research. All such data are kept on password-protected devices.

Under UK Data Protection laws, the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (Dr. Alison Edgley) is the Data Custodian (manages access to the data).

You can find out more about how we use your personal information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

With your consent, we will keep your personal information on a secure devise in order to contact you for future studies.

Anything you say during the walking interview will be kept confidential unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons.

What will happen to the results of the research?

The research will be written up as a thesis for a Doctorate of Philosophy. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access. The data may also be used in the form of academic peer-reviewed articles, information and training for healthcare professionals and the public. The data may be used in leaflets, on educational websites or in books.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests.

Who is organising and funding the research?

This research is organised and self-funded by Nina Young, PhD student at the University of Nottingham.

What if there is a problem?

If you have a concern about any aspect of this project, please speak to the researcher, Nina Young, or her supervisors, Dr. Alison Edgley or Dr. Sara

Borrelli who will do their best to answer your query. I will acknowledge your concern and give you an indication of how I intend to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via Email: FMHS-ResearchEthics@nottingham.ac.uk.

Please quote ref no: FMHS 61-1123

Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Nina Young

Email: nottingham.study.gd@gmail.com

Appendix 4: Consent Form

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences

Participants Consent Form
Version 4.0, 07.01.24

Title of Study: A Qualitative Exploration of the Emerging Phenomenon 'Maternal Gender Disappointment'

REC ref: FMHS 61-1123

Name of Researchers: Nina Young, PGR, Supervisors – Dr. Alison Edgley, Supervisor – Dr. Sara Borelli

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version 4.0, 07.01.24 for the above study which is attached and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without disadvantage. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the walking interview will be blue-tooth audio recorded using an automated transcription service and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that best efforts will be made to ensure confidentiality while the walking interview is taking place. However, I understand that this cannot be guaranteed as the interview is in a public space and so there will be no control over who may be in that space at the time of the interview. ☐
6. I understand that information about me recorded during the study will be made anonymous before it is stored in a secure database. Data will be kept for 7 years after the study has ended and then deleted. ☐
7. I understand that what I say during the interview will be kept confidential unless I reveal something of concern that may put myself or someone else at any risk. It will then be necessary to report this to the appropriate persons. ☐
8. I agree to take part in the above study. ☐
9. I agree that my anonymous research data will be stored and used to support other research during and after 7 years and shared with other researchers including those working outside the University. ☐
10. I agree to my contact details being stored for the purpose of being invited to participate in future research studies. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes.
QEEPMGD,v4.0:-8/01/24

Appendix 5: Semi-Structured Interview Schedule

Below is an outline of the suggested interview guide. The interview guide will contain open-ended questions, such as the ones below, and is based on the aims and objectives of the study:

1 In what ways would you say that the term ‘gender disappointment’ reflects your experience?
   a) What does disappointment mean to you?
2 Can you tell me about the feelings and emotions you have experienced in relation to ‘GD’ ?
3 What does the term ‘gender disappointment’ mean to you?
4 Are girls and boys different?
   a) How would parenting them be different do you think?
5 How has ‘gender disappointment’ impacted your life?
6 In what ways, if any, did you seek support?
   a) If yes, can you tell me about that support-seeking journey?
   b) If you didn’t seek support, can you tell me about that decision?
7 Which 3 words would you choose to describe your ‘gender disappointment’ journey?
   c) Can you explain your word choices?

Appendix 6: Initial Email or Text to Participant

This was the template that I based my initial correspondence on:

Hi xxx,

A huge thank you for showing an interest in my research, it is a topic that I am very passionate about. The research is only possible because Mums like you kindly share their stories. there will be no judgement, and you will be anonymised.

I have attached further details about the study, an informed consent document, and a background information sheet.

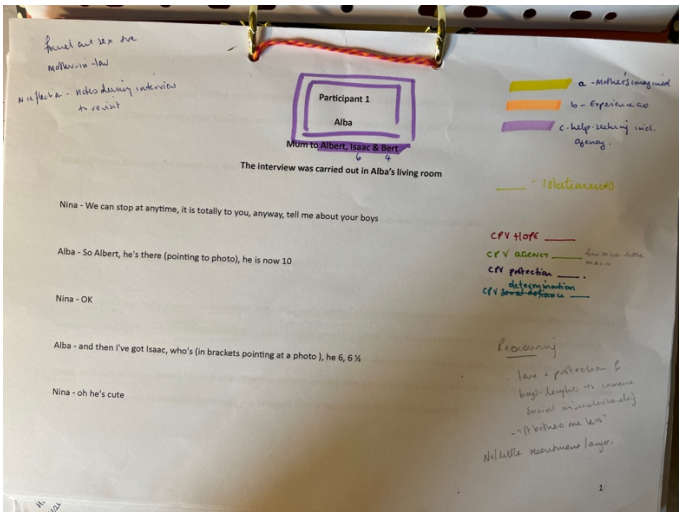
Please take your time to read through them all and ask any questions. If you are happy with everything, then please sign and return the documents. I will then double-check everything against the study's inclusion criteria, if this all lines up we can arrange a time for an informal interview.

Please just email or WhatsApp with any questions.

Take care,

Nina

Appendix 7: Example of LG Transcript Analysis with Colours



Participant 1

Alba

Mum to Albert, Isaac & Bert

6 4

The interview was carried out in Alba's living room

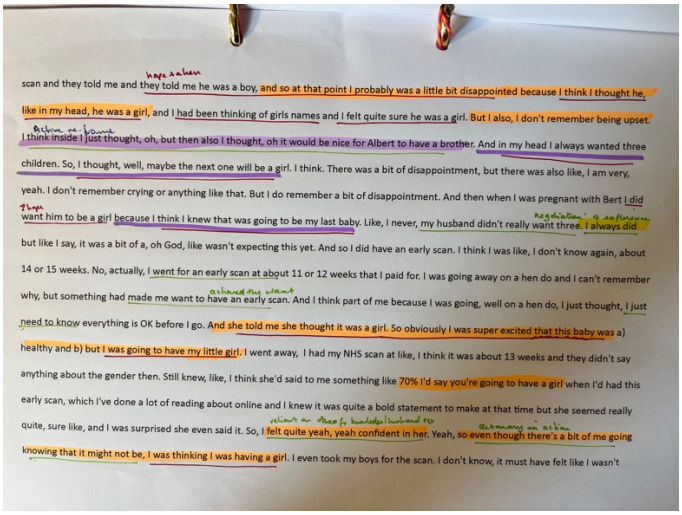
Nina - We can stop at anytime, it is totally to you, anyway, tell me about your boys

Alba - So Albert, he's there (pointing to photo), he is now 10

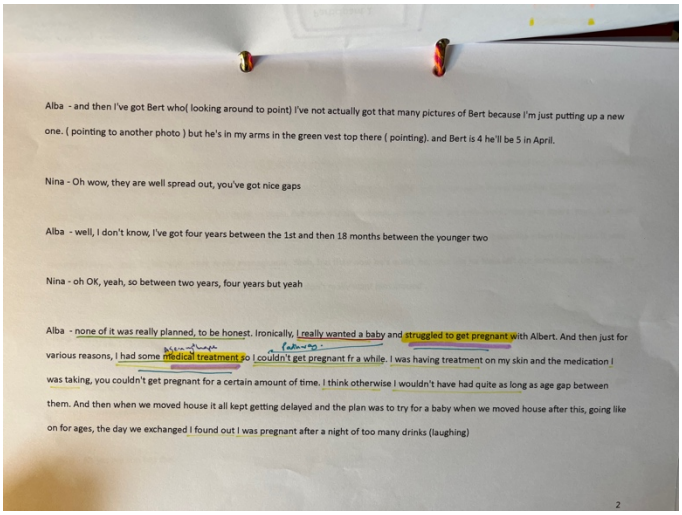
Nina - OK

Alba - and then I've got Isaac, who's (in brackets pointing at a photo), he 6, 6 ¾

Nina - oh he's cute



scan and they told me and they told me he was a boy, and so at that point I probably was a little bit disappointed because I think I thought he, like in my head, he was a girl, and I had been thinking of girls names and I felt quite sure he was a girl. But I also, I don't remember being upset, I think inside I just thought, oh, but then also I thought, oh it would be nice for Albert to have a brother. And in my head I always wanted three children. So, I thought, well, maybe the next one will be a girl. I think. There was a bit of disappointment, but there was also like, I am very, yeah. I don't remember crying or anything like that. But I do remember a bit of disappointment. And then when I was pregnant with Bert I did want him to be a girl because I think I knew that was going to be my last baby. Like, I never, my husband didn't really want three. I always did but like I say, it was a bit of a, oh God, like wasn't expecting this yet. And so I did have an early scan. I think I was like, I don't know again, about 14 or 15 weeks. No, actually, I went for an early scan at about 11 or 12 weeks that I paid for. I was going away on a hen do and I can't remember why, but something had made me want to have an early scan. And I think part of me because I was going, well on a hen do, I just thought, I just need to know everything is OK before I go. And she told me she thought it was a girl. So obviously I was super excited that this baby was a) healthy and b) but I was going to have my little girl. I went away, I had my NHS scan at like, I think it was about 13 weeks and they didn't say anything about the gender then. Still knew, like, I think she'd said to me something like 70% I'd say you're going to have a girl when I'd had this early scan, which I've done a lot of reading about online and I knew it was quite a bold statement to make at that time but she seemed really quite, sure like, and I was surprised she even said it. So, I felt quite yeah, yeah confident in her. Yeah, so even though there's a bit of me going knowing that it might not be, I was thinking I was having a girl. I even took my boys for the scan. I don't know, it must have felt like I wasn't



Alba - and then I've got Bert who(looking around to point) I've not actually got that many pictures of Bert because I'm just putting up a new one. (pointing to another photo) but he's in my arms in the green vest top there (pointing). and Bert is 4 he'll be 5 in April.

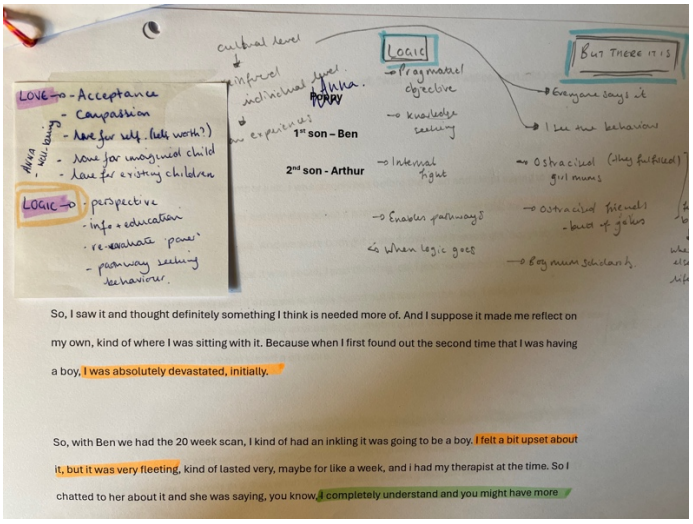
Nina - Oh wow, they are well spread out, you've got nice gaps

Alba - well, I don't know, I've got four years between the 1st and then 18 months between the younger two

Nina - oh OK, yeah, so between two years, four years but yeah

Alba - none of it was really planned, to be honest. Ironically, I really wanted a baby and struggled to get pregnant with Albert. And then just for various reasons, I had some medical treatment so I couldn't get pregnant fr a while. I was having treatment on my skin and the medication I was taking, you couldn't get pregnant for a certain amount of time. I think otherwise I wouldn't have had quite as long as age gap between them. And then when we moved house it all kept getting delayed and the plan was to try for a baby when we moved house after this, going like on for ages, the day we exchanged I found out I was pregnant after a night of too many drinks (laughing)

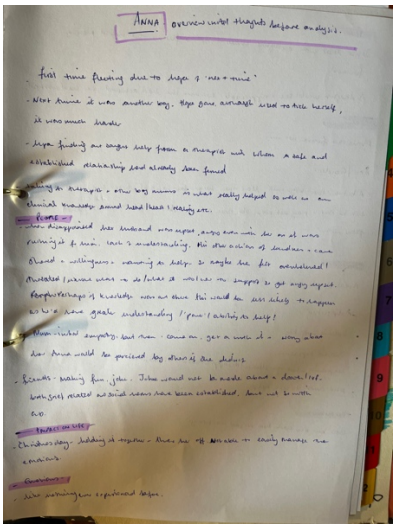
2

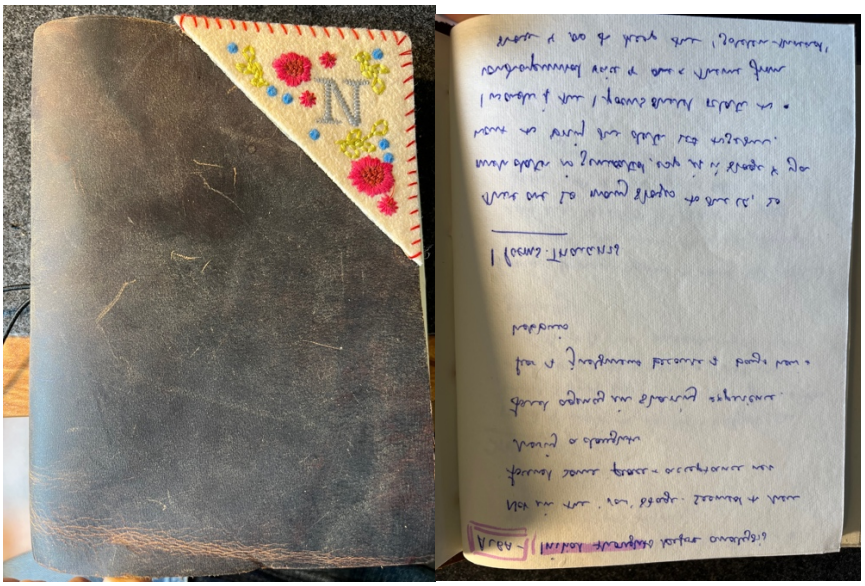


So, I saw it and thought definitely something I think is needed more of. And I suppose it made me reflect on my own, kind of where I was sitting with it. Because when I first found out the second time that I was having a boy, I was absolutely devastated, initially.

So, with Ben we had the 20 week scan, I kind of had an inkling it was going to be a boy. I felt a bit upset about it, but it was very fleeting, kind of lasted very, maybe for like a week, and i had my therapist at the time. So I chatted to her about it and she was saying, you know, I completely understand and you might have more

Appendix 8: Example of Reflexive Engagements





The book that followed me everywhere

Appendix 9: Reflexive Case Study

I entered my research with an awareness of the risk of conflating my own experience with that of my participants. I was conscious not to impose my experience of maternal 'MDL' onto others, nor to interpret their stories through the lens of my own outcomes. I have three boys, and although I had always hoped for a girl, from the moment they were born, I loved them very much and would not swap or change them for the world. As they have grown up (Fin is almost 18 now) I have had the opportunity to develop a deep and enduring relationship with them, and they have caused me to question some of the gender assumptions I held about sons and daughters.

But I am aware that some mothers can hold resentment (conscious or unconscious) towards their boys for what the mothers might see as them taking up their chance of a daughter. This is not only alien to me, but the thought also caused me discomfort, 1) because I want to protect the child from any sense of rejection and did not want this to be the case 2) because I did not want these more sensational narratives, if they were to arise, to be used to socially condemn the mothers for their bravely in expressing their difficult emotions that can often be misunderstood, however, 3) it was also important that I highlighted this if they were to arise. But I was aware of these tensions going into my research.

My awareness to not conflate my own experience with that of my participants was challenged during one interview in particular, when a mother disclosed that she had terminated a pregnancy because the baby was a boy. In this instance my concern for the child was removed, as the child was not born; however, I was aware that such data could be used to position mothers who experience maternal 'MDL' as "bad" or "unworthy" mothers also possibly cause her existing children to question their worthiness. I navigated this, not by judging Nora, but instead by asking myself what about a daughter meant so keep her last chance for a daughter alive. What was it about society, support, and herself that meant she felt unable to seek or find other options of support? I reflected on how much Nora must have been suffering to take this course of action.

I did not avoid this data, but I tried to approach it in a supportive way to further our conceptual understanding of the phenomenon rather than expose this traumatic experience in a way that could invite further perceived social judgement and criticism. PND is not socially viewed as a woman being a "bad" mother for having sometimes intrusive thoughts and experiencing

difficult emotions, but rather as someone who needs support. This positioning is where I believe ‘MDL’ needs to be if we are to adequately support mothers who are struggling with ‘MDL’. Nora is not a “bad” mother because she chose to have a termination; she is a mother who is isolated, scared and socially silenced. She and other mothers like her need our support, not vilification. But this itself may be viewed as conflation. However, I aimed to remain reflexive and transparent at every stage, which was supported by my past career as a teacher and my current work as a coach, and I hope that this helped to reduce conflation and supports credibility.