



# The hegemonic role of biomedical discourses in the construction of pregnancy loss



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## ABSTRACT

*Background and problem:* Pregnancy is constructed as a joy-filled and natural experience with a taken-for-granted expectation that the outcome will be a healthy baby. However, in South Africa approximately 1 in 4 pregnancies end in miscarriage and the stillbirth rate is 24 per 100 live births. Despite the overwhelming statistics, reproductive loss is considered a cultural taboo and continues to be silenced in various ways by the medical fraternity and society in general.

*Aim:* Our study aimed to demonstrate the role that biomedical discourses play in shaping both women's experiences of reproductive loss as well as how those close to them respond to these losses. The study was located within a social constructionist framework.

*Methods:* Seven South African women were recruited via snowball sampling to participate in in-depth interviews. A discourse analysis was conducted to deconstruct hegemonic discourses implicit in the participants' dialogues.

*Findings:* The adoption of medical framing of miscarriage and the social awkwardness of loss framed the participants talk about their miscarriages. Our study highlights the centrality of biomedical discourses in influencing both the experiences of our participants as well shaping social discourses. The adoption of the medical framing of miscarriage were identified in the following themes: no answers to first trimester miscarriage and the normalization of miscarriage. The social awkwardness of loss were identified as lack of cultural scripts, lack of acknowledgement and unhelpful words and actions.

*Conclusion:* The paper highlights the power inherent in medicine and demonstrates how this hegemony pervades societal understandings of reproductive loss. Caught in this crossfire are grieving mothers with few alternatives in terms of their grief processes.

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## Statement of significance

### Problem

The way pregnancy loss is constructed by the medical fraternity filters through into all institutions in society and structures how these losses are thought of and responded to.

### What is already known

Reproductive loss continues to be considered a cultural taboo by the medical profession contributing to the challenges women face during their grieving processes.

## What this paper adds

Our study highlights the centrality of biomedical discourses in influencing both the experiences of our participants as well shaping social discourses.

## 1. Introduction

### 1.1. Background

In this paper, we demonstrate the role of hegemonic biomedical discourses in shaping how women and those close to them construct meaning and therefore influence how their pregnancy losses were experienced. Reproductive losses are predominantly located within the medical arena hence medicine's dominance regarding how these losses are construed. Biomedical discourses

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refer to biomedical language and is inclusive of all its striking artefacts, images, architectures, social forms and technologies.<sup>1</sup> Foucault's seminal writings in *Birth of the Clinic* highlights the remarkable shift in biomedical practice where the question that doctors asked of patients changed from 'what is the matter?' to "where does it hurt?".<sup>2</sup> Sarah Nettleton<sup>3</sup> in her analysis captures this sentiment by stating that biomedicine draws on a mechanical metaphor where doctors are seen to act as engineers always ready to repair parts that malfunction. Emily Martin<sup>4</sup> contends that reproduction as a form of production is the thread that weaves itself throughout medical/health discourse. In this narrative, the woman is the labourer, the body the machine, the baby the product and the doctor or medical staff the supervisors of the labour process. According to these accounts, the body is alienated from the woman giving birth, it functions almost independently of her will or desires, and the uterus is (re)presented as an involuntary muscle that automatically performs the task.

The term 'reproductive loss' seems to be slippery, shifting and with no fixed definition. Martel<sup>5</sup> argues that reproductive loss is a very contentious and ambiguous event because it seems to refer to bereavement on the one hand while on the other hand being unable to declare that a death has occurred. At the heart of the experience of this loss is the issue of personhood which has assumed a multiplicity of meanings.<sup>8,30</sup> For example, in one view foetal personhood is conceptualised as implicit and established through biology.<sup>8</sup> This model of personhood is commensurate with a biomedical notion of personhood that equates life to the physical; the biological. Morgan<sup>30</sup> argues that the Western ethnobiological view proposes that foetal personhood results through the literal act of a physical birth. In other words, the physical birth of the baby separates the 'being' from the 'non-being'.

Based on a model from Melanesian cultures, Morgan developed her 'relational body-person' framework which argues that the foetus is the result of a combination of various social interactions and events. She thus contends that biological and social birth are distinct, thus permitting both pregnancy termination and pregnancy loss to be re (conceptualised)<sup>30</sup>. In this framework, a foetus deeply desired by its parents may already be imagined as a person. It is this framing of personhood as constructed and negotiated, that we argue frames the experience of miscarriage for many women. A framework that stands in stark contrast to the biological/biomedical understanding of foetal personhood that proposes that the reproductive losses and the subsequent bereavement that mothers experience is discursively structured as a medical and legal procedure producing reproductive or pathological waste, rather than as an emotional event requiring care and support.<sup>7</sup> The biological/biomedical construction of foetal personhood has stringent stipulations for what constitutes a 'real socially recognised person', one of which is life personified.<sup>10, p 159</sup>

The general response to a woman grieving a pregnancy loss, even though unintentional, in most instances result in the invalidation of their grief by healthcare staff, counsellors, friends and family.<sup>6–8</sup> Cosgrove<sup>9</sup> asserts that from a biomedical perspective women's grief is conflated with gestational age, where women who deliver a stillborn would be considered to have more reason to grieve than women who miscarry during early pregnancy. However, the meaning that a woman assigns to a pregnancy may be a better determinant of her emotive reaction to loss than gestational age.<sup>9</sup>

The experience of pregnancy loss for the grieving mother is usually accompanied by a rollercoaster of emotions ranging from guilt to shock and numbness.<sup>10,11</sup> Social support is integral to coping with grief. An integrative review of studies that described the emotional responses of parents who experienced the loss of a child concluded that social support from family and friends were important to parents who lost a child.<sup>12</sup> However, optimal support

is not necessarily provided when needed. Parents who have experienced losing a child have reported that they encountered both good support from family and friends and hurtful responses to their loss.<sup>13</sup> For women who have suffered a miscarriage, their partners and other women who previously experienced miscarriage were considered important sources of support.<sup>14</sup> These women also reported receiving insensitive comments and even blame for their loss.

Interactions with healthcare professionals shape the grief experience for women who experienced pregnancy loss. A qualitative study conducted among 15 women who miscarried in Australia revealed that women thought that their healthcare providers had a medicalised view of pregnancy and that they framed miscarriage as common and normal.<sup>15</sup> Some women reported that their doctors were insensitive and dismissive and that this increased their perceived distress following their loss.<sup>15</sup> Similar research, conducted among healthcare professionals, indicate that they focus on the physical needs of women who experienced loss.<sup>16</sup> The healthcare professionals reported that they used their medicalised view (i.e. by telling patients that the loss was not their fault and by referring to the frequency of pregnancy loss) in order to comfort women and minimize their self-blame.<sup>16</sup> These studies indicate that there is a mismatch between what women who experience pregnancy loss need and what healthcare professionals perceive that the patient needs.

Grief in the context of pregnancy loss is often underestimated especially within first trimester pregnancy losses. Often women are not afforded the same level of acknowledgement for a pregnancy loss compared to other types of types of loss such as the loss of a spouse or parent. Callister<sup>17</sup> explains how grieving a pregnancy loss may be complicated as it is the mourning of hopes, dreams and expectations rather than a tangible outcome and explains the shock in lieu of pregnancy loss being in contradiction to the 'natural' order of life where a child is not expected to pass on before a parent.

While pregnancy and its associated biological processes are complex and expressed in an assortment of ways, they are lived out in equally complicated sets of social and power relations.<sup>18</sup> In an attempt to understand how women construct meaning surrounding their miscarriages and pregnancy losses it is important to unpack the concomitant social and power relations within which these events are situated. Within a social constructionist framework, events such as pregnancy loss are embedded in various contexts and thus the meaning of these events are understood to be socially constructed through language. Discourses both shape and inform the way that individuals make meaning of various events in their lives.<sup>19,20</sup>

While social constructionists in general argue that all perceptions of reality are shaped by discourse, Foucault in particular believed that these discourses are able to form power relations whether consciously or unconsciously by virtue of the fact that objects are framed by the manner in which they are constructed by hegemonic discourses.<sup>21</sup> Furthermore, he argued that power dyads were produced from the discourses used to explain experiences and proposed that it was not just the discourses but the silences that shape our respective understandings of any given experience.<sup>21,22</sup> Drawing on a Foucauldian analysis Martel<sup>5</sup> argues that both discourses and silences are not polarities, rather they are interwoven in a way that makes reproductive loss an object of biomedical knowledge. In this paper we present how the dominance of biomedical discourses, informed by inherent biological personhood, shape women's experiences of pregnancy loss. In doing so we demonstrate how these biomedical discourses shape the experience due to the authoritative position of medical science within society.

## 2. Method

A qualitative approach using in-depth interviews was used to gain insight into the discursive resources women draw on to construct meaning of their pregnancy loss. As discourse was a central component of the study we decided only to interview women who were comfortable speaking English.

### 2.1. Participants and sampling

We used convenience and snowball sampling to recruit participants. The inclusion criteria for participation were: women had to be 18 years and older; they had to have experienced at least one pregnancy loss at any gestational stage.

The seven participants' ages ranged between 28 and 49 years. Most of the women were married ( $n = 5$ ), while one was divorced and one was separated from her husband. The women were well educated with two of them completing high school and the remaining five having obtained University degrees. Five of the women identified their race as 'coloured', one as "Indian" and one as "Caucasian". Three women identified their religion as Islam, three as Christian and one as Hindu. Six of the seven women identified English as their first language with the last woman having Afrikaans as her first language but able to converse comfortably in English.

The number of overall pregnancies that the women had experienced ranged from one to eight. Five women had experienced only miscarriage, two women had experienced only stillbirth, whilst three experienced both stillbirths and miscarriages. Most of the miscarriages were first trimester miscarriages (First trimester: 1–12 weeks gestation; Second trimester: 13–26 weeks gestation; Third trimester: 27–42 weeks) (Table 1).

### 2.2. Data collection

Data was collected using semi-structured interviews which allowed the participants to narrate their stories without much prompting from the second author. The literature and the aim of the study served as a guide for the development of the questions that were asked in the interview. A semi-structured interview format was used where the questions were open ended to allow the participants to reflect on and express their experiences. The interviews were approximately an hour in duration.

### 2.3. Data analysis

Since Foucault did not have a prescribed method to completing discourse analysis, in light of the basic tenets of Foucault and based on suggestions highlighted in Parker<sup>27</sup> and Nikander,<sup>28</sup> the analysis involved the following: The first and second authors immersing ourselves in the data by reading and listening to the audio recordings. Thereafter a process wherein we deconstructed the discourses was engaged in. Deconstructionism calls attention to

the constructive nature and ability of language as it functions as a system of signs as opposed to the constructive work of the individual person. In essence the function of deconstructionism is to unpack and understand the systems created and constructed by language in order to understand how people are constructed and make sense of these constructions through the structured use of language. Deconstructing the dominant discourses in the analysis involved asking the following questions per guidance from Nikander<sup>28</sup>: What are the speakers producing as relevant in their account? Is the speaker doing extra discursive work? Why is this particular category/detail being mentioned here? Why do I feel that there is a silence or that some topic is being avoided or only alluded to? Nikander<sup>28</sup> p. 419 asserts that "discourse researchers look for patterns and order in terms of the manner in which text and talk are organised, they also look for how inter-subjective understanding, social life and many institutional practices are accomplished, constructed and reproduced in the process". Based on this guideline the process of coding the transcripts involved the usage of the initial analytic questions, reference to literature for previous coding that was used to describe similar discourses and listened to what women emphasised in their interviews as important.

### 2.4. Ethical considerations

This study was granted ethical approval from a South African University. Participants were informed of the nature and purpose of the study prior to the interviews and granted written consent. Women were made aware that participation was voluntary and that they could withdraw from the research at any time and that in such an instance all voice files and transcripts would be destroyed. Due to the sensitive nature of the study, participants were made aware that some of the questions that they were asked may elicit some painful memories and that psychological assistance would be made available in the form of a referral should they request it.

## 3. Results

To recap our study aimed to demonstrate the role that biomedical discourses play in shaping both women's experiences of reproductive loss as well as how those close to them respond to these losses. We found that women's constructions of their pregnancy losses were located in two broad domains. First, discourses related to medicine played an important role in shaping the experience immediately following the loss (i.e. when seeking medical treatment). Second, discourses located at a social level in their interactions with friends and family members also played a pivotal role in shaping the experiences. Interestingly, we found that the biomedical discourses were often used as a basis for constructing the social discourses, implicit in the participants' discussions. This formed the basis of two broad themes, namely *The social awkwardness of loss* and *Adoption of medical framing of miscarriage*.

**Table 1**  
Demographic details of participants.

| Participant (pseudonym) | Age | Marital status | Education           | First language | Ethnicity | Religion  |
|-------------------------|-----|----------------|---------------------|----------------|-----------|-----------|
| Fatima                  | 31  | Married        | Grade 12            | Afrikaans      | Coloured  | Islam     |
| Nuraan                  | 34  | Divorced       | Grade 12            | English        | Coloured  | Islam     |
| Laiqa                   | 41  | Married        | Postgraduate degree | English        | Coloured  | Islam     |
| Sheila                  | 46  | Separated      | Postgraduate degree | English        | Coloured  | Christian |
| Rani                    | 49  | Married        | Degree              | English        | Indian    | Hindu     |
| Julia                   | 38  | Married        | Degree              | English        | Caucasian | Christian |
| Christine               | 28  | Married        | Degree              | English        | Coloured  | Christian |

### 3.1. Adoption of medical framing of miscarriage

Participants commonly adopted language that reflected medical framing of their miscarriages. Biomedical language or discourse on reproductive loss is echoed in medicine, popular culture, epidemiology, and demography.<sup>7</sup> However, research suggests continued silences pervade these domains ultimately culminating in the ‘culturally sanctioned non-existence’ of pregnancy loss.<sup>8</sup> Understanding silence through a Foucauldian lens demonstrates the ways in which reproductive loss has been produced as knowledge/power through both strategic silences and strategic discourses. These strategic silences and discourses were evident in two sub-themes described by participants. These sub-themes were named (1) no answers for first trimester loss, and (2) miscarriage regarded as routine or normal.

### 3.2. No answers for first trimester pregnancy loss

Women reported that they did not receive any information regarding the possible causes of their pregnancy losses, particularly losses that occurred within the first trimester. The silence around first trimester pregnancy loss rests with the edict from a biomedical perspective that miscarriages are not routinely investigated until three consecutive miscarriages have been experienced. Women in this study reported that they would have preferred to know why their pregnancies were terminated but they accepted that there was simply no medical reason for first trimester losses, as put forth in biomedical discourses.

The medical policy not to investigate the reasons for miscarriage until three consecutive ones have occurred left some women feeling that they felt ignored and unimportant. Despite wishing to know the reasons for their loss, the dominance of these biomedical discourses resulted in women accepting that “this is the way it is” highlighting the taken for granted nature of medical interventions in these situations and reinforcing the strategic silences. For instance, Sheila described her acceptance in the following statement:

*“I would have liked that. Let’s try and find out what the causes are, what is causing this because for me anything that happens more than twice cannot be coincidental but that was never forthcoming, this was just, this is the way it is”*

Similarly, Christine also referred to a medicalised framework when she spoke about not receiving answers for the loss. Christine stated that pregnancy loss was a common occurrence and that it was not feasible for doctors to investigate the causes of every episode of miscarriage.

*“As to why it happened? No I haven’t, but, and I probably won’t because (.), how would they, how would anyone be able to tell me what caused that miscarriage, you know. You know, these things are only investigated if you have three or more (miscarriages), because these things are so common, they, they opt not to investigate if you’ve had a first miscarriage, you know”*

However, other participants reported that they were dissatisfied with the lack of explanations for their losses. For instance, Rani was adamant that the reason for her loss should have been discussed with her.

*“So there was no explanation whatsoever and that is something I think should have been explained”*

From the above, it is evident that women received no reasons for their loss and they were aware that the much-needed answers were not available to them. This heightened awareness that answers would not be forthcoming indicates that women were acutely aware of the prevailing biomedical discourses that position these losses as common and therefore do not warrant any further

investigation. These types of discourses imply that women should refrain from asking any questions and that carers are exempt from providing explanations reinforcing the entrenched view that because miscarriages occur frequently they are classified as ‘normal/natural’ bodily processes requiring routine interventions. The dynamics set up from such a relationship meant that the participants inadvertently settled for cursory explanations or silences thereby perpetuating the unequal relations of power between doctor and ‘patient’.

However, a lack of answers can affect women negatively. Côté-Arsenault and Dombeck<sup>23</sup> maintain that the lack of answers as to why a miscarriage occurs leave women with a sense of powerlessness and disorientation. Corbet-Owen and Kruger<sup>24</sup> suggest that lack of information leave women to construct their own understandings of why their miscarriage occurred, which often culminates in an enduring perception of self-blame.

### 3.3. The normalization of miscarriage

Participants reported a general lack of interest from those around them regarding their first trimester miscarriages and attributed this lack of interest to the view that miscarriage was common, not life threatening and treated using a routine procedure.

For the women in this study, the perception that miscarriage was routine or normal had implications for them at the time of the loss (i.e. it affected the time that it took for women to receive medical treatment) and in the days following the loss (i.e. it affected what was expected in terms of leave from work). In addition, this construction of miscarriage as routine or normal played a role in de-legitimising women’s emotional responses to their loss. The view that women reported miscarriage being normal and requiring a routine medical intervention was expressed by Rani in the following interview extract:

*“It was just like it’s like normal there was no fuss about anything, you just went in you had your D & C (dilation and curettage) and then you left then you came around you left. So there was nobody fussing over you or nobody trying to explain, you know, why you went through this and what could happen there was no explanation to it or no uhhh talk about it with anybody”*

Rani reported that she felt overlooked or even ignored when seeking medical treatment. Other participants also reported this and stated that their miscarriages were not treated with a sense of urgency. For example, Julia reported that she was reluctantly offered an option of a dilation and curettage procedure within 24 h and not immediately as the medical personnel did not view the miscarriage as an emergency. Julia reported her experience in the following extract:

*“But technically it’s not an emergency but she said, you know I know the guy and he probably will do it but it won’t be me doing it”*

Christine reported a similar experience to Julia, also indicating that a medical professional did not attend to her immediately as miscarriage was not regarded as a physical emergency. This experience is reflected in her extract below:

*“The gynae wouldn’t come out to do that then (D&C), you know, it wasn’t something that was urgent or not considered urgent because it was such an early pregnancy”*

The statements above indicate that while healthcare professionals are seen to view miscarriage as normal and the treatment as routine, patients view miscarriage as a medical emergency that requires urgent care. This may be related to the conflicting concepts of reproductive waste and foetal personhood. On the one hand, the medical profession may view the product of the miscarriage as medical waste that may be disposed of when

doctors are available to do the job. Mothers on the other hand, experience the miscarriage as a dead baby on the inside of her and needs to be removed as soon as possible.

This sense of pregnancy loss being normalized leaves women with an inability to grieve their loss appropriately and marginalizes them as they are not afforded the permission to grieve due to the silence around the emotional component of their experience. By normalizing the experience, women internalize the notion that their experience is not significant.<sup>24</sup> Miscarriage being normalized and described as natural contributes at a fundamental level to cementing the general lack of acknowledgment ascribed to the pregnancy loss experience.<sup>25</sup> In addition, the normalization of miscarriage can be used as a coping strategy to counter the self-blame that women may experience. Healthcare professionals reported that they used their medical knowledge of miscarriage to comfort women and minimize their self-blame.<sup>21</sup>

Adolfsson et al.<sup>11</sup> describe how health professionals may view miscarriage as a routine event due to the number of women who experience miscarriages daily and note that though dealing with the physical aspects of a miscarriage may be routine, for the women who may be experiencing her first pregnancy or even her first miscarriage, the experience may be overwhelming and disturbing especially if she is not involved in the decision making process. Côté-Arsenault and Dombeck<sup>23</sup> explained how health care facilities regarded the first instance of miscarriage as unremarkable and did not consider it to be an emergency.

### 3.4. The social awkwardness of loss

Davidson and Stahls<sup>26</sup> assert that a lack of sustained social acknowledgement, validation and support is common to all maternal grief because we live in a society where death is an unmentionable topic and discussing death is a challenging dialogue. Grieving mothers are often silenced by many role players, particularly after some indiscriminate time limit. Davidson and Stahls<sup>26</sup> argue that the silences are often due to the fact that people do not know what to say or say something that can be quite hurtful. In our study, this was precisely what was reported by the participants. They reported that they experienced discomfort when interacting with family members, friends and colleagues after their loss. Uncomfortable social discourses is therefore an important theme for women in the study and consists of three sub-themes namely a lack of acknowledgement, lack of cultural scripts and unhelpful words or actions. We contend that the hegemonic biomedical discourses seems to be the thread that filters through into social discourses and therefore how we engage or fail to engage with pregnancy loss.

### 3.5. Lack of acknowledgement

Participants reported that they experienced a lack of acknowledgement from their friends, family and colleagues about their pregnancy loss. This lack of acknowledgement resulted in feelings of loneliness or isolation and meant that their loss was not validated. Their need for acknowledgement was not met and this was an important part of their experience.

Sheila explained her need for acknowledgement of her first trimester pregnancy losses. For her, acknowledgement from others that she was pregnant would have served to validate her pregnancy and loss. The lack of acknowledgement meant that the pregnancy did not exist at all. Sheila also stated that acknowledgement brings a sense of 'realness' to the experience, making it tangible.

*"But when somebody acknowledges and validates what was then it makes it real. And I think that is what I was looking for, the realness off, that yes this did take place; that this did happen."*

Rani experienced a lack of acknowledgement in her work environment. Rani reported that there was a lack of empathy for her and that her miscarriage was regarded as purely a physical experience. She was expected to return to work the next day following the medical procedure. Furthermore, she reported a complete lack of acknowledgement of the emotional toll that the pregnancy loss had on her. This lack of acknowledgement at her place of work also resulted in feelings of isolation and Rani reported that she felt that she had to deal with the emotional aspects of the experience on her own. Furthermore, biomedical discourses legitimises employers' insistence that women return to work immediately following a pregnancy loss. Rani's challenges at her place of work are reflected in the following interview extract:

*"Yes they knew about it, uhm the people at work actually after my D&C one of the managers said to me that I could have a D&C and return to work the same day uhm there was no need for me to take time off and all that I had taken time off for was the D&C and I was back at work the very next day. So there was no time to mourn there was no time to uhm deal with it, deal with the fact that you have lost a child. There was no time to set aside time for yourself and say okay this is what's happened and try and work through it, there was just no time for that. It was sort of like these things happen. That's the way I felt uhm no sort of recognition or people didn't realize what a person could go through. You had to just carry on with your day's work or with your life or you just carried on"*

Some participants reported that they actively took steps to validate their loss by choosing to participate in certain rituals. Julia, for instance stated that she had a small ceremony to allow those around her to address the issue more openly, however she felt that the silences still ensued.

*"We had a very small kind of tea, just with my mom and my husband's parents and, and they came to that and sort of acknowledged the loss um but after that they didn't really talk about it"*

Christine repeatedly used the term 'product of conception' when referring to the baby that she lost. This may indicate that even she failed to acknowledge the loss in some respects. Christine's comments below may be related to the lack of personhood of the foetus. Her use of the term adequately encapsulates the manner in which medical science envisions first trimester pregnancy. Christine attributes her use of the term to her medical background (she was a trained medical professional), where physician's thinking around pregnancy loss is shaped by this particular discourse.

*"Cos I never (...) never did not refer to it as anything else. And that's probably to blame (...) on my medical background because I should actually have been calling it my baby or something, not product."*

The use of this kind of discourse may have a minimising effect in terms of the emotional component of the pregnancy loss because of the apparent denial of personhood. The pregnancy is viewed as a biological by-product and the pregnancy loss is not viewed as the destruction of the hopes and dreams invested in what could have been but rather as a consequence of either a 'defective' reproductive system or the normal biological process of the body ridding itself of what could have been an abnormal foetus. Côté-Arsenault and Dombeck<sup>23</sup> explain personhood in terms of the occupation of a social position in society where one is born and functions within the society before being accorded recognition as a member of that society.

The socially and legally sanctioned acknowledgment of personhood in most countries begins with the issuing of a birth certificate. In the case of miscarriage, this public acknowledgement is not provided thus reinforcing the marginalization of the pregnancy loss experience and maintaining the profound silence associated with it.

It is evident that there was a lack of acknowledgement of loss for women in this study. Acknowledgement plays an important role in meaning-making within the context of pregnancy loss with women feeling a sense of validation.<sup>24</sup> St John, Cooke and Goopy<sup>27</sup> reveal how women in their study felt that the silence surrounding their loss began immediately when they were classified as no longer pregnant. According to Corbet-Owen and Kruger,<sup>24</sup> the foetus leaves no tangible trace of its existence behind, especially in the case of first trimester miscarriage, unlike in the case of a family member who has passed. This translates into a complicated grieving process for the parents as the baby is not acknowledged because there are no tangible remains. The lack of acknowledgement also speaks to the silence around foetal personhood. Côté-Arsenault and Dombek<sup>23</sup> describe the manner in which the assignment of foetal personhood and level of attachment during the course of a pregnancy may influence the emotional experience of a pregnancy loss.

Finally, participation in rituals provide grieving women with a platform to validate their experience and express their grief related to the loss they have experienced.<sup>28</sup> Some women in this study reported that they engaged in rituals and that while it served to validate their experiences temporarily, it did not result in ongoing validation from others confirming Davidson and Stahls<sup>29</sup> findings that bereaved mothers lack sustained validation.

### 3.6. Lack of cultural scripts

Cultural scripts are a way of making explicit local conventions of discourse and refer to common held conceptions of how people interact in social contexts. Participants explained how a lack of cultural scripts informed their everyday interactions with people after their miscarriage. Participants reported that it was evident that people who they interacted with were uncomfortable in discussing their loss and utilised discourses like pregnancy loss is normal and this type of script undermined women's experiences. People's failure to provide verbal support for the women were sometimes met with feelings of anger. For example, Fatima stated that the responses that she received evoked feelings of anger as she felt that people who have not gone through a similar experience were unable to empathise and give her advice because they did not understand the depth of her pain and grief.

*"Some people say, no its ok, it's just normal, lots of women lose their babies, I mustn't take it so hard but that makes me angry because what do they know? They didn't go through the same thing and for a woman to lose her baby is the most painful thing anything could ever feel. So people, whoever they are cannot say how it feels, that is a pain that you have to experience yourself and you will never forget it, forever, (forever) you will wonder what would have happened, would this have been or would that have been, how would I have felt."*

Another participant, Laaiqa stated that the types of comments that she received (though she understood that they were well-meaning) enhanced her feelings of guilt and self-blame. Laaiqa felt very strongly that her loss was not understood and went unacknowledged. In fact, she preferred that people not say anything at all, as they did not understand the maternal grief that she experienced. Silence could therefore be considered her preferred cultural script.

*"I actually would have preferred most of them to say nothing . . . like where people die, you hear, people would say things like oh you know um, you must be strong and he's, he's in a better place or um it happened for a good reason, you know things like that. How do you know what the person is going through? You know, rather say nothing uh, um or just say I'm so sorry for your loss or whatever and that's it"*

The distinct lack of cultural scripts with regards to responding to pregnancy loss more often than not leaves the women who are grieving feeling that there is nobody who understands their loss. Layne<sup>7</sup> attributes the inability of people to respond appropriately to such a loss to the lack of appropriate cultural scripts. This has a ripple effect for women in terms of the support that is subsequently available or not<sup>11</sup> as well as the social sanctioning of women's grieving processes. This lack of appropriate conventions for responding to such losses highlight the need for mothers to have authority over their own grief processes.<sup>29</sup>

### 3.7. Unhelpful actions or words

Subsequent to their losses, participants reported that they encountered statements of actions that were unhelpful for them. For the most part, these statements and actions were interpreted as attempts to minimise their experiences to a certain extent and this culminated in feelings of anger, frustration and isolation.

Fatima reported experiencing a great deal of anger towards people who tried to provide advice to her without having had a similar experience. She felt that they were unable to relate to her maternal grief and she regarded any attempts to pacify her as shallow and unhelpful.

*"That's another thing that made me angry, because many people came to me and said 'Ag, um, next time, there are more times, you can try again', I don't need that, if you didn't go through it then shut your mouth, don't tell me what to do, if you didn't feel the pain then don't, don't come talk to me about that."*

Similarly, certain actions from others were seen as unhelpful. Nuraan was emphatic about not wanting relative strangers to attend the funeral of her stillborn baby. Directly following her loss, she did not want people in her space.

*"I didn't want them here I didn't know them don't sympathize with me because you don't know me"*

In addition, some comments were particularly hurtful for participants. Laaiqa reported being upset by a comment made by a friend who assumed that she (Laaiqa) was 'defective' and suggested that her husband should find another wife who was capable of providing him with a child. These blatant responses left some of the participants with a sense that they have failed in their biological and social expectations. This statement illustrates how biomedical discourses justify social discourses. In this case, the participant's reproductive 'failure' made it acceptable for her husband to take on a new wife. In addition, there was an underlying sense that they have been devalued because of this, to the extent that there is justification for Laaiqa's husband to take another wife to do what she failed to do.

*"a close friend of mine then and she once made a statement . . . saying like, you know, there's a reason why men can get married to more than one wife and she said no you can't. And she said Auntie Laaiqa's husband can have a second wife because, and I was sitting there and it was such a horrible statement to make you know"*

Christine reported that she was told that she may have lost her baby due to foetal abnormalities. This comment once again indicates the pervasiveness of biomedical discourse in loss. In this case the commentator may have been trying to alleviate Christine's suffering by sharing her medical 'knowledge' with Christine. However, for Christine, this comment was unhelpful and did not ease the emotional pain associated with her loss.

*"One person that said to me, you know maybe the baby would have ended up with some, some, some abnormality or something in that line. And I didn't take very kindly to that because ( . . . ) like for me that doesn't make much of a difference"*

The theme of unhelpful words or actions is similar to the previous two themes of lack of acknowledgement and lack of cultural scripts. However, while the two previous themes relate to subtle discourses following loss, the unhelpful words or actions are more direct and reported as causing great distress in women following their loss.

#### 4. Discussion and conclusion

In this paper, we described the experiences of pregnancy loss as reported by seven women in South Africa. Two major themes emerged from the analysis, namely the adoption of a medical framing of miscarriage and the social awkwardness of loss. We argue that adopting a medicalised framework (in which foetal personhood is seen as inherent and biological) is central to the experience for women and plays an important role in shaping and influencing social discourses.

The adoption of the medical framing of miscarriage in this study played the role of providing women with knowledge of how medical science deals with reproductive loss. According to this body of knowledge there are no medical reasons for first trimester pregnancy losses and miscarriages are regarded as 'normal'. For the participants in this study the normalization of miscarriage may have functioned in two particular ways: first, it resulted in women feeling subjugated with their emotions being relegated to the periphery. Secondly, it may also have functioned as a buffer to counter the self-blame that they experienced.

These biomedical discourses also played an influential role in shaping the experiences within the social realm. The authority of biomedical discourses meant that those surrounding the participants also embraced these discourses and often adopted those discursive strategies in their social interactions following loss. For example, the lack of acknowledgement of pregnancy loss we argue is tied to the biomedical discourse that miscarriage is normal and therefore needs no acknowledgement. The normalization of reproductive loss is linked to the notion of biological foetal personhood with the birth of a live baby being the deciding factor in determining personhood and non-personhood. Thus when a woman miscarries early on in the pregnancy the medical fraternity constructs the loss as reproductive waste rather than a baby that died. The lack of cultural scripts may find its roots in the biomedical notion that there are no answers for a first trimester loss and therefore this study demonstrates how significant others did not know how to react to such a loss. Notably many significant others reacted to these losses by expressing hurtful comments and displaying awkward social behaviours. Positioning reproductive loss as a cultural taboo steeped in silence<sup>8</sup> leaves both the grieving mother and those close to her with limited repertoires from which to respond.

#### 5. Limitations

All the women interviewed were selected by snow-ball sampling. Finding women who were willing to be interviewed was challenging and this meant that the study was limited to middle class women, most of whom were professional as they were the women that we could access within the time-frame. Including women from different socio economic backgrounds would have served to enhance the study by providing data with a potentially different set of experiences.

#### 6. Recommendations

There is a distinct lack of research around the pregnancy loss experiences of women in South Africa from lower socio-economic or impoverished backgrounds, with virtually no literature on the

experience within the context of HIV. There is also a dearth of literature on the emotional experiences or narratives of women in South Africa who have experienced miscarriage. More research could be done in terms of the moderating factors of adequate primary health care, social and partner support in terms of overall mental health following a pregnancy loss. South Africa has a myriad of cultures and it would be useful to examine the different responses to pregnancy loss within a cultural context based on the particular cultural scripts that exist within the dominant cultural groups in South Africa.

Support structures within the context of hospital settings appear to be lacking both within public and private health care facilities. Our recommendations for possible support structures and methods include: (a). Referrals for psychological assistance from casualty units, obstetricians or any medical centre where medical assistance is requested/required during a pregnancy loss experience. (b). Treatment and care from healthcare professionals that allows for sensitivity and acknowledges not just the physical impact but the emotional impact of the pregnancy loss. While this may not apply to every health care provider, there still is a general lack of acknowledgement towards the emotional impact of pregnancy loss particularly in the case of first trimester pregnancy loss. (c). Establishment of a pregnancy loss website where women who have access to internet can share their stories with women in a South African context. Where information can be shared, this may even provide an impetus for the establishment of local pregnancy loss support groups which are either lacking or very poorly advertised.

#### Ethical statement

We hereby confirm that this study received ethical approval from the Senate Research Committee of the University of the Western Cape, at their meeting held on 29 September 2006.

#### Conflict of interest

None declared.

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