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Grice's conversational implicature revisited: A discourse analysis of reproductive loss in women's talk

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GRICE'S CONVERSATIONAL IMPLICATURE REVISITED: A DISCOURSE ANALYSIS OF REPRODUCTIVE LOSS IN WOMEN'S TALK

by

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Date 05-30-2007

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ABSTRACT

In my thesis, Grice's Conversational Implicature Revisited: A Discourse Analysis of Reproductive Loss in Women's Talk, it is my intent to explore the discursive modalities of reproductive loss narrated by women, who, at different stages of gestation, have lost one or more children. Rooted in a theoretical framework in discourse analysis, my thesis seeks to analyze how women, having participated in an interview with a female interlocutor who lost a child herself, narrate their experiences of reproductive loss.

My hypothesis is that the more personal information about the experience of reproductive loss the participant is supposed to share, the more often she expects the female interlocutor to rely on the cooperative principle and the conversational implicature introduced by Grice. In order to understand the meaning of what is said in this special form of women's talk, the female speaker expects or forces the female hearer to refer to the participants' mutual knowledge (including scripts, schema, and cultural and gender concepts), contextual reference of the utterances (linguistic and otherwise), and the filling-in of gaps. Having analyzed personal interviews with eight women from my home country of Switzerland, I further look at the ways in which these women handle and relate to their experience, which, after all, is still considered a taboo in society, before raising questions about gender specific modes of narration.

In other words, personal or intimate questions about the experience of reproductive loss negatively influence the flow of speech insofar as it generates, as an

effect of it, a limited presence of crucial semantic elements. I anticipate the results that in this form of conversation among women, a speaker relies upon a hearer's cooperative principle and conversational implicature by mainly providing fragmental information about the traumatic event.

CHAPTER I

INTRODUCTION

"Ending a pregnancy without a baby to hold in your arms is heartbreaking"

(Mayo Clinic Staff).

*

Although pregnancy loss occurs frequently, little is known about women who have experienced reproductive loss.[1] Society does not provide a platform for women who have suffered reproductive loss to share their grief, their fears, or their stories.

The principal aim of this research is to linguistically analyze how women narrate their experiences of pregnancy loss(es) by means of discourse analysis. It is my intent to explore the discursive modalities of reproductive loss narrated by women, who, at different stages of gestation, have lost one or more children. The linguistic field of discourse analysis allows me to embrace other fields related to it, such as sociology, psychology, and communication, in order to provide a solid informational background.

Another aim of linguistically analyzing women's narratives about reproductive loss is to shed light on a topic that is only marginally recognized in our society. Talking about reproductive loss is still treated as a taboo, and because of that, women who experience an involuntary loss of pregnancy and those close to them do not know how to cope with this situation. The unexpected turn of events from being pregnant and (mostly) full of hope and joyful anticipation to having to face the death of a child yet to be born is

shocking, frightening, and confusing. When talking about pregnancy loss, people seem to feel uncomfortable. They start looking for potential reasons, possible explanations or clumsy words of consolation. The fact that only a small number of children who have been conceived are born alive is not well known.[2]

Despite advanced technological and medical procedures, not all pregnancies end successfully. In most cases a happy outcome is not within the range of human possibility. Most pregnancies end before a woman knows that she is expecting a child, that is, before the next regular menstruation. "After a pregnancy may be clinically recognized (between days thirty-five and fifty) about twenty-five percent will end in miscarriage" (Hummel 45). This number depends on the age of an expecting woman: the chance of suffering a miscarriage is about twenty-five percent for a thirty-year-old woman, and fifty for a forty-year-old woman (Borg and Lasker 50). These figures are remarkable. Since feelings and experiences of child loss are not broached and discussed openly, it is not surprising that there is almost no support system for these women. Society does not regard reproductive loss as an equal loss to any other death, which explains, in part, why there is no room for women to grieve and talk about their experiences. Women have to find their own strategies to cope with what happened. Only recently, as Gray and Lassance argue, have people become aware of the impact of reproductive loss for the family in which it occurs. In their book, Grieving Reproductive Loss, they state,

> Reproductive loss is gradually (at last) being recognized as a source of grief as great as any other important loss in the human experience. Because of the slowness of society to see these as tragedies to grieve the

> usual rituals and support after a death have not been available to mothers, fathers, and families who experience these losses. (121)

Hopefully, this work will contribute—even if it is only a small contribution—to a more far-reaching understanding of what reproductive loss is and helps to handle this topic in a more natural way.

All the participants of this study were interviewed by a female interlocutor—myself—who, herself has experienced reproductive loss. The hypothesis stated for this thesis is that the more personal information about the experience of reproductive loss the participant is supposed to share, the more often she expects the female interlocutor to rely on the cooperative principle and the conversational implicature (Grice). In order to understand the meaning of what is said in this special form of women talk, the female speaker expects or forces the female hearer to refer to the participants' mutual knowledge (including scripts, schema, as well as cultural and gender concepts), contextual reference of the utterances (linguistic and otherwise), and the filling-in of gaps.

Conducting interviews with ten women from Switzerland and listening to their personal stories about reproductive loss was a deeply moving experience for me. In every meeting the atmosphere was a mixture of warmth, tension, and distance. At the same time, feelings of familiarity and intimacy prevailed. Right at the beginning of our interviews, all the women suggested to drop the polite form of address ("Sie" in German). All the participants were willing to share their intimate and emotional experiences of having suffered a loss of a child. I also talked to women I had known previously. These conversations were very warm, and a friendly connection was soon established. Even though at some point in our sociolinguistic interview the sense of grief was tangible,

given these women were talking about something very emotional, our conversation remained within emotionally controllable confines. Despite frequent mood changes both interviewee and interviewer seemed to feel comfortable.

Since the subject was likely to elicit emotive responses of some kind, in some stronger, in others less, their stories do not simply recast a traumatic event but rather constitute important pieces in these women's biographies. The presence of emotions causes their narrations to be rather disorganized and digressive at times. Sudden glottal stops, interruptions, and a lot of hedging occur quite often and make it difficult for a reader to always capture the meaning of what these women try to convey. The interviews were conducted in Swiss German. I have translated them into English. Appendix B and C at the end of this thesis provide information about the translation work and about transcription conventions used for this research.

One of the main reasons that inspired me to write about reproductive loss is my personal knowledge and connection to this topic. I had to let go of what I thought was already mine, a child. This experience was deeply disturbing but at the same time eye-opening. I came to realize that there is not enough knowledge and awareness about involuntary pregnancy loss to embed them naturally in our daily lives. The social restrictions to talk about the loss of a child create a contradictory force when a pregnancy fails. Women's health movements embellish the concept of pregnancy and birth and in so doing suggest that pregnancies are happy events and therefore end happily. This picture is propagated by the media and deeply entrenched in society. However, problem pregnancies, negative results of antenatal tests, or pregnancy loss are uncomfortable subjects to talk about. "The cultural denial of pregnancy loss challenges the validity of

the social and biological work already undertaken in constructing that child and belittles the importance of the loss" (Layne 17). I understand the sense of helplessness and the loss of words for those who have to confront women who have suffered a pregnancy loss. At the same time, from the point of view of a woman who has experienced reproductive loss, "saying something" out of pity or for the sake of saying something is not what a woman wants and needs to hear.

Death is part of life. In our society, however, only a few can treat death as a natural phenomenon. For most of us, death usually represents a tragic event regardless of the age of the deceased person. It is particularly tragic if a life expires before it is born. Although only the mother could establish a close bond between her and the child in her womb, not only the bereaved mothers but also fathers, close friends, and family are entitled to grieve. The death of an unborn child is a death like any other death. I hope that this thesis will contribute to a better understanding of pregnancy loss and will eventually help women who experience reproductive loss to find an approach towards healing and acceptance.

In chapter two, the discussion of how women relate to and narrate reproductive loss will begin with an explanation of medical procedures, which is instrumental in understanding the analysis of my data. In almost all the interviews women refer to medical expressions or weeks of gestation. This chapter also provides background information—such as forms of reproductive loss, social implications of reproductive loss, and emotional impact of losing a child during pregnancy—necessary to understand my data. I shall also offer some sociological speculations on the culturally mediated positions

if womanhood related to pregnancy and in particular the social implications of reproductive loss.

Chapter three explains the linguistic devices I have used to analyze my data. It also provides information about the methodological strategies, the theoretical framework and the hypothesis.

Chapter four is an analysis of my data informed by discourse analysis, a field of linguistics. In my analysis, I will draw extensively upon Grice's detailed account of conversational mechanisms, discuss his concept of the cooperative principle, and present a critique of his elaborate scheme by eclectically utilizing other linguistic material that either problematizes or complements Grice's theory in significant ways.

Chapter five evolved from my interest in the comments about guilt and self-blame related to pregnancy loss by the interviewees. All the participants blamed themselves for the death of their unborn. I decided to elaborate on the notion of guilt in narratives of women who have experienced a form of reproductive loss. Previous studies point out that grieving reproductive loss includes self-blame, searching for answers, and a feeling of lost hopes for the future (Van and Meleis 30). All the women I have interviewed mention feelings of guilt and self-blame when talking about their experiences and felt responsible for the death of their child.

Chapter six concludes my research with a synthesis of my findings.

NOTES

[1] One in four recognized pregnancies ends with the death of the baby (Hummel 45).

[2] The estimated number differs from source to source. Qualimedic, for instance, claims that seventy percent of all pregnancies end before the expected period and therefore are not known (Qualimedic.de).

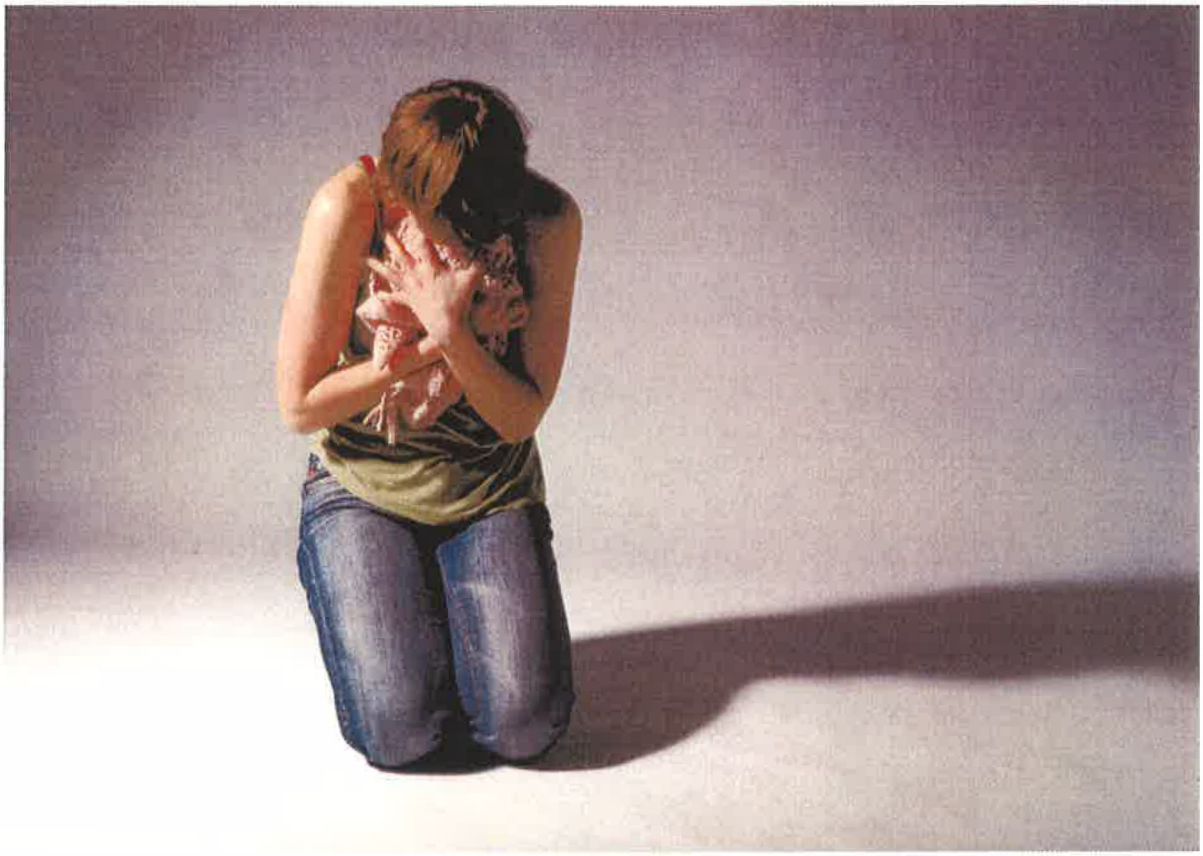

Fig. 1. Photographical Exploration of Reproductive Loss: Grief. Subject (W 10): "I held the dead baby in my arms for more than an hour. I didn't want to let go of him." (Seelisberg, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

CHAPTER II

BACKGROUND INFORMATION OF THIS STUDY

This chapter provides medical explanations about reproductive loss and expounds on its social implications. Firstly, it gives insights into the latest development in reproductive technology in general, as well as medical procedures of pregnancy commonly applied in Switzerland in particular. Secondly, it elucidates and informs about the different and most common forms of reproductive loss. The last section of this chapter discusses the social implications of reproductive loss in Switzerland. This information is crucial in order to analyze and understand the data used for this thesis. Additionally, the chapter briefly talks about the social implications of pregnancy loss in an Asian society and their approach towards reproductive loss.

2.1 General Information on Reproductive Loss

In the past twenty years, reproductive and antenatal medicine has undergone rapid transformation. Pregnancies are commonly considered to be safe and controllable. Reproductive medicine and prenatal diagnosis can help in many cases, such as infertility and problem pregnancies.[1] In some cases physicians even undertake medical procedures on the unborn while the baby is still in the womb. All the new technologies and medical advances have not only changed the security of a pregnancy and the health of women compared to women in previous generations but have also affected the emotional

relationship between an expecting woman and her unborn offspring.

Emotional bonding has an immediate impact on the woman in case of a pregnancy loss. Layne puts these changes as follows: "The scientific determination of pregnancy (hormonally and electronically via electronic stethoscopes and sonograms) before the sensation of fetal movements is undoubtedly changing the experience of those who have early pregnancy losses" (82). Women can buy pregnancy tests in supermarkets that ascertain a pregnancy within three minutes, even as early as one month after conception. This kind of testing contributes to a woman's feeling of expecting a "real" child long before she physically experiences her pregnancy.[2] It has a psychological effect on the woman who knows through the results of the pregnancy test that she is expecting a child. If the pregnancy was desired, the bonding to the child starts with the knowledge of being expectant.

Today, even a very early pregnancy loss is perceived as a loss of a child and can therefore have a serious psychological impact on the mother-to-be. An expecting woman perceives her involuntary reproductive loss "as the death of her baby, as opposed to the loss of their pregnancy" (Van and Meleis 34). In case a "pregnancy was unplanned but wanted, the couple may express feelings of loss in retrospect since parenthood is something they might have welcomed" (Hoenk Shapiro 116). Thirty years ago, the same event might have been interpreted as a "late period." A woman who knows (even though she does not feel it) that she is pregnant starts to grapple with the new situation and takes precautions to ensure, as much as she can, a successful gestation. Davidson, as cited in Hsu et al., writes, "For a woman, awareness of pregnancy initiates the transition process toward motherhood, throughout which she experiences an integration that results in a

new identity" (411). The knowledge of pregnancy causes identity changes to occur, no matter whether a pregnancy was desired or not. The authors of Interpretation of Stillbirths state that "The unborn gradually binds with the woman's self-identity and becomes part of her future" (Hsu 409). One of my participants (W 10) did not want to become pregnant at the time, but the positive pregnancy test and the idea that a child is developing inside her body triggered an array of feelings in her—mostly negative ones in the beginning—and contributed to the formation of a new identity. According to her description, she felt a responsibility for becoming a mother and gradually developed an affective bond to her baby. In addition to her initially negative feelings towards her pregnancy, in her second medical check-up (in week twelve) she (W 10) was confronted with an unfavorable prenatal diagnosis. A series of prenatal checks followed and she (W 10) and her husband had to decide whether they would have an elected abortion,[3] or whether they would carry to term a baby with genetic or physiological defects. The couple decided to stop further tests and go on with the pregnancy, which eventually ended with a stillbirth in week twenty-two. In the following section I will explain the medical methods (and the emotional ordeals for couples) to detect possible anomalies.

2.2 Medical Methods to Detect Anomalies in Prenatal Diagnosis

Hoenk Shapiro writes, "Although most couples want to have tests for possible birth defects, few of them actually believe that the results will be anything other than routine—unless one or both of them may be carriers of a defective gene" (113). Because medical technology is so advanced and early pregnancy checks are routine, women and/or couples do not consciously make a decision whether they want such tests or not.

Nikcevic et al. state that "Ultrasound scanning at 10-14 weeks of gestation is being introduced into routine antenatal care for early diagnosis of major defects and effective screening for chromosomal abnormalities" (808). In Switzerland, women are advised to see a doctor as soon as they realize that they are pregnant in order to rule out an ectopic pregnancy (see page 17). The main reason for which women are encouraged to undergo their first testing lies in the fact that around week twelve chromosomal defects can be detected by means of ultrasound. The sonographic imaging methods that "Most practitioners consider [...] perfectly safe, and strongly dismiss the concerns of anyone who questions this" (Kmom par 10) are standard in measuring the weight, position, and the biophysical profile of the fetus. It is done at an interval of four weeks.[4] Borg and Lasker write that

> There are many reasons why a woman might have prenatal tests. The most common one is her age, since women have a greater chance of bearing abnormal children as they get older. Legal decisions have determined that physicians must advise women thirty-five and older of the risks of childbearing and of the possibility of prenatal tests. There are other situations that might lead a physician to advise parents to consider prenatal testing. A previous pregnancy that produced an abnormal child, a history or genetic disease in the family, the experience of three or more miscarriages, or the presence of male relatives with such sex-linked diseases as hemophilia are all reasons for suggesting prenatal diagnosis. (50)

Since the mid-nineties a fetus's nape region, that is, the thickness of the nuchal or neck fold, on the ultrasound image has been identified to estimate risks of chromosomal disorders. Alder argues that "if the nape region is 3 mm, the risk is threefold, at 4 mm it is 18-fold, at 5 mm it is 28-fold, when the thickness exceeds 5 mm, the risk is 36-fold, when less than 3 mm, the risk is decreased three-fold" ("Indications in Ultrasound"). One participant (W 10) who was twenty-seven at the time of her pregnancy (which is not within an age of increasing risk of genetic disorders, such as trisomy 21 or trisomy 18) was told by her physician that the nape of her male child measured 6 mm; the chances of having a baby with a serious genetic defect were high. With a reliability of up to eighty percent, Alder writes, the value of sonographic imaging lies in providing more clarity than what is offered by assumptions made on the basis of maternal age or biochemical tests (22).

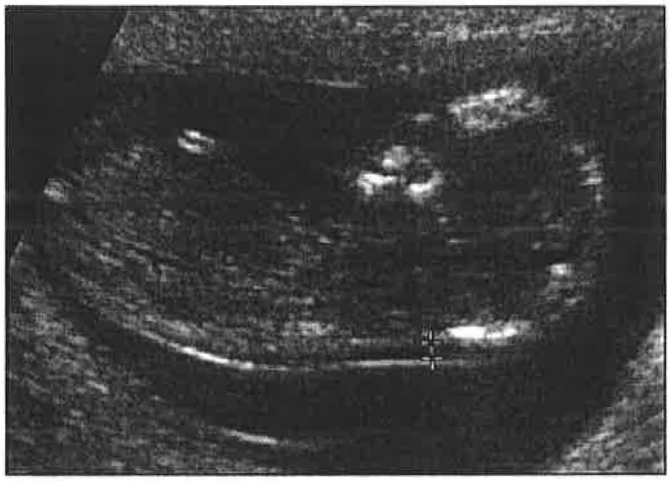

Fig. 2. Ultrasound picture showing the nape region of a fetus (Nuchal Translucency/Early Anatomy Ultrasound).

With the nape region of a fetus larger than 3mm, the likelihood of having a child without disability is rather small, even if the presence of gene mosaics in the placentary cells may account for the fetus's increased nuchal translucency.[5] Alder states,

> The advantage of this method is that it can provide a rapid result in an early week of pregnancy. Its disadvantage is mainly that compared to amniocentesis it bears a slightly higher risk of miscarriage, the latter being assumed to range at about 1–2 %. Moreover, in approximately 2–5 % of the cases the findings are unclear due to the natural presence of gene mosaics in the placentary cells. In such an event later amniocentesis will be necessary for clarification (26).

Aside from standard procedures of prenatal testing, of which ultrasound imaging is the most frequent one, there are other techniques—in fact more intrusive ones, such as amniocentesis, chronic villi sampling, cytogenic analysis. These are follow-up procedures when atypical formations had been detected via transabdominal and vaginal ultrasound. Amniocentesis is conducted between weeks fourteen and twenty of gestation and requires the passing of a needle through the abdominal wall of the expectant woman to retrieve amniotic fluid containing cells of the fetus. Organic abnormalities can be detected with this method. One of them is the growth of the fetus's lungs.

It is agreed, in the medical context, that the analysis of amniotic fluid does not generally present any danger for the woman. It can happen, albeit rarely, that the poking of the needle through the abdominal wall might puncture the fetus, a technical mishap most likely resulting in spontaneous abortion. One of the participants of this study (W 10) had to undergo this kind of prenatal check after which she and her husband decided to

stop further testing. She recounted the cold attitude of the specialist who advised her to relax and not move or the baby might get hurt and die immediately. The sight of the long needle and the tensions about the outcome of the test added to what she explains as traumatic experience of her prenatal diagnosis.

According to an online source, Family Guide to Women's Health, amniocentesis is referred to as "the granddaddy of modern prenatal testing" and has become a standard procedure for women over the age of thirty-five (www.healthsquare.com). Presenting an uncomplicated picture of the procedure itself, the authors of the website state that "If there's a danger that the baby will be born with a congenital defect, your doctor will probably recommend amniocentesis to rule the problem out." What this "ruling out the problem" means is the prospect of aborting the baby when it is already between fourteen and twenty weeks old. "By the time most couples are faced with a decision about abortion, the baby usually has started to kick and the movements become a dramatic reminder that he or she is alive" (Borg and Lasker 54). The decision about an elective abortion puts immense pressure on the expecting mother, the expecting father, and their relationship, and is likely to be bound to moral and religious beliefs. An abortion of a supposedly abnormal child triggers an enormous emotional reaction including grief, guilt (chapter five), fear about future pregnancies, and ambivalences about abortion itself (57).

Chorionic villus sampling is another procedure of prenatal testing and is administered after the results of amniocentesis have shown indications of chromosomal aberrations. Although this test can be done around the eighth week of gestation, it is usually considered a back-up procedure to make sure, as one practitioner calls it, that the results of the amniocentesis are in fact accurate. With the insertion of a needle through

the abdominal wall, the cervix, or vagina, the specialist can extract samples of the surface of the placenta (chorionic villi), allowing for the detection of congenital defects. This procedure involves a higher risk of premature labor and spontaneous miscarriage, a fact rarely mentioned in medical discourses (see page 25).

In Switzerland, pregnancy checks are covered by public health insurance. If these tests are requested and suggested by a physician, all of them are covered. However,

> The technologically derived diagnosis of imminent abortions is also changing the mechanics of pregnancy loss. Whereas in the past a woman would learn that she was 'losing a baby' by physiological changes in her body (bleeding and cramping, premature labor, the absence of kicking), now it is frequent through the routine use of devices such as dopplers or sonograms that people learn that their fetus has died (or in fact never lived). (Layne 85)

It is not unusual that an embryo or fetus dies in utero. However, signs of its physical death always occur with a time delay. If there is no natural expulsion of a defunct embryo, a woman might develop a life-threatening situation resulting in poisoning the pregnant woman. This does not happen very often anymore, but at the beginning of the last century, toxicity caused by necrotic embryonic tissue caused many deaths. Physicians distinguish the time of the death of an unborn child and the moment of its birth (natural or induced) and medical technologies can determine exactly when a child died. Layne argues that "from an experiential point of view, however, the two events [the demise of an unborn child and the expulsion of the body] are often synchronic but also synonymous" (85).

2.3 Emotional Responses to Pregnancy Loss

> When perinatal loss occurs, there are multiple frustrations, many disappointments, and much deprivation. The course of the parent's development is derailed, usually abruptly, without warning, sometimes permanently. [...] A specific person who can never be replaced has died. A part of oneself, an embodiment of the future, and the best one has to offer has died as well. A sense of power, of having defeated death, is extinguished by occurrence of death when it is least expected. (Leon, 26-27)

Loosing a child is a disturbing experience. Nikcevic et al. investigated the causes resulting in miscarriage and their influence on women's psychological distress. With the help of pregnancy scans they were able to determine the biophysical profile of the fetus. In case the fetus was found dead, they assessed the psychological responses of pregnancy loss on the women who had experienced it. The study concludes that "the diagnosis of pregnancy loss is, for most of these women, a shock, and a trauma that may lead to significant levels of affective disturbance persisting for several months after the event" (808). The emotional response after an involuntary pregnancy loss (but also after an unwanted yet elected abortion after prenatal diagnosis) include grief but also many other emotions including "self-blame, lost hopes for the future, shattered dreams of parenting, lack of a tangible person for whom to grieve, silence from others, lack of appropriate rituals, questioned legitimacy of grieving, unknown cause of death, and a variety of emotional triggers" (Van and Meleis 30). One of my participants recounted the moment when she was told by the physician about the death of one of the twins she was expecting

after twenty-six weeks of gestation. The ultrasound showed that one of the two unborn children no longer had a heartbeat. Her situation was very unusual insofar as she had to carry both children—the deceased and the living fetus—until week thirty-one, when she gave birth to both of them. In the following excerpt of an interview (example one), the subject (W 4) narrates the moment when she realized that one of her twins had died. Phrases or parts of phrases that will be explained are highlighted or emphasized through italicized letters. This mode will be used throughout this thesis. For transcription conventions, see appendix B.

Example 1:

I: Was the death of the child noticeable? Were there any physical changes or did you notice something peculiar?

W 4: Well, I mean before I had to go to L* [a hospital in a nearby city] for the checkup where the doctor said that the cardiac sounds were not there anymore- … then *I had a very bad feeling. I said to my husband "something is not good."* We went to some place back then and I did not feel good. We had to go home. No, I had a very bad weekend and *I had a strange feeling* and a strange stomach for the whole time. And from this moment on I thought that this was the moment it happened. And when the doctor then told me that [one of the twins had died], luckily my husband was there. I don't know whether I would have made it home at all. I mean—I did not understand that [i.e., the finding of the death] at the very moment. When he told me there were no cardiac sounds, I thought that cannot be true at all.

I: Did you see it yourself in the ultrasound?

W 4: =Yes, yes. He showed it to me on the ultrasound. There I have already become very nervous, I had an ultrasound for at least forty-five minutes. He could almost not understand that himself … then *I was aware that <u>something was not right</u>*. He became nervous and said, "something is not right." Yes, and then I realized something is not good …

As evident in the excerpt above, women frequently feel that something is not good or something is not right, as stated by the subject (W 4) in the example above, although oftentimes there are no physical signs of the death of an unborn child. The subject (W 4) also mentions that she had strange feelings. Other interviewees told me that they suddenly felt sad. In retrospect, women identify those moments as the point in their pregnancy at which their unborn expired. Schmid, a Swiss journalist who wrote an insightful article about her personal experience of losing her son after eight months of pregnancy, describes her feelings of leaving the birthing center after her last checkup when her baby was still alive. "When I was leaving the center, with a limp, [she suffered from a trapped nerve which caused a pain spreading down her leg], I was on the verge of crying, a mood I was recently getting in when thinking of the child" (10).

2.4 Forms of Reproductive Loss

In order to frame the analysis of my project, it is indispensable to provide descriptive and explanatory information about different forms of reproductive losses: miscarriage, stillbirth, ectopic pregnancy, abortion, and infertility. All of them share the

trait of prematurely terminated pregnancy, usually before the ninth month, resulting in the death of the unborn child. I focus solely on the loss of children through miscarriage, stillbirth, and ectopic pregnancy. The reason for my selection is that these kinds of reproductive losses have in common that a child is conceived (naturally or via artificial insemination) and the embryo/fetus dies without external influence and in most cases without obvious reason. Van and Meleis created the term "involuntary pregnancy loss (IPL) to refer to miscarriage, ectopic pregnancies, fetal deaths and stillbirths" (28). I will use this term as well. The chance of suffering IPL is higher during the first three months and the number of unsuccessful pregnancies decreases drastically after twelve weeks of gestation. Week twelve is usually the threshold when a pregnancy is considered to be "safe." This is also the reason why a woman or a couple usually waits until the first three months have passed to officially announce the pregnancy. Before week twelve, only close family members or friends know about a pregnancy.

2.4.1 Miscarriage

Miscarriage refers to the spontaneous ending of a pregnancy before a child is able to survive, that is, before twenty-four weeks of gestation. Physicians distinguish two forms of miscarriage: spontaneous abortion and missed abortion. In a spontaneous abortion a woman loses an embryo through heavy bleeding, while in a missed abortion the embryo stops developing and necrotizes inside the woman's uterus without signs of bleeding or cramping. Since the child's movement is not perceived at this early state of pregnancy, a missed abortion is most likely discovered during an ultrasound check. In case of a missed abortion a woman has to undergo surgery ("curettage"), wait until

bleeding starts and the embryo is rejected, or induce labor during which the woman has to be fully conscious. A woman who has suffered a spontaneous abortion sometimes has to undergo surgery to make sure no other remains are left in the womb. "In most cases of miscarriage," Gray and Lassance contend, "there is no known cause" (121).

2.4.2 Stillbirth

If a pregnancy ends after the twenty-fourth week, including if the child dies during delivery, it is referred to as stillbirth. The cause of stillbirth is mostly unknown. "The pregnancy can be normal and progressing well. Then the baby stops moving, bleeding occurs, or labor begins" (Gray and Lassance 122). Sometimes there is no sign of bleeding or contractions at all; the heartbeat of the baby just stops. Most of the causes are assumed to be of a genetic defect or of a defect during the child's development that could interfere with the growth of the brain, heart, skeleton, etc. In Switzerland, in cases of stillbirth, a woman is strongly advised to give birth to her child consciously and not undergo surgery. There are two reasons for this. First, at that stage of pregnancy, surgical measures could harm a woman's uterus and threaten a woman's future reproductive ability. Second, for psychological reasons, a woman has to be conscious to experience the loss of her child in order to process the traumatic experience.

2.4.3 Ectopic Pregnancy

One of my interviewees experienced an ectopic pregnancy.[6] If a fertilized ovum does not implant in the uterus but settles in the fallopian tube (in ninety-five percent of the ectopic pregnancies, see Borg and Lasker 42), it is referred to as ectopic pregnancy

(also known as "tubal pregnancy"). There are also cases of cervical, ovarian, or abdominal pregnancies, but they are extremely rare. In the case of an ectopic pregnancy an embryo develops normally during the first few weeks. "As it becomes bigger, it exerts pressure on the tubal walls, which do not have the ability to expand and stretch as the uterus does. Unless detected and treated early enough, the tube will burst, leading to internal hemorrhaging" (Borg and Lasker 42).

In Switzerland it is recommended to see a gynecologist before week eight in order to exclude the possibility of an ectopic pregnancy, which can be a serious threat to a woman's health. Borg and Lasker state that "Ectopic pregnancy is a life-threatening condition which has almost quadrupled in number [in the U.S.] since 1970" (Borg and Lasker 42). A woman has to undergo surgery to remove the embryo because the fallopian tube does not provide enough nurturing tissue, nor space for the embryo to develop. In some cases the fallopian tube needs to be removed as well. Infections, often caused by pelvic inflammatory diseases or deformities of the fallopian tube, are possible reasons for an ectopic pregnancy to develop, although in half of the cases, the causes remain unknown.

Even though the number of IPL is relatively high, the causes for these sudden and traumatic losses remain unknown. The woman is left with no explanation why it happened.[7] Since most miscarriages or stillbirths happen before the expecting parents publicly announce their pregnancy, not many people know about it. My data indicates that, many women who had suffered an IPL did not know that miscarriages and stillbirth happen so frequently. The following example (example two) taken from an interview with another subject (W 5) affirms this fact.

Example 2:

I: Did you know that this [miscarriage] happens relatively often?

W 5: Hmh [neg]. *No, I haven't been concerned-* .. myself- with it before that. *It never occurred to me to read something or-* .. *also from my mother or my sister?- nothing hmh* [neg].

I: What about friends or acquaintances?

W 5: *No, nothing, nothing at all-* .. as I read it later that- many- that this is happening, I thought that cannot be: I am the only one .. but- ...

Example two shows that the lack of knowlege about the frequency of pregnancy losses and IPLs in general causes the impression that "I'm the only one." It also can intensify the shock over the news about having lost a child, and make women think that there might be physiological problems she was not aware of. Lincoln, a physician who experienced miscarriage herself writes, that,

> Another very difficult aspect of miscarriage is that we women are very rarely taught about it, what to expect, how to handle it, and so on. It's a part of life that is often very hidden and discrete—until it happens to you. (2)

2.5 Social Implications of Involuntary Pregnancy Loss

Switzerland, along with other countries, is affected by demographic changes. The following table shows the demographic development in terms of births in Switzerland according to the official website of the Swiss government (Bundesamt für Statistik).

Table 1. Birth Rate in Switzerland 2003 - 2005

	2003	2004	2005
Live births	71'848	73'082	72'903
Boys	36'902	37'340	37'569
Girls	34'946	35'742	35'334
Swiss women	52'431	53'680	53'722
Foreign women	19'417	19'402	19'181
Per 1000 inhabitants	9.8	9.9	9.8
Boys per 100 girls	105.6	104.5	106.3
Unmarried women	8924	9705	10'013
First births[1]	29'323	29'888	30'143
Twins, triplets etc.	1088	1170	119
Stillbirths	306	276	307
Birthrate (child per woman)	1.39	1.42	1.42
Average age of the women giving birth (in years)	30.2	30.4	30.5

[1] Only married women

(adapted from the official website of the Bundesamt für Statistik 2006. Translated from German into English by Barbara Hauser.)

First, members of society continuously grow older, causing long-term problems for retirement and pension. Second, education and emancipation[8] are main factors influencing a woman's decision to have children or not. According to recent statistics published by the Swiss government, the average number of children in Switzerland is 1.3 per woman (total fertility rate; TFR); a small number compared to the USA where the TFR in 2006 was 2.09 (The World Factbook).[9] Third, a demographic trend shows that

women tend to give birth to children much later than some decades ago. In Switzerland, the average age of a mother giving birth is 30.5. The increase in age influences the number of IPLs because pregnancy loss is correlated to the age of a woman (Borg and Lasker 50).

Despite the liberty Swiss women have of choosing a personal lifestyle, women in their thirties, especially if they are in a relationship, but also single women without partners, are still expected to have children. Friends and family members remind women of social expectations, that is, bearing children. Apart from friends, family, and acquaintances, the presence of media is another factor telling women, quite unmistakably, that there are age limits to reproduction. The Swiss government tries to introduce family-friendly plans, attempting to provide financial relief in order to make family life more attractive, because finances are one of the major influences on family planning.

Once a decision is made to have a family, a couple—and women in particular—start imagining a life with a child. Pines points out that

> Pregnancy, particularly the first pregnancy, is a crisis point in the search for a female identity, for it is a point of no return, whether a baby is born at the end of term or whether the pregnancy ends in abortion or miscarriage. [...] It implies the end of the woman as an independent single unit and the beginning of the unalterable and irrevocable mother child relationship. (60).

Hsu et al. have demonstrated that the bonds between mother and child are established early on and argue that "As a pregnancy develops, a woman establishes closer links with her unborn baby and within her social network" (409). They also assert that

"The unborn gradually binds with the woman's self-identity and becomes part of her future" (409). Physical changes in a woman's body, seeing the heartbeat of the child in the ultrasound check, feeling the baby's movements, all contribute to the mother's relationship to her unborn child. Literature about conception and pregnancy promotes this bond between the fetus and the mother with the result that women pay more attention to pregnancy issues at a very early stage. Today, women in Switzerland attend special gym classes designed for pregnant women, for instance yoga or Pilates. There are several clothing stores, such as H&M, Gap, and Esprit, that promote fashionable clothes for pregnant women. The child is present in a woman's daily life. Layne describes a woman's awareness of her pregnancy as follows,

> New reproductive technologies, particularly home pregnancy tests and ultrasound imaging, as well as related movement toward medically managing pregnancy at ever earlier stages [...] have moved up the time and pace with which many women begin to socially construct the personhood of a wished-for child. (Layne 17)

Schmid, recounting her experience of a pregnancy loss after eight months, uses the name of the baby and describes his personality. Borg and Lasker state that "This creation of a person, with an identity and life of his or her own, is a typical part of pregnancy and is encouraged by society" (14). They further write that pregnancy is a special period in a woman's life and that

> For many women, becoming a mother represents the fulfillment of their own adult role and of people's expectations. As poet Adrienne Rich wrote about her own experience of being pregnant: "The atmosphere of approval

in which I was bathed—even by strangers on the street, it seemed—was like an aura I carried with me… this is what women have always done." (16)

Being pregnant provides a woman with a special social status; she is recognized and appreciated as a mother-to-be. When she involuntarily loses her unborn child, however, she is pushed to a tabooed zone in society where people do not know how to approach a woman who had experienced IPL.

As the last excerpt from one of my interviews shows, expecting women (and people in general) often do not know about the frequency of IPL. Layne explains that "The demographic shift towards a smaller family size and the related, though not identical change toward a later age for women to have their first child, has resulted in less shared common knowledge among women about the frequency of pregnancy loss" (17). When an expecting woman realizes that she will not be able to bring her pregnancy to full term, the first thought is that there is something wrong with her. Or she is doing something wrong because in their opinion 'everyone else's' pregnancy went well. Women start to question themselves in order to find explanations for what has happened. Example three from the interview with a subject (W 2) of this study illustrates her search for possible reasons for her second miscarriage. She had two miscarriages before she had her first successful pregnancy. Now, she is a mother of three healthy children.

Example 3:

W 2: =Yes, I mean mainly also with the second one. *I thought, no, now it does not*

happen to me again. And at that time, I was riding horses a lot and my physician always told me, "no, this does not do anything", if I have been riding horses, then I should continue doing it and I did that actually with the first two, and with the third, I did not do it anymore, thus, I just became more careful.

(Her three year old boy comes in and wants to show something)

I: You say, you had been riding horses. Were you searching for possible reasons for your miscarriages?

W 2: =*yes, I, I thought, this does not happen just like that, because she told me, everything is all right with me*=

I: Yes.

W 2: =Yes, and then she always told me about the riding horses, because I have been riding horses for a long time, *my body is used to that, it cannot be because of that*=

I: =Hmh.

Another participant (W 6) not only searches for possible reasons but mentions doubts as to whether her body has the strength to carry twins to term. She says, "my body is not strong enough for that [pregnancy]" and later in the same interview she contends, "I thought maybe I did something wrong [...] I did not work-out like crazy but at my workplace, I should have reduced my working hours earlier." Both women (W 2 and W 4) assume that there was something wrong with them and question the quality of their bodies or that there was something they had done that caused the death of their children, such as being exposed to stressful environments at the workplace or riding horses. In

chapter five, I will have a closer look at these kinds of interpretation of IPL and the feeling of guilt and self-blame which accompanies most pregnancy losses, that is, desired pregnancies but also unplanned pregnancies.

2.6 Taboo and Cultural Approach to Pregnancy Loss

The still prevalent taboo of talking about the loss of a child during pregnancy has several social implications and influences a woman's (and the expecting father's or future grandparent's) grieving process. Layne says that "The silence that surrounds this topic [IPL] does not result from its lack of consequence; on the contrary, taboo status signals the importance of these events" (64). This taboo status is also mirrored in the absence of words in the language. Neither English nor German has a word for a miscarried child, a stillborn child, or an aborted child. Japanese language uses the word *mizuko* for miscarried or electively aborted babies. There are *mizuko* statues (often a monk with a little child beneath) to remind parents of and rituals to honor their deceased unborn children. Japanese culture has a ritual to honor a deceased unborn child. The word *mizuko,* translated literally, means "water child." Water, in Japanese culture, stands for both the concept of rebirth and the recognition of death. The belief states that "when the fetus or newborn dies, it goes from the warm water of the womb to its former liquid state, in which it prepares itself for an eventual rebirth" ("Mizuko Kuyo" par 2). According to Roshi,

> Both the *Mizuko Jizo* and the *mizuko* ceremony arose in Japan in the 1960s in response to a human need, [sic] to relieve the suffering emerging from

the experience of a large number of women who had undergone abortions after World War II. (par 5)

Another source claims that this ritual of *mizuko jizo* existed for many centuries. Whether the increase of abortions led to a revival of *mizuko* or whether it was only introduced in the last century does not deny the fact that, first there is a name for children who die before they were born, and second, those deaths are acknowledged.

Fig 3. Mizuko Jizo at Hase Dera in Kamakura, Japan. (Japanese Buddhist Statuary).

In Switzerland there is no official place, no acknowledged symbol, and no common form of grieving or remembering children who died before they were born.[10] I

know of some women/parents who planted a tree in their yard in memory of their departed child, others who collected a special stone on a walk or kept the already-bought shoes to remember their baby. A culturally adapted version of *mizuko* would certainly allow women to properly grieve the death of their unborn children (whether they are IPLs or elected abortions) and realize that IPLs are a frequent occurrence, which can be shared with other women/parents. When I first came across the ritual of *mizuko,* I was impressed and fascinated. I used the opportunity to talk to Japanese women explained that *mizuko* is a well-integrated part of Japanese culture. I am surprised that I did not come across this culturally embedded ritual of remembering and honoring deaths of stillborn children earlier and more frequently.

More than fifty years ago, it was common that many children died before their first birthday. Today, advanced medical sciences and technologies including prenatal examinations give women the illusion of control and security. With an almost blind belief in the advances of sciences, a woman subjects herself to the increasingly sophisticated forms of testing and assumes that the specialist knows what is right or wrong. Babies and children are not supposed to die.

> In the United States [as well as in Switzerland] [...] dead newborns combine the potency of women's life-giving power with the destructive, polluting power of life-forces gone awry; thus, it is not surprising that such entities should be subject to taboo. Dead embryos or newborns are an unwelcome reminder of the fragility of the boundary between order and chaos, life and death. (Layne 65)

Medical journals write that one fourth of all known pregnancies do not come to full term—this is a significant number. Despite the frequency of IPL, social or psychological strategies of coping with the aftermath or a reproductive loss are only now developing. Medical journals have made IPL the subject of discussion but only mention in passing that there are psychological consequences. Layne points out that

> The medical neglect of pregnancy loss is also evident in many of the lay-educational materials available on pregnancy and childbirth, including feminist ones. Often how-to books of pregnancy take a woman step-by-step through a pregnancy starting with the moment of conception, without making clear that a pregnancy may end at any point along the way. (71)

In Switzerland, expecting couples visit birth preparation classes, where they are taught how a partner or husband can support a woman during childbirth as well as teaching them the basics of baby care and legal matters about having a child. The possibility of IPL is not mentioned in those classes at all. The exclusion of information about the frequency and forms of reproductive losses plays a crucial role for women who experience IPL. In case of IPL, women are often overwhelmed and do not know how to handle this situation.

In Switzerland, talking about IPL is still a taboo that burdens women who suffer from it. The silence about IPL probably has multiple causes. First, death is an unpleasant topic, especially in the case of a pregnancy which symbolizes a new and hopeful future. People in general, but also expecting parents, do not want to hear about the possibility of pregnancy loss. "For most, a pregnancy loss is experienced as an abrupt, unthinkable deviation from the natural, normal biological and social progression that pregnancies are expected to entail" (Layne 175).

Another reason as to why pregnancy loss is not adequately included in information about pregnancy or in feminist agendas "is the fact that pregnancy loss contradicts two fundamental premises of the women's-health discourse of pregnancy and birth—that women can control their reproduction and that birth is a natural, joyful experience" (Layne 241). The fact that discourse about IPL is still treated as a taboo is crucial for my analysis, since most of my participants did not talk about their reproductive loss other than to closely-related people; some of my participants did not share their experience with others at all. The fear of being judged or criticized by others overshadows the need of sharing their grief. Often this silence hinders a healthy grieving process, one in which they are able to articulate the pain of their loss. Layne states,

> When a woman's pregnancy fails, she is exposed to the judgment of others given that she, too, is a member of society, it is not surprising that she may have internalized societal norms and may judge herself according to these standards as well. Because of how closely motherhood and womanhood are tied in our culture, her virtue as both woman and mother may be questioned. (145)

The way IPL is acknowledged in a society is conditioned by cultural mores and customs. One study of IPL among Taiwanese women shows that

> In Chinese-speaking communities, stillbirth and prenatal deaths trigger many death-related beliefs that have direct ties to Confucian and Taoist values. In addition to enduring the suffering of their babies' death, many of these women feel burdened by having the culturally sanctioned

> emphasis on 'good death', which is death that comes only after one has fulfilled the obligation to raise children to adulthood. (Hsu et al.)

In Asian societies—especially in China where the government introduced the one-child-policy in 1979—women are expected to give birth to a healthy child, preferably a boy. This study shows that the way women talk about IPL unveils cultural values and religious beliefs.

In Switzerland, however, such expectations or religious beliefs are not an extra burden to women who lose a child during pregnancy. Nevertheless, IPLs are not openly discussed and people usually do not know how to react to a person who suffered from IPL. Layne states that "The cultural denial of pregnancy loss clearly has a profound effect on those who experience a loss" (69). Schmid had to give birth to her son who died in her womb one month before he was due. She describes the day when she was in the hospital to deliver her dead baby. Usually, rooms in birthing centers are lovingly decorated with colorful little lamps. Since Schmid expected a dead child, they removed everything that might have reminded her of a happy event. "When the midwife moved me to another floor, I could see the colorful little lights in one of the other rooms through the open door. The little lights were on" (Schmid 17).

If an IPL occurs after a pregnancy has been announced, it becomes a public event and the woman whose pregnancy failed is exposed to comments and speculations. Colleagues and acquaintances often comment on an IPL, "She should not have worked so hard" (implying that it was the woman's fault that the baby had died), or "I thought she was such a healthy person" (implying that she must have had a medical problem which caused the death of the child). In most cases, the cause for the death of a child is and

remains unknown and is neither caused by a woman's behavior (such as drinking alcohol, or practicing sports), nor is it caused by a women's health condition. Midwives and physicians can only say that the heart stopped beating and that there were no signs of life anymore.

Comments intended to be comforting, for example "you are still young," "it was probably meant to be," or "you should be happy because you already have a healthy child" are often actually disturbing. Even nurses and physicians are unintentionally insensitive when they offer these sorts of platitudes. These comments also sometimes trigger feelings like anger and irritation and end in social withdrawal. People do not know how to confront a woman who just lost her baby. These situations can become awkward. The woman's grief may be compounded by the responses of family and friends who treat the loss as a nonevent (DeFrain et al. 196). Apart from the linguistic interpretations of my data, I hope that this study will add to a better understanding of IPL and draws attention to this tabooed issue in society.

2.7 Summary

This chapter has discussed the different social concepts, expectations, and medical technologies which contribute to our understanding of involuntary pregnancy loss. Neither the English nor the German language knows a word to describe a child who dies during pregnancy. Not having a word implies the assumed insignificance of pregnancy loss in society. In Switzerland, involuntary pregnancy loss is still a taboo—an unpleasant subject and therefore ignored or written in the margin when talking about pregnancy. Women who suffer from IPL rarely talk about their experience with anyone other than

close friends or family. This plays a crucial role in the analysis of my data (chapter four). Knowledge about the different forms of reproductive loss as well as a basic understanding about medical procedures and prenatal diagnosis is also important in order to comprehend the subject of this thesis.

NOTES

[1]Women or men who are carriers of a genetic defect can sometimes be treated and/or women can be medically accompanied during pregnancy to ensure a positive outcome of a pregnancy. Prenatal diagnosis (as discussed on page nine and the following pages) is almost a common procedure in Switzerland, especially for women over thirty.

[2] Throughout this research I use the term "child" to refer to the embryo/fetus. Chapter three (subchapter 3.9) provides detailed information about the definition of the term "child."

[3] Newman et al. assessed the outcome and effects of ultrasound imagining and Doppler blood flow in 2834 women. He argues, among other things, that they do not exclude the possibility that the frequency with which the test group had been subjected to this procedure might have an effect on the growth of the child as a result of repetitive exposure to ultrasound. Kmom, a fervent defender of sonographic imaging, writes in a response to the possible correlation between fetal weight and ultrasound that Newman's findings are highly controversial and do not represent the benefits of ultrasound screening.

[4] The two terms 'elected abortion' and 'abortion' refer to a selected removal or expulsion of the fetus/embryo from the uterus. Missed abortion, spontaneous abortion, and other

terms formed with the word abortion usually refer to forms of miscarriage and stillbirth where the fetus/embryo is naturally expulsed or dies in utero without signs of bleeding as explained in section 2.4.

[5] The word nuchal is a medical term which refers to the back of the neck or nape.

[6] Her (W 4) case is very special and probably also very exceptional. She was expecting twins. One embryo was in utero and the other one was in her fallopian tube.

[7] Only in a few cases there are obvious factors responsible for a miscarriage or stillbirth, such as an infection, medication, alcohol or drugs, a malformation of the fetus, genetic abnormalities related to chromosomal aberration (which is assumed to be the most likely cause for almost every miscarriage) or violence. The example is taken from interview six (with the subject W 6).

[8] The term emancipation refers to the women's liberations movement in Switzerland.

[9] "The total fertility rate (TFR) is a more direct measure of the level of fertility than the crude birth rate, since it refers to births per woman. This indicator shows the potential for population change in the country. A rate of two children per woman is considered the replacement rate for a population, resulting in relative stability in terms of total numbers" (The World Factbook).

[10] Behind the Frauenklinik Zürich (Women's Hospital Zurich) there is a common burial place for electively aborted, miscarried or stillborn children—babies who are not big enough to have an official funeral and grave. The common grave is anonymous. Some women place colorful windmills with names and dates of their children, while others bring flowers. Other hospitals might have different places for bereaved parents, some hospitals have no such area at all.

Fig. 4. Photographical Exploration of Reproductive Loss: Mourning. Subject (W 4):"I-me- always had the feeling I have to bear this … there's no other possibility." (Unterägeri, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

CHAPTER III

METHODS AND STATEMENT OF HYPOTHESIS

This chapter presents the hypothesis for this research and the linguistic devices used to analyze the present data. Grice's concept of conversational implicatures and the cooperative principles—two linguistic theories established in the field of pragmatics—build the theoretical framework for the discussion of the data. Giles' accommodation theory will complement the theoretical background. Information and motivation about the data collection, including settings, procedures and questions, will be provided in this chapter. A special emphasis is given to sociolinguistic interviews.

3.1 Hypothesis

"One in four pregnancies ends in a miscarriage; stillbirth, one in eighty pregnancies" (Gray and Lassance vii). Yet, one hardly hears a woman say, "I have had a miscarriage." In the book, Grieving Reproductive Loss, Gray and Lassance show that the death of an unborn child affects a woman as much as any other death. They state that,

> In addition to grieving the heart-breaking loss of a baby, bereaved parents are faced with other difficult issues including additional losses (loss of part of their self, loss of self-esteem, loss of innocence, loss of identity) resulting from and related to the nature of a reproductive loss as well as the unique characteristics of the parental bond to the child. (81)

Feelings of helplessness, anger, and isolation arise frequently, and phases of depression are quite normal. It is very difficult for a woman to grapple with traumatic experiences or grieve the loss of a child if society fails to recognize the impact of reproductive loss. Gray and Lassance contend,

> Comments which communicate that the loss does not need to be grieved minimize their freedom or permission to grieve, resulting in disenfranchised grief. When this occurs, the bereaved might go through a time of denial and subsequently be unable to accept the reality of their loss. (57)

It is only now that physicians, midwives, and counselors come to realize how important it is to talk about the loss of an unborn child. In fact, the ways in which this taboo is handled and discussed depends on the cultural context in which it appears and the forms in which it might be expressed. As discussed in the previous chapter, Japan uses a ritual called *mizuko* to honor and remember miscarried, stillborn, and electively aborted children.

It is my intent to give voice to women who have suffered reproductive loss and offer a reconsideration of tabooed discourses. At the same time, it is vital for me to examine the linguistic maneuvers through which women talk about their experiences of reproductive loss. I will also explore the role that I assume in conducting the interviews, during which sudden emotions may influence the flow of narration. When conducting these interviews, I—in the role of the interviewer but mostly as the hearer—always played a very active part even though I did not always speak much. Wilson and Sperber assert,

> We are all speakers and hearers. As speakers, we intend our hearers to recognize our intention to inform them of some state of affairs. As hearers, we try to recognize what it is that the speaker intends to inform us of. Hearers are interested in the meaning of the sentence uttered only insofar as it provides evidence about what the speaker means. Communication is successful or not when hearers recognize the linguistic meaning of the utterance but when they infer the speakers' meaning from it. (23)

All the participants openly talked about their personal experience, but often struggled for the right words or the appropriate beginnings of their utterances. Despite the truncated and fragmentary modes of narration it was possible for me to fully understand the content of the interviews despite and regardless of these flaws. My aim is to use Grice's conversational implicature and the cooperative principle to demonstrate how the assumption of mutual knowledge can facilitate communication in this context. In so doing, I will revisit Grice's concept of cooperative principle and expand it accordingly for a much larger understanding of conversational implicatures.

My hypothesis therefore is that the more personal the questions in my interview are—i.e., the more personal information the speaker (interviewee) is supposed to share—the more often the speaker expects the hearer to rely on the cooperative principle and the conversational implicature. In order to understand the meaning of what is said, the speaker expects or forces the hearer to refer to the participants' mutual knowledge (including scripts, schema, and cultural concepts), the contextual references of the utterances (linguistic and otherwise), and the filling in of gaps.

3.2 Grice's Conversational Implicature and the Cooperative Principle

Discourse analysis deals with spoken language as opposed to written language, such as texts. Spoken language or discourse is embedded in a communicational context framed by two or more people involved in a conversation. One crucial difference between written texts and spoken language is that texts are well thought-out in terms of grammatical structures, use of language, and order of events. Spoken language, on the other hand, is characterized by sentences uttered while thinking. Sudden stops, start-overs, and grammatical inconsistencies or errors frequently occur in spoken language. Not only is spoken language grammatically and linguistically "less perfect" than written texts, but also more complex and pragmatically challenging when used in communication. There are straightforward conversations where person B answers person A's question in a straightforward manner, shown in the example below:

Person A: Are you hungry?

Person B: No, I'm not hungry anymore. I had a lot of cookies at grandma's place.

Person B's answer of what is asked is synonymous to what is meant. Other utterances in conversations are not always articulated in a straightforward manner and what is said can significantly differ from what is meant. Despite this difference of what we utter and what message we actually intend to convey, we still manage to successfully communicate with others. Grice's conversational implicature describes how much information a speaker has to provide in order to generate an implicit meaning so that the hearer is able to process meaningfully. The following example illustrates the discrepancy of what is said and what is meant and why we're still able to imply meaningful information.

Person A: Are you hungry?

Person B: I was at grandma's.

Person B's response to person A's question provides enough information for person A to imply that B is not hungry anymore. Person B provides just enough information for A to draw the conclusion that one always gets food at grandma's, therefore person B is not hungry anymore. Grice describes the concept of conversational implicature: "An inference about speaker's intention that arises from a recipient's use of both semantic (i.e. logical) meanings and conversational principles" (Schiffrin 193). He introduced four maxims underlying the conversational implicature, namely, the maxims of quality, quantity, relation, and manner. The main idea on which the cooperative principle is based is as follows.

> Communication means cooperative action. [...] The goal of communication is the exchange of ideas [which does not necessarily mean agreement or understanding]. This is a basic prerequisite, an inevitable postulate; communication cannot take place if those involved do not share a minimal common interest. (Linke 196)

The cooperative principles can be largely defined as a set of norms that are upheld and respected in a conversation. In a conversation-like interview, the interviewer can assume that the interviewee does not just randomly utter a series of unrelated sentences, but tries to convey meaningful information. Cruise states,

> A prototypical conversation has something in the nature of a general purpose or direction, and the contributions of the participants are intelligibly related both to one another and to the overall aim of the

conversation. By participating in a conversation a speaker implicitly signals that he or she agrees to cooperate in the joint activity. (367)

The cooperative principle assumes that speakers share as much information as necessary and hearers are willing to process this information and infer implicit meaning from what is said. "A crucial feature of implicatures is that they must be capable of being calculated by a hearer" (Schiffrin 195). Grice explains five factors needed for a hearer to process conversational implicatures, they are:

1) The conversational meanings of the words used, together with the identity of any references that may be involved.
2) The cooperative principle and its maxims.
3) The context, linguistic or otherwise, of the utterance.
4) Other items of background knowledge.
5) The fact (or supposed fact) that all relevant items fall under the previous headings are available to both participants, and both participants know or assume this to be the case. (50)

Schiffrin summarizes that "implicatures rest primarily on a principle of communication—the cooperative principle—rather than principles of language per se: implicatures allow us to account for how people convey messages not provided through the stable semantic meaning of their words" (196-97).

3.3 Accommodation Theory

Another theory, accommodation theory, has to be introduced in order to complement the theoretical background of this study. When involved in a discourse,

speakers frequently shape their way of phrasing utterances according to the person they talk to. Social status, relationship/power, and knowledge of stereotypes guide a speaker's language in a particular conversation (Kramarae 97). Accommodation theory describes these changes of attitude which influences a speaker's way of articulation and interpretation in a conversation.

> One important aspect of accommodation theory (Giles and Powesland 1975; Giles and Smith 1979) suggests a speaker will, when she or he wants to impress or please someone, use knowledge of the beliefs and values of the addressee and alter, for example, style, accent, pitch or rate to make the speech behavior more acceptable to the person addressed. (Kramarae 97)

The aspect of pleasing someone does not play a dominant role in the analysis of the data for this research, partially because the topic itself was delicate. Both interviewer and interviewee were speaking honestly and respectfully about IPL, making linguistic accommodations to sustain their counterpart. The word "yes" appeared frequently during the interview. In this particular context, encouraging words such as "yes" did not function as an answer to a question, but as a sign of agreement with the function of conveying, "I'm interested in what you are saying, go on." Apart from words like "yes," approving sounds like "mhm" or extra linguistic features such as nodding or affirmative facial expressions were used to accommodate the speaker (an example will be provided later in this chapter). As the interviewer, I never contradicted or questioned the personal beliefs of the participants, but genuinely approved of whatever my participants shared with me. Accommodating each other linguistically is especially prevalent in discourse between

women, as noted by Kramarae: "Women are 'supposed' to be more careful and caring in their speech" (98). This was certainly true in this research, since the topic demanded a careful and caring approach. This gentle approach was not only used by the interviewer, but also by the participants of the study. In chapter four, I will provide and explain examples of linguistic accommodation.

3.4 Sociolinguistic Interviews

The data collection, transcription, and translation process lasted nearly a year. In order to collect data, I conducted sociolinguistic interviews. The way a sociolinguistic interview is conducted, that is, not strictly based upon the question-answer principle (as in research interviews for instance), generates a more conversational atmosphere as opposed to an interrogation. Schiffrin distinguishes three kinds of interrogative procedures in a sociolinguistic interview: information-seeking questions, information-checking questions, and clarification-questions.

3.4.1 Information-Seeking Questions

As the name already suggests, information-seeking questions are questions that ask for new information. Most of my questions were of this kind (see appendix A). Coates explores the mechanisms of information-seeking questions in women-talk. She argues that "questions often occur as a prelude to stories" and adds that "sometimes a speaker [interviewer in my case] will ask another speaker [a participant] a question in a way which functions as an invitation to tell what has been happening to her" (182). By investigating the particulars of my interviews, I have found that this sort of questioning

functions like a trigger for further stories to emerge. The answer to my question "Did you have any kind of health problems?" can be answered by either "yes" or "no." None of the women, however, just responded in such a manner. Most women understood the question to be an invitation to narrate more profusely what happened, as example one from an interview with one of my participants (W 4) illustrates:

Example 1:

I: Yes. Mhm. Did any kind of health problem occur during the pregnancy or-

W 4: =I mean until- until two weeks before- I did not really have problems, I mean, for the first seven weeks, I was sick all the time and then- They gave me drugs until after the twelfth week and then it was okay I had problems with throwing-up, but other than that I did not have any problems until right two weeks before the contractions started…I mean before it died- .. then I just really had contractions, I had premature ones… […]

The previous excerpt (example one) constitutes the beginning of a detailed monologue during which the interviewee restates the death of one of her twins in utero after twenty-six weeks of gestation. In accordance with Coates' observation that the information-seeking question can serve as a trigger for stories to be told, I illustrate in the following example (example two) from an interview with a woman (W 5) who has lost her first two children, that my participant does not answer my question in a straightforward manner. Instead, she uses this question as a starting point to retell her difficulties in trying to get pregnant.

Example 2:

I: =Yes. Both of your pregnancies were planned, as you stated. Were there any kinds of health problems? Did you want to become pregnant earlier or=

W 5: =Yes, we married relatively early, when I was twenty-four, because we thought we wanted to have a family … and then it did not work out, it did not happen. And then after four years, I thought, now I want to go and see a doctor and he said, "Hospital, right away." He would have a look and he made an arthroscopy and then we saw how everything was fused. And he said he could not do anything, I had to see Professor Smith* in B*. And then I had the first surgery by Professor Smith= […]

Example two illustrates that she (W 5) does not answer the interlocutor's question but uses it to elucidate her ordeal of finally conceiving and carrying to term a child. The last excerpt (example two) taken from the interview with one of the participants (W 5) is only the beginning of an elaborate monologue.

3.4.2 Information-Checking Questions

One purpose of information-checking questions is to double-check whether information which had just been uttered was correctly received. For instance, if an interviewer adds the adverb "really?" to the proposition in question, this question tag designates the reception of information, which the speaker has just provided, rather than the expression of doubt. Schiffrin makes an interesting observation about information-

checking questions by arguing that they do not necessarily interrupt a speaker's speech flow, but are markers of reception and acknowledgement of what the speaker has just stated (183). Information-checking questions and question tags also signal that the speaker comes to an end and the hearer is invited to respond. In Swiss German we have tag questions such as *gell?* (right?) or *oder?* (or?) but also questions, such as *wie findest du das?* (what do you think about it?) (Linke et al. 268).

Unlike English, in German and Swiss-German the word order (subject-verb) is not altered with reversed polarity (You should help your mother, shouldn't you?). In my interviews, I have not come across information-checking questions as Schiffrin defines them. In colloquial language, information-checking questions are frequent, whereas distinguished use of language avoids tags. The only reason I can think of why I could not find information-checking questions was that the conversation was about a serious topic as opposed to talking about a trivial topic or gossiping. More often, semantically non-related elements ("mhm" and "yes") were used by the hearer to indicate the reception of what was communicated; the intonation of the word "yes" for instance is sometimes also slightly raised. The following example (example three) taken from the interview with one of the subjects (W 6) illustrates the interviewer's use of "yes" in order to signal agreement and a certain level of encouragement as explained in the accommodation theory. The conversational flow is not disturbed.

Example 3 a:

W 6: [...] The child died during pregnancy, and that's still something different as if a

child is born and you take care of it and you raise it and sometime later it dies .. that is probably again very different.

I: =*Yes? Yes.*

W 6: =I did not have such a close contact as I have now. This is probably- I think- very special but it is also- you really had to digest that and get over it … […]

Or later in the same interview: interviewer and interviewee use the "yes" as an element of connection embedded in their conversation. Again, the conversational flow is not interrupted.

Example 3 b:

W 6: Whenever I read a report or a book about parents who lost one- … the situation they describe is really different for me …

I: *Yes.*

W 6: =*Yes.* Because I- there- had a second one and I- it took my mind off my worries=

I: *Yes.*

W 6: = *Yes.* And for those, who really lose a child in the middle of their pregnancy or even towards the end or during childbirth, that must be something completely different and this is probably even more difficult to deal with. […]

The above examples (3 a and 3 b) do not simply contain a marker ("yes") indicating, as Coates states, that "speakers signal their acceptance of others' contribution by their use of minimal responses" but rather, constitutes a repetitive pattern (212). She further states: "Repetition of a single word ties the speakers' utterances together and signals that what

each of them says is the jointly achieved viewpoint" (221). As I tried to illustrate in example three, the repetition of the word "yes" used by the two parties (interviewer and interviewee) establishes a certain common ground or comfort zone that allows both interviewee and interviewer to safely explore this emotional topic.

3.4.3 Clarification Questions

The third type of question in a sociolinguistic interview as defined by Schiffrin are clarification questions. They seek explanations of what is said by the other party so that a misunderstanding or misinterpretation can be avoided. Clarification questions allow a hearer to ask back if certain items in the question have not been understood. Clarification questions did not occur very often during the collection of the data for this thesis. In one interview a participant (W 6) required two clarification questions because, acoustically, she did not understand what I had asked her. When "R [participant] seeks clarification of S's [interviewer] questions, the floor is nevertheless returned to R after S's clarification, so that R can provide an answer" (Schiffrin 174). This assertion can be observed in the following example. "When S seeks clarification of R's answer, then R's clarification continues the answer initiated earlier" (Schiffrin 174), as the excerpt below exemplifies.

Example 4:

I: Do you still remember what went through your head? You have two children and all of a sudden you have to grapple with death.

W 6: *I don't know exactly what you mean.*

I: I mean you get the diagnosis one child is not able to survive. First you come to realize that you are expecting two children, then you get the diagnosis, one child won't survive and won't be in you pretty soon. I am talking about this phase to realize what might possibly happen.

W 6: Yes, that was at nine o'clock in the morning until one o'clock in the afternoon. This was not even a day! That all happened so fast. [...]

Example four illustrates that the participant (W 6) did not understand what kind of information I was seeking. She needed clarification in order to respond, which is expressed by stating in a straightforward manner, "I don't know what you mean." Then I rephrased my question and provided more information that was received by the interviewee (W 6), who could then respond to my question. In another interview, I sought clarification by rephrasing what the participant (W 5) had just said, as illustrated below:

Example 5:

W 5: [...] I mean, "why, why always me?" I mean, this feeling was so strong.
I mean, this feeling was so strong, always me! Me! Always.
There have already been incidents, for instance surgeries or something like that ... just .. yes .. as I would have to be punished, that was my impression.

I: Yes=

W 5: =Hmh=

I: How did your personal [environment react?]

W 5: [yes, they also said] oh no, not you again!

I: *Aha, you mean like a confirmation?*

W 5: =*Yes*, this was very- this was the good thing=

When I asked for clarification questions, they were intended to check whether I had understood what the woman tried to describe.

3.5 Data Collection

In order to provide sufficient research material to make this study a valid and relevant object of research, I have conducted sociolinguistic interviews with ten women. Through these interviews, I managed to gather enough data for an academic analysis of discursive specificities and patterns. I meticulously prepared and organized questions for the interview in advance and gave all the participants my question sheet as well as the consent form (see appendix A and D) before conducting the interview (this was also to ensure transparency). I also informed them that I might ask additional questions (related to prior information) depending upon the course our conversation would take. Although I asked all my participants the same questions, I allowed for elaborations on aspects of great importance for an individual participant. In doing so, the interview kept a conversational flow, which allowed the women to freely steer the conversation where they wanted, and to reveal the uniqueness of their stories. I could get access to valuable and personal information. Their stories provided the rich data needed for this research. From a subjective point of view, this approach seemed very natural, and both interviewee and interviewer felt comfortable with this situation as opposed to an interrogation which

restricts the natural flow of narration and therefore hampers the amount of significant information.

As Schiffrin points out, persons who conduct sociolinguistic interviews "use their knowledge to guide the way they themselves speak and the way R [interviewee] speaks. [...] It is believed that casual speech can be increased by 'allowing' people to introduce what may seem 'tangential' to the topic proposed by S [(interviewer]" (162). Such "tangential" information, for instance, included explanatory comments on the role of the father or stories of their children.

My personal biography played an important role in the process of collecting the data. I experienced pregnancy loss myself—I lost a child very early during my first pregnancy and a second one after twenty-one weeks of gestation. This experience made it possible for me to fully understand the range and the significance of IPL. While introducing myself to my participants and explaining the purpose and procedures of this research, I divulged my personal connection to this topic. Knowing about my personal experience along with my acquaintance of medical procedures associated with prenatal loss, these women considered me as part of the conversation, rather than an interviewer. Knowledge of our common experience provided a natural and safe access to valuable and profound information. I was overwhelmed and thankful for their openness, which enriches this research with meaningful and personal contributions. Lemke explains that "Data is only analyzable to the extent that we have made it a part of our meaning-world, and to that extent it is therefore always also data about us" (Lemke par 2).

According to Lemke, researchers tend to "clean up" when they transcribe spoken data because features such as false starts or repetition of fillers are considered to be

irrelevant and "very often some of them turn out not to be irrelevant at all" (par 6). However, for this study, I did not clean up my data because it is precisely in and through these fillers that something significant happened. I transcribed my data into German and translated it into English (see appendix C). In addition to keeping the meaning at the lexical and semantic level, I also paid attention to the length of pauses, repetition, sudden stops, fluency, as well as intonation. Sometimes, I took notes about the situation, such as slight interruptions when a third person entered—for instance a child.

All the women I had interviewed expressed at some point in the interview that they had severe feelings of guilt for the death of their child. Many of them blamed themselves and voiced claims that they could have prevented the death of their unborn child. This sense of responsibility really struck me, and I developed my observations into an additional chapter (chapter five), which deals with the expression of guilt and self-blame.

3.6 Participants

The ten sociolinguistic interviews I conducted were with women who had experienced one or more reproductive losses between week eight and week thirty-one of their pregnancy. Table 2 provides detailed biographical information about the participants of this study. All the participants were born in Switzerland and still live in the central region of Switzerland, mainly in the cantons of Zug, Schwyz, and Uri. The majority of the participants (six out of ten) were solicited by a friend of mine who works as a kinesiology therapist (*Kinesiologin*).[1] The following table provides bibliographical information about the participants.

Table 2. Biographical Information About the Participants

	W1	W2	W3	W4	W5	W6	W7	W8	W9	W10
Age at the time of the interview	39	38	41	38	45	36	32	36	68	29
Number of children	2	3	4	2	3	1	3	2	5	0
Number of unsuccessful pregnancies	3	2	1	1	2	1	8	1	7	2
Week of pregnancy	14 10 8	16 9	11	26	16 13	8	12- 16 31	12	6- 12 38	11 22
Age at loss	34 38 38	26 27	29	30	28 29	32	21- 31	27	23- 38	26 27
Planned pregnancy?	Yes	Yes	Yes	Yes	Yes	Yes AI[1]	Yes	Yes	Yes	No
Birth[2]	IN AS	CU SA	SA	CA	SA	SU	SA D CU	SA	SA D SU	IN
Unsuccessful pregnancies in family? (sister, mother, mother-in-law, grandmother)	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	No

Note: To indicate the participants "W" is used for women.
[1]Artificial insemination (AI)
[2] Curettage (CU), Spontaneous Abortion (SA), Induction (IN), Surgery (SU) Aspirate (AS), Caesarian (CA), Delivery (D)[2]

Only later did I contact them in person to introduce my study and to set up a time for the interview. I saw six of my participants for the first time when I conducted the interviews and I did not know how often and to whom they had spoken about their experiences prior to the interview. Four of my participants (W 7, W 8, W 9, and W 10) were women I knew personally. One woman experienced an ectopic pregnancy, eight women went through one or more miscarriages, four women suffered a stillbirth, and two women lost their premature children shortly after giving birth. Section 2.4 discusses ectopic pregnancy and

stillbirth. Two of the participants were expecting twins but lost one of the twins through IPL. One of them (W 6) experienced an ectopic pregnancy by which one of the twins settled in the fallopian tube, whereas the other embryo was nested in the uterus. The second woman (W 4), experienced the death of one twin in utero at seven months of gestation. All the participants (except W 10) had one or more children at the time when the interview was conducted. One woman (W 1) was visibly pregnant at the time of the interview. Seven out of the ten women lost their first two children (W 2, W 5, W 6, W 7, W 8, W 9, and W 10).

3.7 Setting

Setting was a vital element in the collection of the data. Since the women were talking about very personal and emotional experiences, interviews had to be conducted in a safe environment in which a possible emotional outburst would be private and confidential. Public places, such as cafés or restaurants were out of the question because discussions of IPLs are still somewhat taboo and therefore not addressed openly. To ensure that my participants felt at ease to talk about their pregnancy losses, I was open to conduct the interviews wherever the participants felt most comfortable, and allow them to select the place for our conversation. All except one of my participants invited me to their homes. One participant (W 7), whom I knew personally, suggested my home as the place for the interview. The interviews were held between 9:30 AM and 5:00 PM, the time when children and husbands were at school or at work, respectively. In three cases (W 1, W 4, and W 6), one preschooler was at home.

3.8 Procedures and Concepts

Before the interview was started, I explained the purpose of the study and clarified the procedures of the interview. I encouraged the participants to ask questions whenever they needed clarification or sought explanations. I also reminded them of their right not to answer a question, or to withdraw from the interview. I offered the participants to have the question sheet in front of them to look at during the interview which half of them did. The other half preferred not to have a paper to look at but rather desired to be part of an ordinary conversation.

None of the women mentioned any concerns about telling their stories. The participants started to tell me right away about their experiences and all of them were very open. In the excerpts of the interviews used for this thesis, different names are given and marked with an asterisk in order to guarantee anonymity. I did the same with names of places.

The average time for an interview was approximately one hour.[3] Since most of the questions were open-ended, the participants' answers influenced the time of the interviews. Except for the first interview, I used a dictaphone to record the conversation in order to ensure the accuracy of the data.[4] Wood and Kroger state that

> The report [of a conversational discourse] will be inadequate even if the reporter attempts to include verbatim speech rather than a summary, because speech occurs far too rapidly to be taken down completely and without misquotation. [...] Only a recording can allow the multiple listening that are required for analysis. (56)

Almost all the woman started talking even before I could set up the recording with the result that the very beginning (personal questions and information they gave about their unsuccessful pregnancy) could not be recorded. Interestingly, more than half of the participants told me that their case was somewhat different and that they would not know whether I could use their example at all. Very rarely did a woman interrupt me when I was talking.[5] Lastly, I had the impression that those conversations were very special moments for these women. Many of my participants did not talk about their experience other than to close friends or family members. For those women, I was the first outsider with whom they had shared their stories. I realized that some of my participants have probably never talked about their experiences in such a detailed manner. It was not only an interview for them, but also an opportunity to talk to another woman who also experienced IPL. I was invited by most of my participants to stay longer than the interview and they still talked about IPLs.

3.9 Questions

Most of the questions I posed were open-ended. The women would provide as much information about their personal experiences and lives as they wanted to reveal in a conversational manner. I divided my questions into three parts. In the first part, I wanted to gather information about the time before the IPL occurred. In the second part, the questions focused on the actual moment of the IPL and the possible indications preceding it. The third part concentrates on the time after the IPL. It often happened that a woman already answered a question, or parts of a question, that I was supposed to ask later in the interview. Some women would narrate their experiences in a rather chronologically

disorganized way. This is a common phenomenon when talking about traumatic or distressing experiences. Nonetheless, in each interview, I always posed all of my questions. The questions of my interview are listed in appendix A.

3.10 Definition of Terms

Most of the time I use the term "child" to refer to the unborn, even though, biologically and medically, the correct term would be "embryo" or "fetus" depending upon the stage of gestation.[6] All of the women who shared their experiences with me (including the woman with the unplanned pregnancy), looked forward to having a baby, and established a relationship with the child. Since this study does not claim to be a medical report, I feel free to use the term "child" instead of "fetus" and "embryo." While conducting the interviews, I used the term "birth" when referring to the delivery of the dead child regardless of the correct medical terminology for removing the "child" from the uterus, simply because they are not used in conversational language. Both terms, "child" and "birth," are also used by the participants of this study when referring to their unborn and their form of delivery, respectively.

3.11 Summary

This chapter explicates in detail the hypothesis of this thesis and specifies the linguistic devices used to analyze the data. It explains the three basic theoretical frameworks used for this research, namely, Grice's conversational implicature and the cooperative principle, and Giles' accommodation theory. Those theories are used to explain and understand the rather disorganized and chronologically disordered narratives.

Information about the participants, the questions, and the setting elucidates the process of gathering the data. A particular emphasis is placed on the function and role of sociolinguistic interviews which provided the tool to collect the data for this thesis. Within this subchapter, the function of the interviewer as a crucial part of the sociolinguistic interview was discussed and its importance illustrated.

NOTES

[1]Unlike in English, in German and Swiss German the word "Kinesiology" describes an alternative form of therapy. The goal is to establish and/or restore the balance of mental and physical well-being through activation of a person's energy.

[2] Definition of terms: After an IPL (but also sometimes after a regular delivery), women have to undergo a special type of surgery in which possible rests of tissue are scraped out. This medical procedure is especially necessary when a fetus or embryo dies in utero without bleeding, either through a missed abortion (none of the products of conception is naturally removed) or an incomplete abortion (where remains of conception are only partially expelled). A spontaneous abortion is when a fetus or embryo is expelled, mostly through and/or accompanied by heavy bleeding and spotting. This is a common form of IPL and frequently performed before week sixteen. If a pregnancy has already progressed and a child has died in utero, labor has to be induced, as it is for regular birth without signs of contractions. Women who suffer an incomplete abortion or a missed abortion at an early stage of gestation can sometimes ask for an induction as well. This conscious form of loss helps some women to grieve their pregnancy loss in contrast to curettage where the fetus is removed under anesthesia. Another, less common form is aspiration;

this is another surgical method of removing the fetus/embryo of other remains of conception at an early state of gestation. In case of a stillbirth or an IPL later than week twenty, women have to deliver the death child. A Caesarian is not possible. Since one of my participants was pregnant with twins, she had to have a Caesarian in order to deliver one child who was dead and one who was alive.

[3] Forty-five minutes was the minimal and ninety minutes the maximal limit of the interviews.

[4] For organizational reasons, I had to use a common tape recorder for the first interview.

[5] I would say that is maybe a cultural habit. Swiss people wait and do not talk or interrupt the other person while the person opposite is speaking in such a setting.

[6] The term embryo is used for the first three months of gestation; later, it is referred to as fetus.

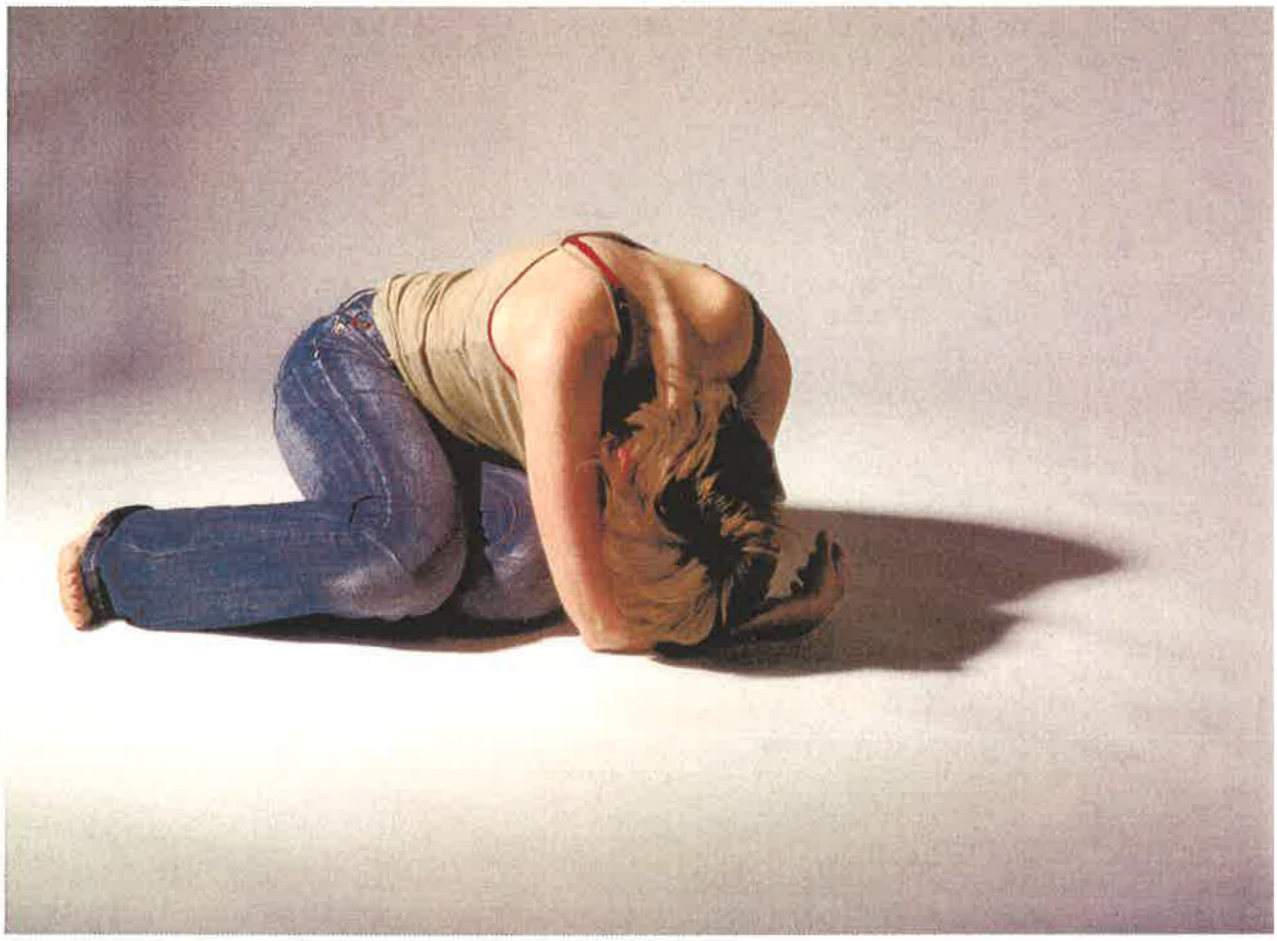

Fig. 5. Photographical Exploration of Reproductive Loss: Despair. Subject (W 9):"My husband was away .. when all this happened .. and I was all by myself when I lost it. I was all alo::ne with the whole situation." (Zug, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

CHAPTER IV

DATA ANALYSIS AND DISCUSSION

While the focus in the previous chapter was on methods and linguistic devices used to gather and analyze data, this chapter is concerned with the analysis and discussion of the data. From the extensive data I have gathered in Switzerland, I have selected examples in order to support my hypothesis, that is, tabooed subjects have an impact on conversational implicatures and the cooperative principle. By drawing examples from my data, this chapter focuses on and clarifies the issue of personal questions. It also seeks to expound Grice's evaluation of the cooperative principle and describes the mechanisms of communication that come into play when highly intimate and personal issues are broached and disclosed.

4. 1 Definition of Personal Question

For a better understanding of my data, it is necessary to first have a closer look at the schedule of interview questions used for this research. Eighteen questions grouped in three parts (before, during, and after IPL) form the rough guideline for the interviews. The interlocutor posed all questions but showed flexibility in terms of their chronological sequence, since some of the participants would answer certain questions in advance. Additional questions were asked to expand on a particular topic introduced by the participants. One can argue that all of the questions used for this research are personal

questions, since they ask for intimate details about a very personal experience that the interviewee has rarely shared other than with close friends and family. However, there are different levels of personal questions which I would like to distinguish. Some of the personal questions trigger emotional responses for example questions which ask for a description of the moment in which an expecting woman realized that her child had died. Others induce women to share private information yet do not stir up emotions. All of the questions in the first part (1–5) were asking about the time before IPL, which were mainly seeking background information, such as:

1. Who knew about the pregnancy?
2. Was it a planned pregnancy?
3. Did you have health problems during your pregnancy, and if yes, what kind of problems were they?
4. Did you know about the frequency of reproductive loss?
5. Did this influence you?

(see appendix A)

Even if one can claim that question two is as personal as question three, I argue that the latter explores more personal information and does not ask to reveal a story.

Another reason to support my argument of subdividing my questions as more and less personal is that with the exception of question one, all of the subsequent questions in the first part can be simply but sufficiently answered by "yes" or "no." The participants are not prompted to reveal personal stories which could trigger emotional responses. If a

participant wants to provide more information than necessary, and therefore violating the maxim of quantity, she can freely decide what kind of information she wants to share with the interlocutor.

4.2 Analysis of Responses to Question Number Three

In the following ten examples, I look at the participants' responses to question three. Question one ("Who knew about the pregnancy?") as well as question two ("Was it a planned pregnancy?") are likely to be answered in a short manner, i.e., by a list of names like "my husband" or "my family" for question one, and "yes" or "no" for question two. The same is valid for question four ("did you know about the frequency of reproductive loss?") and five ("did this influence you?"). As we will see later in chapter five, IPL is still tangled up with the idea that a woman either did something that caused the death of the unborn or that IPL is a result of a health-related problem. Therefore, question three—even though the question can be answered by "yes" or "no"—could possibly trigger other responses. Question number three ("Did you have any health problems?") asks for the most intimate information of all the questions in part one, but since it is still a yes-no question, I am inclined to argue that women are not expected to share more information than "yes" or "no." However, as shown in the following ten examples, taken from the interviews with each of the ten participants, it becomes clear that some participants reveal more information than necessary.

Example 1:

I: *Did you have any health problems*?

W 1: No. *I did not have any problems*. No.

Example 2:

I: Did you have any health problems?

W 2: hmh [neg] nothing, hmh [neg].

The two subjects (W 1 and W 2) in example one and two above answer the question in a straightforward manner without providing further information. In the first example of this short spoken discourse, the subject (W 1) uses the same verbal structure and vocabulary, guaranteeing discursive coherence. Both participants (W 1 and W 2) follow the cooperative principle by providing the required information which is without violating one of the maxims. In the following two examples (example three and four), both subjects (W 8 and W 9) provide more information than necessary and, in so doing, violate the maxim of quantity. One participant (W 8), who is a friend of the interviewer, also answers the question with "no," which would be an adequate answer, but adds further information about her well-being before and during her two pregnancies as shown in the following example:

Example 3:

I: Did you have any health problems?

W 8: *No*. I'm very healthy. Also later in my pregnancies I never had any problems. [The subject lost a child during her first pregnancy. The next two pregnancies

were successful and she gave birth to two healthy children, four and six years later, respectively]. It [the child] just did not want to stay…

In the example above, the subject (W 8) uses the third person singular pronoun "it" but grammatically there is not an antecedent in her utterances to which this deictic expression could refer. The interlocutor has to process this piece of information and interpret the pronoun "it" as a reference to the child that died in utero. As uttered by the participant (W 8), the deictic expression has to refer to "something" that has a free will and "did not want to stay." The interlocutor's previous knowledge of the subject's spiritual/religious approaches constituted the frame in order to put the personal pronoun "it" in the context appropriate to understand the sentence. In example four, the participant (W 9) provides only slightly more information than necessary. In contrast to example three, her (W 9) utterances are accessible. Example four illustrates how the participant (W 9) emotionally suffered during her pregnancies. Forty years ago, she lost four children before she could bring a pregnancy to term. She lost three more between her first and her second child. At that time, family situations were different and women—especially farmer's wives like the subject (W 9)—were expected to have many children. Getting married and not getting pregnant right away (as women generally did) put a lot of pressure on a woman or, as the subject (W 9) states, "That was hard."

Example 4:

I: Did you have health problems before your pregnancy?

W 9: *No. Not that I know*... but I started to doubt whether I had. *Everyone around me was getting pregnant only I lost one after another*... *That was hard*...

In the two preceding examples, both participants (W 8 and W 9) deny having health problems prior to their IPLs. At the same time, both participants provide more information than the interlocutor had asked for and therefore violated the maxim of quantity. The next two examples (example five and six) illustrate the same discursive pattern. They only differ in terms of the information content, which in the next two examples are lengthier.

Example 5:

I: *Well, we already have talked about this a little bit*. Did you have any health problems during or before your pregnancy?

W 6: *No, hmh* [neg]. Only the stomach ache, which I had, before the twinge yes ... but this could also be normal. Maybe you could have discovered that earlier, if you had looked at it. The womb is stretching and this twinges and that- that it was the Fallopian tube- in addition- the doctor- but you don't think about looking there until it already has happened ...

During the interview, the subject (W 6) had already talked about health-related issues due to her ectopic pregnancy at an earlier stage of the interview. The interlocutor still posed question three as shown in the preceding example in order to ensure that this question is fully answered, but acknowledged that she processed the subject's prior information by

saying, "Well, we already have talked about this a little bit." Even though the participant (W 6) has already provided sufficient information, she did not answer the question in a straightforward manner by "yes" or "no," but violated the maxim of quantity by elaborating on her health issues with regards to her ectopic pregnancy.

Another participant (W 10) answered the question in a similar way, as shown in the following excerpt:

Example 6:

I: Did you have health problems?

W 10: *No*... well, during both pregnancies- *I was sick all the time and had to throw up which I never do. I hate that.* But then it was normal... I really felt sick and tired- but I guess that's normal.

Both subjects (W 6 and W 10) provide information about how they felt; they (W 6 and W 10) present additional information about their well-being during their pregnancies. The following four examples (example seven, eight, nine, and ten) show how a simple question, "Did you have any health problems?", can trigger an elaborate and extensive narration.

Example 7:

I: Mhm. Did you have any health problems prior to your pregnancies?

W 3: Ehm … (3 sec). No, everything was all right ..bu:t.. *I wasn't sure. I wasn't sure whether I wanted a third child.* From the beginning. I still remember that. *Do I really want a third child*?=

I: Okay.

W 3: =*I didn't really want to accept it* [the pregnancy]. Yes, I remember- It was a big gap [between her two first and the third child]=

I: Yes

W 3: =I still know that. Yes.

I: Yes.

W 3: I also thought sometimes-…maybe it has gone away because of that. .. and when I accepted that I was really pregnant.. then it did not go well anymore..=

I: Yes.

W 3: =there were complications.

In example seven, the subject (W 3) not only answers the question as to whether she had health problems or not, but also imparts information about how she felt towards her pregnancy. She provides more information than necessary, which according to Grice is violating the maxim of quantity. Her statement that she was not really sure whether she wanted the child and perhaps that was the cause of the death of her child could be interpreted as latent self-blame. As highlighted in example seven, in this short discourse, the subject (W 3) repeats several times that she was not sure whether she wanted to have

the child: "I wasn't sure. I wasn't sure whether I wanted a third child." Later in the same passage the subject states, "Do I really want a third child?" and again, "I didn't really want to accept it [the subject again refers to the pregnancy and/or child]." Repetitive words or parts of utterances can signal importance or as Tannen states "it [repetition] generally underlines a key phrase or idea which constitutes a kind of evidence of frame" that is certainly true because she links her doubts of wanting a third child or not to the cause of the death, resulting in self-blame and feelings of guilt (42). It took her a while to get used to the thought of being pregnant again and from the moment she accepted her pregnancy, there were complications which eventually terminated her pregnancy with an IPL.

Examples eight, nine, and ten (from interviews with W 4, W 5, and W 7) illustrate that the question, "Did you have any health problems?", which could be answered with one or two words, was not answered with brevity. Instead the following participants would take this question as an invitation to narrate their stories, or part of it, more abundantly (Coates 182). Coates studies the ways in which women communicate with each other and defines them as very special forms of talk. One reason is that women, especially women friends, accommodate each other (similar to accommodation theory discussed in chapter three), and therefore provide a welcoming and inviting atmosphere to share personal stories (and violate the maxim of quantity). Another reason is that talk among woman establishes a sense of "friendship and femininity" (232). Coates clarifies the term "femininity" as follows: "By femininity I mean the abstract quality of being feminine (just as masculinity is the abstract quality associated with being masculine): doing femininity can be paraphrased as 'doing being a woman'" (232). She explains that

women perform different forms of femininity. There is femininity as being a mother who nurses a baby (being a mother is "doing being a woman"), but the same woman performs another feminine role as a manager of her company, for instance (Coates 232-262). Talk between two women (the interviewer and the interviewee) who shared the same experience of prenatal loss (IPL is "doing being a woman") inevitably establishes a femininity and, according to my subjective impression in the role as the interviewer, also friendship. The talk about the experience of IPL, performed by two women who both experienced reproductive loss, constitutes a setting in which the participant can feel secure to relate her personal story. The next example shows a gross violation of the maxim of quantity, but at the same time acts according to Coates findings about woman talk, that is, the participant (W 8) takes the question, "Did you have health problems?", as an invitation to narrate her story.

Example 8:

I: Did you have health problems?

W 4: I *mean until- until two weeks before- I did not really have problems*, I mean, for the first seven weeks, I was sick all the time and then- They gave me drugs [for morning and pregnancy sickness in general] until after the twelfth week and then it was okay. I had problems with throwing up, but other than that I did not have any problems until right before the two weeks when the contractions started…I mean before it died- .. then I just really had contractions, I had premature ones… And then, I had to go to the hospital. Then I had to go to the hospital, first in B* and then, later I could go home for the weekend after the two weeks. And then I

did say, the last night when I was in the hospital- I was- I have had a really bad night and then I said something is not right. Then after Tuesday- after this weekend- the doctor and he then found out that one of them had no cardiac sounds anymore and then they said, 'right away to L'. Then they did not even know what to do with me in L and they first said, "Caesarian right away," because they did not know how the second one would react. Then I said, "No, I don't want that." I was not ready for that, just because twenty-sixth week- the doctors *said "it is really very*"-..yes, they would not know what happened with the other twin .. they just waited for the first three we- days to see what happens. The whole situation- they always took blood- .. and contraction inhibitors and- and- and- after these three days it stayed stable and then they told me we would wait…until, until then to the thirty-second week, where it was not bearable- I mean I could not hold it anymore.. I had contractions which we could not put back anymore. Huhuu .. and then so it started.

The subject (W 4) did not have health problems that could have been diagnosed as the cause terminating the life of one of her twins at twenty-six weeks of gestation. Nevertheless, she explains in a detailed manner what kind of health problems she experienced during her pregnancy, thereby violating the maxim of quantity. Even though the participant's (W 4) recounting contains stops and false starts ("I mean until- until two weeks before", or , -"the doctors said "it is really very"-..yes, they", and "in the hospital- I was- I have had a really bad night"), it is more or less coherent and narrated in a chronological order.

Example nine is taken from a different interview. The participant (W 5) narrated part of her story right at the beginning of the interview. The interview with her was one of the longest in terms of time and density of information she shared with the interviewer. She and her husband eagerly awaited the birth of their first child. Their wish of starting a family was fulfilled after she underwent an ordeal of medical procedures, complicated surgeries, and two distressing IPLs.

Example 9:

I: =Yes. Both of your pregnancies were planned, I think. Were there any kinds of health problems? Or=

W 5: =*Yes* we married relatively early, when I was twenty-four, because we thought we wanted to have a family … and then it did not work out, it did not happen. And then after four years I thought, now I want to go and see a doctor and he said, "Hospital, right away." He would have a look and he made an arthroscopy and then we saw how everything was fused [her womb showed polyps and other medical conditions that made it impossible or very difficult to conceive]. And he said he could not do anything, I had to go to Professor Smith* in B*. And then I have had the first surgery by Professor Smith=

I: Mhm.

W 5: =and then, he was the one who told me, within three months [I had to get pregnant] … otherwise .. everything is fused again=

I: =Mhm, yes=

W 5: =Exactly.

Example nine is interesting because of the ways in which the subject (W 5) narrates her health-related problems. Due to anatomical deformities and internal fusions she had difficulties conceiving. Special surgeries were performed to help her get pregnant. The following questions posed by the interviewer were about what had happened during the three months during which the subject was supposed to get pregnant, otherwise the efforts of the surgery would have deteriorated and the fusion would have recurred. Her answer to this follow-up question ("Yes. Both of your pregnancies were planned, I think. Were there any kind of health problems? Or-") was extensive and detail-oriented, describing all the difficulties before and during her first two pregnancies. In example ten, another subject (W 7), who lost eight children through IPLs, speaks of one particular pregnancy where she had light chemotherapy shortly before conceiving a child, which eventually died in a stillbirth after twenty weeks of gestation. This participant (W 7) also provides far more information than necessary:

Example 10:

I: Did you have any health problems?

W 7: *Yes.* The one in week twenty- prior to that, *I've had mild chemo* but they said everything was all right, *Yes.*

I: Mhm.

W 7: I think that had a certain influence=

I: Mhm.

W 7: =it was as I said relatively early. For a long time they told me I cannot have children. I could not have children. Percentage-wise it was very low. And then we thought if so we stop using contraception because we would have loved to have a child and then we thought we'll see maybe it takes a long time [to get pregnant]. And then ..well- it did go fast- we thought now it wouldn't happen right now.

I: Mhm. Mhm.

W 7: And I didn't want to take the pill anymore=

I: Mhm.

W 7: =Yes, and it really happened.

I: What kind of health problems were they?

W 7: Well, I don't have one fallopian tube anymore since I'm twenty=

I: Mhm.

W 7: =actually always something related to the womb area=

I: Mhm, Yes.

W 7: =and considering that, the chances are smaller.

I: There are actually many women I know who were told that their [chances are]-

W 7: [Yes, right.]

I: [/?/]

W 7: [/?/] Well, I'm glad that I took the pill before (laughing).

Looking at the various answers to question three, it becomes evident that an inviting atmosphere and safe environment made it possible for the interviewees to share much more information than the interviewer sought. As I mentioned earlier in this section, Coates writes about woman talk saying that "The two most important things being accomplished in the talk of woman friends are friendship and femininity" (232). The mutual experience of IPL as an exclusive feminine occurrence, as well as the interlocutor's openness about her experience, resulted in trust on the part of the interviewee. This trust and confidence build the 'safe ground' to share an extensive amount of personal information.

The flow of the narration was relatively smooth and comprehensive. Question three (and therefore all questions of part one, since this is the most personal question of the first part) mainly seeks background information. The participants were free to answer this question in a straightforward manner, as illustrated in example one and two, or expand and elaborate on it, shown in the example seven, eight, nine, and ten. Nevertheless, the information was useful and provided a substantial context adding to the interlocutor's frame of IPL. Even though some of the maxims have been violated, the cooperative principle was certainly respected. By contributing more information than necessary, the participants' intention was to provide as much information as they could.

4.3 Discourse Analysis of an Emotional Experience Based on The Answers of the Questions 6-18

In the following section, I use the responses to the questions from parts two (questions 6-9) and three (questions 12-18) to support my hypothetical claims that the cooperative principle and the conversational implicature come into play in the narration of a personal and emotional experience. The questions listed in part two and part three are the following:

6. How did the child's death become apparent?
7. What happened between the diagnosis and the actual birth?
8. How did you experience the birth?
9. Do you still remember your thoughts and feelings of those moments?
10. Did you try to come up with an explanation?
11. How important was it to have a reason for the sudden death of the child?
12. Did you have feelings of guilt?
13. What was the reaction from your friends and family?
14. To whom did you talk about it?
15. Did you talk to women who lived through the same experience?
16. What value does this occurrence have for you, today?
17. Did the notion of death or life change?
18. Do you want to add something, which is or was important in your eyes that I did not ask?

The crucial difference between questions in part one and part two is that questions 1-5 ask basic information without demanding further elaborations whereas questions 6–9

directly request an explanation of actual events. Question 6 identifies a precise point in time, asking for the moment of death. Also, part three (questions 10-18 asking for information after IPL) contains questions that inquire into personal issues closely related to the actual event of their IPL, which are bound to emotional memories.

In the following section, examples of answers to the questions in part two and three will be presented to support the hypothetical claim that the more personal the questions are, the more essential information is left out by the interviewee. Consequently, the more non-coherent and non-cohesive the narration gets, the more the speaker/interviewee relies on mutual knowledge and the more the hearer/interviewer must draw from background knowledge, including frames, script, and schema. The following example from the interview with participants (W 7) illustrates that a hearer not acquainted with IPL would need additional information to follow the conversation. The shared knowledge of IPL and the procedures accompanying reproductive loss significantly contributes to the understanding of the subject's (W 7) narration. The interlocutor asked how the death of the child became apparent. Since the subject lost eight children, she recounted all of the losses. In example eleven, she tells of the death of her daughter Leila who died after thirty-one weeks of gestation.

Example 11:

W 7: *With Leila- ... though- no that's not true.* Not with Leila. It was like that: I had with Sara* and Linda* who I have- I had premature labor with all of them, I had to go to the hospital and lie down, and so I knew how it was and I had with Lucas* the third and then on a weekend I had the feeling, 'Gosh, something is not

good,' but I didn't have contractions then, but- Steve* was like 'what hospital? Why do you want to go to the hospital? You don't have contractions.' I said yes. I have to go. And then with Leila, I went down, it was on a Sunday, so really baffled- without contractions I went down and told them 'I feel something is not right'=

By reading this short paragraph (example eleven), which does not seem to be coherent at all, as it only provides bits and pieces of information, it is clear to a reader that one has to rearrange information and insert information that has not been stated, in order to obtain meaning. The subject's utterance begins with a "false start" and omission of information. She does not finish her first sentence ("With Leila- … though- no that's not true. Not with Leila"), then stops before providing more information. She corrects herself ("no that's not true. Not with Leila"), and starts again ("It was like that: I had with Sara* and Linda* who I have […]"). In her first two utterances, she omits information that would be necessary to follow her train of thought. After her false start and sudden stop, the participant changes the subject and talks about her two living daughters (Linda and Sara) instead of Leila who died. In the following description of the events, the participant also omits information but still makes her narration accessible for the interlocutor. The cooperative principle, to which participants in a conversation agree and which they take for granted, creates the necessary space for interpretive moves to happen. Grice calls these moves conversational implicatures. This means that the hearer is able to derive information from what is conveyed by going, if necessary, beyond the literal meaning of the words of a given utterance.

In his analysis of discursive modalities, Grice makes use of four conversational maxims, which, when respected, make it possible for the speaker to deliver intelligible statements even in a fragmented narration, as shown in the latter example. The observance of conversational maxims allows for the successful transmission of a given message. If a maxim has been violated, for example, and this can happen without the speaker's being aware of it, the interviewer/listener has to resort to interpretive moves (conversational implicatures) to understand the message despite its linguistic flaws in cohesion and coherence, as in the example above. In this case the hearer is requested to use additional interpretive strategies, which are needed to understand the content of subject's (W 7) narration.

The participant and the interviewer have known each other prior to the interview, and the interviewer was partially acquainted with the subject's IPLs—the interlocutor knew about two of them that happened in and after week twenty. A reader who is neither acquainted with the topic of IPL and its procedures nor the subject's (W 7) personal story, is probably not able to get a meaningful picture of what she was explaining. While answering the questions, the subject (W 7) could assume that the interviewer was familiar with the IPL because the subject knew of one of the interlocutor's IPLs; she (W 7) also could rely on the mutual knowledge of her (W 7) close friends and family, such as her (W 7) husband, her (W 7) children, and her (W 7) living situation, but also the hospitals she (W 7) mentioned.

Additional information is necessary to put the events in a chronological sequence which is done automatically by the hearer (in that case the interviewer). To illustrate this: Linda is her firstborn daughter, Sara, her second, and Lucas is the youngest of the three

children, born after Leila died. Both living daughters were born prematurely, that is, between weeks thirty and thirty-two. Her son was the only child who was born in week thirty-nine after she had been operated upon. She provides detailed information about this special type of surgery at a later point during the interview. Steve is the subject's husband. She recounts that, on a Sunday, she suddenly had the feeling that something was not right, even though there were no signs of premature labor, pain, or other physical symptoms. Her husband, who experienced the two premature births of their daughters, could not understand why she wanted to go to the hospital, since his wife had "nothing at all." The subject insisted on going. The excerpt below is a continuation of the previous interview, which demonstrates that the subject (W 7) omits crucial words ("labor", "contractions" or "live") and/or replaces them with deictic expressions ("it" or "then") without providing referents to frame her statements.

Example 12:

I: Mhm

W 7: =and because my doctor knew me well he did some checks and went *'stay here'*, and half an hour later when I was there, I had contractions=

I: mhm.

W 7: =well, *I had it* [contractions] *then*. But then I laid for about three weeks and then-

I: [Yes]

W 7: [Strict]

And it was also the best pregnancy until then. *And then everything* [the premature labor stopped] *was calm* and they told me I could go home. This was again on a

weekend and they said I could go home on Monday. And strangely, *during the night when I knew I could go home it* [premature labor] *started again.*

I: Mhm

W 7: Despite /?/ *they could not stop it* [labor] and we had to go to L. We went to L like we did with the others. And then.. *yes she came* [she was born]

I: Yes.

W 7: Yes. We could keep Sara and Linda. And *then* I could go back. That's also a back and forth- I could go back. Normal. But they were born in an ambulance in L but they arrived at an stage of development were they could manage to survive=

I: Mhm.

W 7: =and Leila I always thought that would go well. I saw on the ultrasound during the delivery that *it was a girl* and thought *this will work anyway. And she didn't-* well, she didn't wanted to.

Additional information is again needed to understand example eleven and twelve. The subject uses relative pronouns to refer to nouns such as labor, which do not have a grammatical referent in the utterance. Since the subject (W 7) had multiple IPLs and two premature births before the pregnancy with Leila. Her family doctor was well acquainted with her physical and medical conditions.[1] The subject's physician asked her to stay ("My doctor knew me well he did some checks and went 'stay here'") because he trusted her impression that her pregnancy did not progress well, which proved to be right. She developed premature contractions shortly after she arrived at the hospital (" [...] and half an hour later when I was there, I had contractions="). The subject stayed for about three

weeks. The night before she was supposed to leave the hospital, she was moved to another hospital in L, a more specialized hospital for pregnancy-related problems. "But then I had to lie in bed for about three weeks und then-." Later in the excerpt of the interview she says, "*They could not stop it* and we had to go to L." The interviewer is familiar with both hospitals and therefore could reach the conclusion that the subject's condition must have worsened for her to be transferred to the hospital in L. Both Linda and Sara were born in L and survived. Although until that time the pregnancy proceeded satisfyingly according to the subject (W 7), she did not expect this child to die—especially because the child was a girl ("I saw on the ultrasound during the delivery *that it was a girl and thought this will work anyway*"). It is statistically proven and also widely known that in terms of gender, there are more male children than female children who die during a pregnancy because of their genetic predisposition (Bayer par 3).[2] This information was also assumed to be a mutual one.

Example twelve illustrates that the interlocutor is expected to fill in gaps from different sources, including knowledge about the subject's (W 7) personal background, mutual knowledge about IPLs (since both women, the interlocutor and the interviewee, share a very similar experience) but also knowledge about the world known as "frame" (Brown and Yule 338). According to Brown and Yule, "This general knowledge about the world underpins our interpretation not only of discourse, but of virtually every aspect of our experience" (233). The awareness that there are more cases of miscarriage and stillbirth among male fetuses/embryos than female ones can be interpreted as general knowledge, which the participant (W 7) assumed the interlocutor would share. Brown and Yule further state that this is the "type of predictable information a writer/speaker can

assume his hearer/listener has available whenever a particular situation is described" (236). Minsky conceptualized the notion of mutual knowledge and introduced the term "frame" to represent background knowledge. "When we encounter a new situation (or make a substantial change in one's view of the present problem)," Minsky says, "one selects from memory a structure called frame. This is a remembered framework to be adapted to fit reality by changing details as necessary" (qtd. in Brown und Yule 338). These frames, which constitute the referential field, can be evoked, explicitly or implicitly, in the course of the conversation. Using the last excerpt from the interview to exemplify frames: The description of the hospital in S and L evoked frames of hospitals which made it easier for the interlocutor to understand the subject's (W 7) utterances. In this case the interlocutor was able to refer to frames in order to envision a certain scene and comprehend its impact.

Special type of frames—scripts—can locate a situation in an appropriate context. A script usually encompasses a sequential order of narrative elements or procedures. Lehnert argues that a script is only "one type of frame" (86). Schank and Abelson state that a "script is a structure that describes appropriate sequences of events in a particular context," that is, "a script is a predetermined, stereotyped sequence of actions that defines a well-known situation" (41). Taking the example of an obstetrical clinic of which a participant of the interview can assume that the interlocutor is acquainted with, since they both share the same cultural background.

Example thirteen, using an excerpt from an interview with another subject (W 5), also exemplifies that in order to understand her utterance, the interlocutor is expected to

rely on extra linguistic features based on the assumed mutual knowledge, such as context, scripts, and knowledge of the world.

Example 13:

I: Do you have a ritual, something, some have a special stone or a kind of a ritual or are your children just in your thoughts?

W 5: Also it is just *up inside me* (she taps her head), I mean *it is just in me* … but I could- I could *let it go* and could *send it home,* that's the way I feel it, it's right the way it is, I had never had the feeling, now I would have- I also never say, I would have five by now=

Certain terms used by the subject (W 5) in example thirteen ("inside me," "home," or "let it go") are not used in a literal but figurative or metaphorical manner. At the same time, her gesticulations (tapping of her head) clearly support the meaning of the utterance—that she remembers her two miscarriages and does not need any other memorabilia—and gives it even more emphasis. As the interviewer is acquainted with the cultural concepts implied by the terms "home" and "let go," this particular sequence does not necessitate any further explanation, because they are culturally mediated and hence intelligible. "Send it home" and "Let it go" are forms to express the participant's personal religious and/or spiritual belief. However, the spiritual/religious beliefs are not bound to a particular religion and therefore do not constitute a frame in the sense of clearly defined mutual knowledge but rather a notion. By referring to metaphoric expressions, the subject violates the maxim of quality. In this excerpt, the subject (W 5) pauses abruptly ("But I

could- I could let it go" and "I had never had the feeling, now I would *have-* I also never say, I would have five by now=") and did not finish the sentences, but started new sentences.

Later on in the conversation, the woman, once again, idiosyncratically refers to the cultural context. In the following excerpts, the same subject (W 5) explicates her belief to some extent and expresses understanding and trust in a predetermined but righteous course of events.

W 5: *These* [the two miscarried children] *are souls for me who went away, they just had this amount of time* and that was right like that, right and good.

Towards the end of this interview, the interlocutor posed the question whether the experiences of IPL were still present in their lives.

The next example (example fourteen) from the same subject shows a violation of the maxim of relation.

Example 14:

I: What role does it [having lost the first two children] play in your life?

W 5: For me-, for me it was-, it was really a little bit crazy, *but it was meant to be for what's today,* not everyone does understand that probably, but it *was meant to be for what's today* ... and *I let them go, they are at the right place, they are at home*, that's okay just the way it is ... back then- back then-, back then I was angry and I had the feeling, no that cannot be true:, or?=

The woman obviously does not give relevant information to this question, "What role does it play in your life?" which violates the maxim of relation. The interlocutor can infer that it must have played an important role in her life and that she could learn a lot from it. It is evident that the speaker does not reveal pertinent features of her conversation. She fails to name certain terms (death, baby) or propositions (I was afraid), which, when explicitly stated, would identify the traumatic experience and probably cause it to resurface in the conversation where its affects might be felt again. Once more, the hearer relies on the background information—scripts and frames, in particular—which come into effect whenever these discursive omissions appear.

The examples twelve, thirteen, and fourteen show that at times the speakers leave out important information (violation of the maxim of quantity), at others they make abrupt pauses (violation of the maxim of manner) without properly completing their utterances. Despite their idiosyncratic modes of narration, it is still possible to deduce from the discourse itself what these women are driving at. Why is it that the interviewer can still follow the flow of the conversation, which, from a linguistic point of view, is conceptually and structurally flawed? The interviewer constantly reassembles pertinent bits of information and rearranges them by drawing upon background knowledge, which implicates the speaker and the listener in the same referential field. This process of reiteration is fundamental in conversations, yet has not received due attention in Grice's model of conversational implicatures.

Example fifteen is an excerpt of the interview with another woman (W 6). It shows a violation of the maxim of quantity. The speaker provides much more information

than the question implies (violating the maxim of quantity) and the content of the subject's answer does not answer the question (violating the maxim of relation).

Example 15:

I: Did people know about your pregnancy? I mean did you already mention that?

W 6: *Yes*. But I did not know at that time that there were two. I implanted three eggs [the subject had an artificial insemination], once I had bleeding, that was right at the beginning, second, third week, I was afraid that I would *lose it* [the implanted egg] again and the doctor said, no, *it* [the course of the pregnancy] *was good* and I assume *that then one went away* during the bleeding, and then .. with the second [implanted egg] .. *then it was like this* I had .. in the evening I had a stomach ache, my husband was away, at a hockey game, I had to call him, I had so much pain and I had to throw up .. blood and then we drove to the hospital to see what it was and then they told me there's a second one. I only communicated one= [...]

In example fifteen, the answer "yes" as highlighted in the excerpts would sufficiently responds to the question posed by the interlocutor. The subject elaborates and adds information that is not stated in a clear and straightforward manner. The utterances can still be understood by the interlocutor because they successfully abide by one or more of the maxims. They make sense in the co- and context in which they are enunciated and to which they refer.[3] The context, linguistic (register, dialect, sociolect) and otherwise (socio-economic or psychological factors), is one of shared knowledge. If one of the maxims is violated, the hearer resorts to the referential field (context) and tries to

complete the propositional value of the utterances by relying on previously stated information, culturally mediated concepts and beliefs, and psychologically conditioned factors that arise in the course of the conversation.

Example sixteen is an excerpt from my second interview. The subject (W 2) lost her first two children. The interlocutor wanted to know what happened between the diagnosis (i.e. the child was dead) and the actual birth (the moment it went away).

Example 16:

I: You had one day in order to realize what happened and until the child went away.

W 2: =Yes, *she* [the physician, which she mentioned earlier in our conversation] actually already told me *down-* [geographically where the physician had her practice l], that *it* [the baby] is gone, that *it* [she is again referring to the baby] was not there anymore and, yes, but, until *it* [the remains that were still in her womb] was fully away- *it* took then-...how long did *it* go? .. The next day, I was at home and the day after, I had to go *down* [geographically where the physician had her practice] - .. And on the one hand I was also glad in a way, because I knew, *now* [temporal adverb referring to the actual event] *everything* [the remains, which is tissue and blood clusters] is *out of me*. She [the physician] told me, *it* [the natural expulsion of the remains] would take for sure one week until *everything* [the remains] would go away and *then* [temporal adverb to refer to a sequence of the events] I was actually glad that *everything* went away at once.

In the last passage (example sixteen), the subject uses several deictic expressions that, grammatically speaking, do not have a determinable reference. Taking the first utterance of the above example: "Yes, *she* actually already told me *down-*, that *it* is gone, that *it* was not there anymore and, yes, but, until *it* was fully away- *it* took then-...how long did *it* go?" Four times, the subject uses the third-person singular pronoun "it" to refer to its referents: the child, the remains in the uterus and to the time of the natural expulsion of the remains of the child. Coherence, cohesion, as well as grammatical and semantic relationships are violated. The subject does not maintain a logical tense in her narration (she switches back and forth in terms of the chronological order of the events which violates coherence) nor does she provide clarity through a consistency of deictic expressions (she uses deictic expressions without presenting their corresponding referents as shown in the previous example). The subject's narration also does not provide lexical, grammatical cohesion and her narration does not establish a structural content in order to make her narration semantically meaningful. Despite those violations, by drawing on prior sequences, recalling the background knowledge (linguistic and otherwise) and using information that the participant (W 2) previously mentioned the interviewer is able to understand this passage.

The interlocutor is able to interpret these textual fragments appropriately. She predominantly relies on the context here, which has been established and agreed upon prior to and in the course of the conversation; it seems indispensable to specify the operations pertaining to this referential field, to suggest that the Gricean model does not really hold when tabooed or intimate subjects are brought into focus. While Grice provides a useful account of implicatures in conversations, he does not sufficiently

explore the referential field (linguistic and otherwise), which, in my examples, prove even more important than the maxims themselves.

When a speaker only discloses bits and pieces of a traumatic event, the interlocutor necessarily has to infer from the referential field what the meaning of the utterances might ultimately signify. If questions are very personal and intimate, or if they testify to a traumatic occurrence, as stated in my hypothesis, the speaker tends to obfuscate pertinent elements in the discourse by means of deictics, gaps, or pauses (violating the maxim of manner). The cooperative principle, that is, the interviewer's/hearer's willingness to resort to and complete fragmentary information by abiding by the four maxims comes into the foreground and significantly influences the success of the conversation.

> Conversational implicatures are important because (in most views) they are not derivable from semantics alone; one cannot generate the intended meaning of a person's utterance (illocutionary force) by considering the words and their organization in isolation. Rather, the context, including the interlocutors' mutually assumed knowledge, is crucial for determining a speaker's meaning. It is in this way that Grice's framework is clearly a social psychological model of communication; interactants must mutually assume cooperativeness if communication is to succeed. (Holtgraves, 24-25)

The next example (example seventeen) from an interview with another participant (W 9) also testifies to the presence of fragments interwoven into the narrative texture of the conversation.

Example 17:

I: How was it- I mean when a woman loses a child, it often happens that all of a sudden, other women come and share their own stories of having lost a child. It is a rare opportunity to share such a personal story. Like a vessel to deliver grief. Did you experience something similar? Or did you approach other [women?]=

W 9: [No]

I: =or you especially empathize with women who lost their children or that you talk about [your-?]

W 9: [No] No, I didn't do *this* because- I had to do *it* <u>myself</u>. First I had to process that <u>myself</u>. And I kept *that* to myself- but what- I kept for myself- With *Peter**, then *the people* came, but *it* was different *there*. Then a *lot of people* came to see me, but I did not have a problem with *that* at all. And I had *them- They* wanted to take me to support groups and- and- I had many offers, *that* was crazy! But I didn't want to. I didn't need *it.* Maybe *that* was the right thing to do for *other people* but not for me. Because *it* was not a problem for me after all. And today I don't have- I am even thankful- .. because once I tried to approach *them-* ... that was- I mean ... *they* pulled me down! All the positive thoughts and experiences I have had- ... I had the impression, "Can I be happy after all?" The opposite happened. I told myself, I should not be so happy with *it,* so I was looking for something bad, what I had. I just took something negative, but something, that I really didn't feel so bad about *it* and I had to <u>stop</u> with *it*, I really had to <u>stop</u> with *it.*

In example seventeen, the subject (W 9) does not provide adequate information; certain pronouns ("them" and "they") can indeed become the site of potential ambivalence. The interlocutor, by constantly tying in information, which had already been stated, and by adhering to culturally mediated scripts and frames, still manages to understand the speaker's utterances. Peter was the subject's last born who suffered from a cerebral disorder. He was thirteen-years-old at the time of the interview. There are not many support groups for women who have lost children during pregnancy, but there are many support groups for parents who have mentally and/or physically disabled children. The knowledge about the cultural approach towards disabled children and their parents and the organization and procedures of support groups provided the frame and scripts for the interlocutor in order to process the subject's narration.

If one were to apply the Gricean maxims to this excerpt, it would not demand much of an effort to identify the textual moments where they have been violated. Whenever maxims are disrespected, however, the participants automatically rely on the interpersonal and social context in which the conversation takes place, and make use of culturally mediated frames and scripts to complete the information. From these examples, one can surmise that the speaker tries to do her best to follow the cooperative principle, yet something is preventing her from giving more information.

The following table shows the number of violations of Grice's four maxims by each participant. It also shows the total number of violations.

Table 3. Tokens of Violation of Grice's Maxims by the Participants of This Study.

	Violation of the Maxim of Quality	Violation of the Maxim of Quantity	Violation of the Maxim of Relation	Violation of the Maxim of Manner
W 1	1	5	3	3
W 2	2	9	5	6
W 3	2	7	6	2
W 4	3	6	5	4
W 5	1	13	7	5
W 6	0	6	3	2
W 7	4	12	5	8
W 8	0	2	7	2
W 9	2	7	5	8
W 10	0	4	5	5
Total	15	71	51	45

The reasons, for which the subject (W 9) refuses to bluntly state what had happened, as shown in example seventeen, are twofold. First, the speaker (W 9) is aware of the societal constraints imposed upon the IPL, which certainly influences the ways in which this topic is handled in the conversation. After all, it is taboo to talk about reproductive loss. Second, the speaker, probably unconsciously, does not wish to reactualize the devastating effects of the traumatic event in a second-order experience.

By clearly establishing the area of inquiry through the explication of my procedures prior to the conversation in question, the interviewee has a sense of what can be expected and is well-prepared for what is to come. Certain frames and scripts, such as social and medical procedure after delivering a mentally and/or physically disabled child as well as the organization of support groups (for women who suffered IPL and for parents of disabled children), inevitably come into play constituting the participants' mutual knowledge and referential context in which each conversation is conducted. What appears particularly riveting is that despite the glaring omission of linguistic elements

(semantic and syntactic in particular), the interviewer can still comprehend the message conveyed in the conversations.

When analyzing discourse, a researcher often is in the role of the observer, seemingly detached from the discourse itself. In this research, the analyst functions in a double role, namely in the role of the analyst who examines and studies the data, and in the role of the interviewer who collects the data by immersing herself into the conversation because she shares a similar experience. Looking at the data that I have collected, it is my understanding that the Gricean concept of cooperative principle, which involves the application of conversational maxims, needs to be extended in favor and in direction of the referential field through which *all* information is perpetually verified and referenced, especially when the subject of conversation touches upon delicate, private, and intimate issues.

4.4 Summary

Chapter four provides a clarification of the term "personal question," which is necessary to approach the hypothesis. For this research, "personal questions" are questions that ask for intimate information and cannot be answered by "yes" or "no." The examples from my research illustrate that when the subjects talk about their personal experience of IPL, the mode of narration is often fragmented and the interviewer needs to draw from mutual knowledge about IPL, from numerous frames and scripts, such as hospitals, visits at the gynecologist, or support groups. Crucial nouns or references are left out. The omission of such elements makes it necessary for the interlocutor to rely on frames, scripts, and mutual knowledge. Culturally embedded norms and customs also contribute to the

processing of information necessary to contextualize the participants' narration. The cooperative principle and conversational implicatures, scripts, and frames come into play when talking about IPL but are not sufficient for the interlocutor to fully understand the discourse. The interviewee relies upon the interlocutor's mutual knowledge about IPL. This unique and exclusive mutual knowledge, and not the conversational implictures or the cooperative principle, provides the key factor to understand the narratives about the subjects' experience of IPL.

NOTES

[1] In Switzerland, even in hospitals, women are usually examined by the same physician, except in the case of an emergency or the absence of the physician in charge.

[2] In terms of pairs of chromosomes, men and women differ in the combination of the sex hormones. Whereas women have the combination of XX, men have XY. In case one of the X chromosomes does not function properly, or there's a genetic defect, the other X chromosome can substitute some function in a female embryo but not in a male embryo because men do not have the double X chromosome and are therefore less protected.

[3] Co-text designates the immediate linguistic environment in which an utterance appears. It involves the sentence-unit. The context defines the surrounding paradigms (linguistic and otherwise), in which the utterance is placed and is much larger in its amplitude than the co-text.

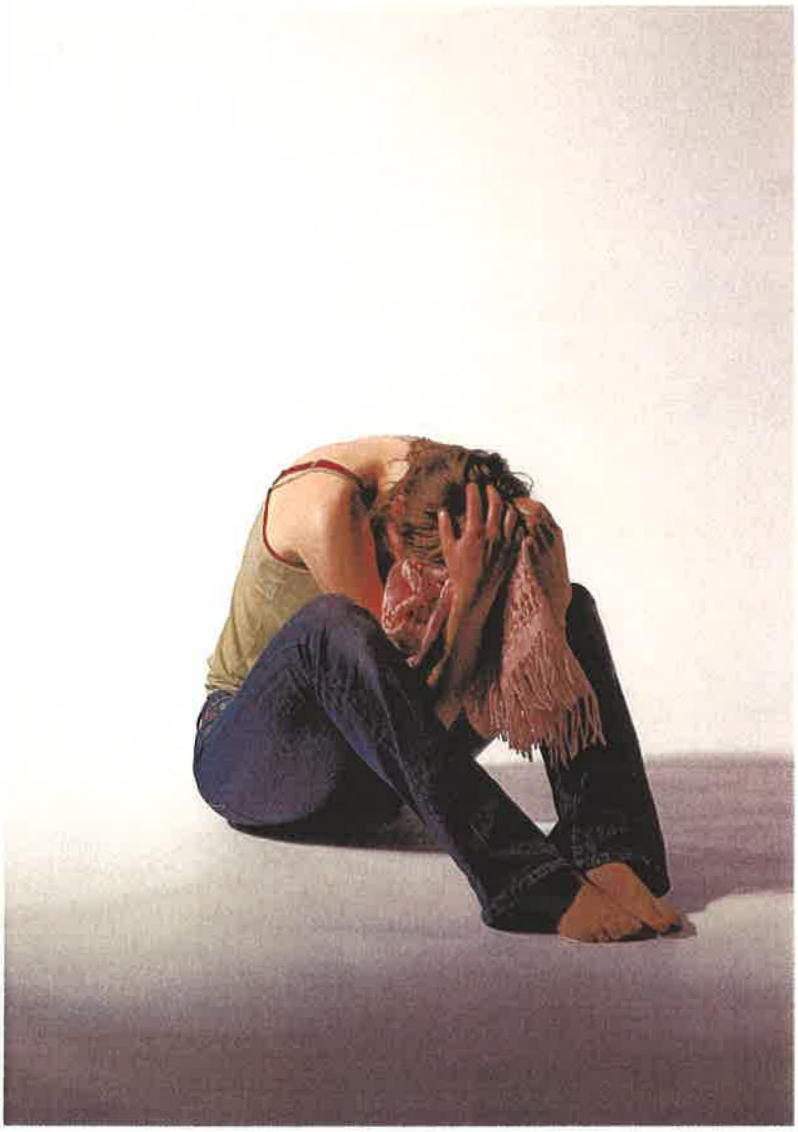

Fig. 6. Photographical Exploration of Reproductive Loss: Guilt. Subject (W 4): "[…] I always thought, now I am guilty, I did something wrong. I went to early .. I did not work out like crazy but at my workplace, I should have reduced my working hours earlier." (Unterägeri, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

CHAPTER V

FEELINGS OF GUILT AND REPSONSIBILITY AFTER REPRODUCTIVE LOSS

While I was conducting and analyzing the interviews, it struck me how often my participants expressed feelings of guilt. All of them felt guilty and responsible to some extent for the death of their child. This chapter is not part of the linguistic analysis. It provides insights into socially- and psychologically-bound aspects of pregnancy loss in ten Swiss women. This chapter not only sheds light on a corollary component of IPL but also defines the words guilt, self-blame, and fault in the context of IPL. By defining feelings and emotions it becomes easier to talk and think about what is actually happening. Different forms of self-blame, feelings of guilt, and the thoughts behind the search for possible reasons will be discussed. Not having a word for a child who dies during pregnancy (as discussed in chapter two) and the taboo of talking about reproductive loss are two main factors that keep women from openly talking about their experiences. It is probable that they are a source of unnecessary guilt for the death of the child. All the examples used in this chapter are from the data collection for this thesis.

5.1 Self-Blame and Feelings of Guilt

Self-blame and feelings of guilt are unfortunately a phenomenon which, in addition to their grief and the social implications (as discussed in chapter two), most

women experience after reproductive loss. During the research for her book Motherhood Lost, Layne talked to numerous women who experienced reproductive loss and summarizes her observations: "One of the most disturbing findings of my research on the experience of pregnancy loss in toxically assaulted communities, is how deeply ingrained and pervasive is this tendency of self-blame" and later in the same chapter she states that "Nearly all women worry that they were in some way responsible [for the death of their unborn]" (151). No matter how cautious a woman was during her pregnancy, the question or the feeling that it might have been her own fault to lose her child was present in all of my interviews. Gray and Lassance's extensive research and work with women who suffered IPL came across this topic and they state that "Guilt, remorse, and regret often accompany self-blame following reproductive loss. Feelings of guilt are more prevalent than most people realize" (46). Borg and Lasker's findings also confirm that, "Guilt is one of the strongest emotions bereaved parents feel" (20).

As I pointed out in chapter two, in today's society, many pregnancies begin long before the actual conception. Women start to change their nutrition, do physical and mental preparations, and read how-to books on pregnancy when they decide it is time to start their family. Peggy Orenstein, recounting her experience of IPL, states that "Prenatal care, including watching every milligram of caffeine, every glass of wine, every morsel of food, as well as choking down that daily horse pill of prenatal vitamins—begins before we have even conceived" (par 10). Doctors and health magazines advise pregnant women (and those wanting to become pregnant) to lead a consciously healthy lifestyle. In societies like Switzerland where almost everything has to be planned and neatly organized, pregnancies fall under this category as well. The underlying notion that what

can be planned can be controlled plays a crucial role in reproductive loss. Borg and Lasker argue that "Because of the advances in modern medical technology and the continuing decline in the infant death rate, most couples will have a favorable outcome" (17). Since rate of infant mortality and dying in childbirth has drastically decreased in the past century, popular culture assumes that the normal course of a pregnancy ends happily. This feeling of security raises illusory expectations about pregnancy and motherhood, which make women even more vulnerable in the case of an IPL. Letherby explains that "Expectations about parenthood and of the child increase the sense of loss or failure. The increase in medical technology has almost persuaded American women to believe that their babies will not die" (qtd. Robinson 258-259). This statement is equally valid for women in Switzerland. There is still not enough information and open knowledge about the frequency and normality of IPL.

Pregnant women are expected to take responsibility not only for their own personal health but also for their unborn child. Individual health care and a certain amount of self-discipline (such as avoiding too much stress, averting anger or negative feelings, staying away from alcoholic beverages, and moderating exercise) is needed and expected in order to give birth to a healthy baby.[1]

> Paradoxically, the women's-health movement has contributed to this ethic of individual achievement, and in so doing has made the experience of pregnancy loss (or any other less-than-ideal birth) more problematic for women. The fundamental premise of the movement that women must wrest back control of their bodies from physicians (especially during

> pregnancy and birth) reinforces the ethic of individual control and responsibility. (Layne 149)

The feeling of guilt after IPL is multilayered: there are feelings of helplessness, of not being able to prevent the baby from dying (lack of protection); there are feelings of guilt, of having done something (wrong) that caused the death of the child: and in some cases there are feelings of guilt imposed by other people, such as friends, family, or acquaintances. The following section investigates the need and impact of having an actual reason for an IPL.

5.2 In Search of Possible Sources of Guilt

An IPL usually occurs unexpectedly, that is, without obvious reasons or distinct signs. It is only natural that one starts to search for possible explanations, and research shows that many women reconsider their behavior and look for possible failures. Layne remarks that,

> If the pregnancy does not end with a desired birth outcome (for example, a healthy baby), it is hard to imagine a woman who would not go back over that daunting list and find at least some areas in which she should have done more, could have tried harder. (150)

In order to understand what happened, bereaved parents-to-be try to come up with possible explanations by recalling past modes of behavior. Hoenk Shapiro, describing the moment after expecting parents have to face the fact that they have lost their child, states, "In an attempt to make sense out of their emotional confusion, the couple may feel compelled to review their behavior during the pregnancy and to absolve themselves of

whatever guilt they feel" (119). Even though in very few cases (especially in an early stage of gestation), there is an obvious reason for an IPL, people who are immediately affected are almost always searching for reasons.

Nikcevic et al. investigated how a medical explanation for an IPL influences women. In their research, Nikcevic et al. not only discovered that women who have a convincing reason for their IPL grieve more freely, but also helps women eliminate feelings of guilt. It is easier to grieve and process a pregnancy loss when there is an identifiable cause. In their discussion, Nikcevic et al. observe that

> Feelings of self-blame decreased generally over a period of four months after miscarriage, but this was significantly more so among those in whom the cause was identified. Thus, having the explanation that the pregnancy failed because of medical reasons, and mainly due to a fetal chromosomal abnormality, appears to reduce women's feelings of self-blame and responsibility for the loss. (811)

The data of my research, however, do not confirm their finding that feelings of self-blame decrease over a period of four months. During the interview, at least four of my participants mentioned that feelings of guilt were still present when thinking about their pregnancy losses even though they occurred between two and eight years ago. The conclusion by Nikcevic et al. that a reason for a sudden death reduces feelings of guilt is not surprising. As long as there exists a medical reason for an IPL, there is something to blame, and uncomfortable questions from outsiders can be replied to with a concrete answer.

5.2.1 Medical Issues

The reason why a medical cause for IPL is desired is the possibility for a cure. In cases where no cause was identified, the fear of a repetition in subsequent pregnancies was still present. Some women also develop the impression of suffering from a malfunction of the reproductive ability. One question in the interview asked about the importance of knowing the reason(s) for the IPL. Almost all of the participants stated that having a reason was important, even though most of them had not received a specific reason for their IPL. The following excerpt from the interview with one of the participants (W 8) exemplifies this:

Example 1:

I: How important was it for you to have an explanation or a reason [for the IPL]?

W 8: Yes. Right after the delivery, I remember the day after when the doctor, the midwife and some assistant doctors came to my room … I was still under drugs and not very clear in my mind. I asked the doctor *will this happen next time, will I be able to have children*? If he could have told me, 'Yes, you can', I could have borne that easier. A medical problem, like a disease for example … something concrete. It's this or it's that.

To know the reason that caused the IPL would have helped the subject (W 8) to better digest and understand the death of her child. A tangible medical problem would have made it easier for her (at least immediately after the delivery of her dead child) to feel more comfortable in the sense that she could have estimated and anticipated possible

risks for future pregnancies. An identifiable cause can enhance the grieving process as well. If a medical problem exists, such as a genetic disorder, feelings of guilt and self-blame can be reduced. In their clinical research on reactions after IPL, Van and Meleis found that self-blame, searching for reasons and explanations, fear of future pregnancies, and the feeling of shattered hopes and dreams were normal after IPL (29). It is interesting that even though medicine tries to explain IPL and physicians usually provide reasons, the reason is not a specific one and the answer does not usually satisfy a woman who lost a child during her pregnancy or alleviate feelings of self-blame. Whereas the chances of finding a reason for recurrent pregnancy losses are higher than in a one-time loss, the following excerpt from a medical study about recurrent pregnancy loss shows how vague those reasons are. Coulam, an MD, states that:

> There are two major reasons for recurrent pregnancy loss. One is that there is something wrong with the pregnancy itself, such as chromosomal abnormality that prohibits the pregnancy from implanting or growing properly. The other reason is a problem within the environment in which the pregnancy grows that does not allow an otherwise normal embryo to implant properly. Problems within the environment or lining of the uterus have been classified as anatomic, hormonal, and immunologic. (328)

In a medical context, the reasons for an IPL would probably specify those two categories for an individual case, but the reality is that usually once an IPL occurs, no further investigations would be conducted. First, the costs of autopsies are high and not covered by the Swiss health insurance. Second, there is little chance for conclusive findings. According to the participants of this study (W 1, W 8, and W 10), even

physicians and midwives dissuade women to initiate further investigations for the latter reason. In most cases, especially early IPLs, the cause of a miscarriage or stillbirth remains unknown.

In example two, the participant (W 7) states that a (medical) explanation was important for her and her husband immediately following the death of their prematurely born daughter, Leila. In her case, there was no obvious medical explanation but an anatomical predisposition possibly influenced the course of her pregnancy. She was told that her anatomical constitution might have caused the premature birth of her daughter, which was the medical reason for her premature birth, but not necessarily for the death of the child.[2] Both of her living daughters, born before Leila, were prematurely born around the same point of gestation as Leila's birth. In the following excerpts, the participant (W 7) recalls the importance of knowing the reason for her IPL:

Example 2:

I: How important was it for you have a reason for this sudden death? I mean-

W 7: Right in that moment, *to calm down the emotions it was surely important* .. in the end, for us when you put away the death for a little bit .. yeah … not very important .. well, to process and digest what happened, I don't think so. Well just for the [moment]=

I: [Mhm]

W 7: =I think we have in the end, we *have other explanations* why this has happened to us.

I: Mhm

W 7: For *the doctor it's clearly the anatomy, for us in the <u>beginning</u> as well=*

I: If the doctors say so

W 7: =in the beginning it was the same for us but in the end it wasn't. I think it was … we grew a lot through it .. maybe that we could gain from what happened .. at least with Leila, we would have either broken up or have like we have it now=

In example two, the subject (W 7) stated that it was important to her to have an explanation—the doctors were convinced that the curtailment of the neck of her uterus caused premature labor and eventually a premature death in Leila's case. Right after Leila's death, this medical cause helped her and her husband in their grieving process and in understanding what happened. Later, though, as they continued to grapple with the death of their daughter, who died at thirty weeks of gestation—the same as two of her living children—the couple came up with their own reasons as to why they had to go through the experience of eight IPLs. According to the subject's (W 7) claim, she and her husband do not fully accept the medical explanation. The couple strongly believes that had they taken care of personal problems in their relationship and within themselves, the anatomical variance wouldn't have made a difference.

Personal beliefs about life, higher powers, and destiny overshadowed medical explanations. During her next and last pregnancy after the loss of Leila, the subject had a special surgery to prevent an early opening of the uterine orifice that would have resulted in premature labor. Her son was born in week thirty-nine. The excerpt from this interview

shows that despite the medical explanation, the subject does not believe that anatomy alone caused the premature births and IPLs. In her opinion, personal problems which she did not solve before her pregnancies always manifested themselves in her womb in the form of cysts or cancer-like ulcers. The subject is convinced that had she taken care of her personal problems, the IPLs would not have occurred. And further, the surgery would not have been necessary. In other words, she feels responsible for the deaths of her children.

5.2.2 Personal Issues

Many of the participants were looking for possible personal problems which, according to them, should have been solved before their pregnancies. Example three is a continuation of the last interview (with W 7) stating that the experiences of Leila's death resulted in the salvation of their marriage. She further searches for reasons in unfinished personal issues.

Example 3:

W 7: =we are lucky that we have it [that the couple stayed together instead of having broken up] like this … but I think- my belly and my womb area are so many- everything goes through that and I think that's one of the reasons too.[3]

I: Mhm.

W 7: And it is- .. *I had to solve some problems first-* and I think could I have children again, I'm convinced I had no problems at all anymore despite the anatomy and I'm not even sure whether I would use the surgeries=

I: Mhm.

W 7: =I'm not sure about that.

I: Mhm.

W 7: But I think now, *I'm finally at the point- where it* [the child] *would probably not go away through my womb area=*

I: Mhm.

W 7: *=or not had to go away because it* [the problem she has solved after her IPLs] *has gone away*

As examples three shows, the subject (W 7) and her husband found their own reason for their pregnancy loss by stating "*we are lucky that we have it like this* [this is the reason they have as a couple. They stayed together because of Leila's death]… but I think- my belly and my womb area are so many- *everything goes through that and I think that's one of the reasons* too [this is the subject's personal reason. She thinks that her unsolved personal issues manifest themselves as medicals problems in her womb]."

After a while, some couples find relief in their personal beliefs about life, destiny, or religion, which can make them accept what happened. Example three of the subject (W 7) illustrates that the couple saw the death of Leila as a chance to improve their

relationship. They talked about death and life together and formed their personal belief why this happened to them.

The next selection of interviews, illustrates the notion of what Jones described as "lost chances." The participant (W 7) blames herself for not having solved personal problems and worked on behavior patterns from her childhood. She believes that this was the reason for her large number of IPLs, as shown below:

Example 4:

I: Yes. .. did you ever think about guilt?- many women have the feeling of [guilt]-

W 7: [That] they were guilty?

I: Yes, whether they had worked too much or did something-

W 7: Well, I did not search for it but with Leila- I went- to a kinesiology therapist[5].. with whom I still work and we worked on stuff which I *should have* worked on before but at the age of twenty-four twenty-five- first of all I did not think about problems in future pregnancies but … *in retrospect .. I have to say I was stupid and because of that I feel some guilt because I could have gone around that=*

I: Mhm.

W 7: =but because I'm already that far and I see what it was good for- I think… we would have been- or we wouldn't be so experienced without it. And because of that the *guilt is alleviated somehow- but it still comes once in a while. .. especially*

when you feel I should have- or I could have- I knew I should have solved some problems before, I always knew there's something wrong in my belly and also knew why=

I: Mhm mhm.

W 7: *=I should have taken care of my things first and worked on my issues* which is now finished through all what happened but *the guilt is surely here*. Maybe with twenty-five twenty-six more than later-

The subject (W 7) feels guilty for not having resolved problems that she—according to her experience of IPL—should have solved before her pregnancies. But she also mentioned that she learned from her experience and since she is going through that form of therapy, understands the underlying motives and origins of her behavior patterns and her IPLs. The deaths of her expected children pushed her personal development forward.

5.2.3 Societal Issues

To have an actual reason for IPL also helps to explain to outsiders what happened. When people know about a pregnancy and later hear about the unsuccessful end of that pregnancy, bereaved parents have to answer all sorts of questions about why this happened. One of my participants (W 10) mentioned that she often explained that it was a genetic reason simply to keep people away. Not having any sort of explanation for a sudden death of an expected child can create space for speculation and rumors, which can hurt and annoy a woman who is extremely vulnerable to any comments after an IPL. In

order to make sense of an IPL, outsiders might suggest that the woman must have done something which caused the baby to die because, in their opinion and what the media suggest, normally pregnancies end happily. This additional pressure of responsibility imposed by persons, such as acquaintances, friends, and family, will be illustrated by the following example from an interview with another participant (W 10) who lost one of her children after twenty-two weeks. This was her second pregnancy. The first pregnancy ended in week eleven with a missed abortion.[4] The following excerpt exemplifies how a carelessly stated question can imply that the pregnant woman was responsible for the death of the child.

Example 5:

W 10: Because I've lost the child relatively late in the pregnancy- at that time everyone knew about my pregnancy .. we've sent out cards..eh..something like an obituary .. to friends and relatives and people who have worked with us and- .. then… eh… a friend of mine called me and asked me *"Hey, what did you do?"* .. yes.. his tone *I know he did not mean it the way he said it* .. he was helpless- he did not know what- what to say but it hurt me… yes..mhm.

I: Did you feel as if he made you responsible for the death of your child?

W 10: Yes I mean- it was not my fault … I mean you asked yourself what- what- you did wrong but when other people do that- yes- *they accuse you in a way. Yes, it's like an accusation they judge you in a way* [3 sec] I know he did not mean it, but still…

The question, "What did you do?", posed by the subject's (W 10) friend is likely to be interpreted as, "What did you do wrong?", or "What did you do that the child died?", which ultimately blames the women for the child's death. In this case what is said and what is meant probably differ. I assume that the subject's friend's intention was to say "I am very sorry to hear that your baby died. How did this happen?" But the subject (W 10) inferred that he accused her of the death of her child. The friend's knowledge about pregnancy loss differed significantly from the subject's background knowledge about IPL's and therefore communication was doomed to fail.

5.2.4 Emotional Issues

One of the participants (W 9) became pregnant six months after the loss of her first child. After the first shock that she was expecting, she looked forward to having the child, but lost it after twenty-two weeks of gestation. She blamed herself for not having wanted the child from the beginning. In the following passage (example six), the subject (W 9) shares her thoughts during her unwanted pregnancy.

Example 6:

W 9: *I knew that the child shares all the thoughts and feelings-* you read that in books and my mother told me.. but when I realized I was pregnant *I hated the child..* the circumstances-.. I was not ready for a pregnancy at all. I even prayed that it would die.... Later, I prayed that it would live but it didn't help ... *I still feel that my negative wishes and thoughts were heard and the child didn't feel loved enough to come to me.*

The subject (W 9) makes herself responsible for the death of her child. She believes that in the end what she got was what she had wished for. Although after the first shock of being pregnant, her feelings changed, and she wanted her child and was looking forward to being a mother. The sentence, "I knew that the child shares all the thoughts and feelings," indicates a strong sense of guilt. Guilt implies a person does something he or she knows is wrong. In this case she was convinced that her negative thoughts and feelings (which were caused by her personal situation and the circumstances at that time) caused the baby to die. In her opinion, had she initially been able to think positively the child might have lived. The belief that positive thoughts positively influence a pregnancy, and negative thoughts negatively influence the outcome of a pregnancy puts a lot of pressure on a woman.

In the literature on reproductive loss (Borg and Lasker, Irving, and Rousselet), self-blame and guilt is not linked to moral or psychological issues, such as negative thoughts or resolution of personal patterns from the past. Rather, they are linked to physical and mechanical influences, like consummation of alcoholic beverages or intensive physical work. In my study the forms of self-blame and guilt varied. Women felt guilt because they had negative thoughts about the pregnancy, as illustrated in the previous example (W 9), or because they might have worked too long, or too hard. They were searching for reasons to justify the feelings of guilt and responsibility. Jones argues that

> Most women develop a sense of enormous guilt and responsibility for a pregnancy loss they could not stop from happening. [...] Although most women are able to recognize the often irrational quality of their assumed

> guilt (as well as the level of responsibility they might rightly assume), this doesn't lessen the insidious force of these feelings. This is only exacerbated by a growing medical rhetoric that holds women singularly responsible for the success or failure of their pregnancies. In such a context, their sense of culpability usually grows as they try to figure out what happened medically and, quite often, their past begins to look like one long tale of bad decisions and lost chances. (Jones 233)

As example seven illustrates, guilt and self-blame can even go so far that a woman (W 4) thinks she might have deserved her IPLs. She also suffered from self-blame and feelings of guilt and even thought that her years of failed attempts to get pregnant as well as her first two unsuccessful pregnancies were a punishment of some sort.

Example 7:

I: Or did you feel guilty? Or were you searching for possible reasons?

W 5: Yes, I was looking for reasons. I thought, exactly, *she* [the subject (W 5) is referring to herself by using the 3rd person singular] *again worked too much ... she did too much .. she could not relax and she had to function in the exa::ct sa::me way as before, if I only had, if I only had, if I only lied down more often, if I only had taken more time for myself.* =

I: =Mhm=

W 5: =And this was already then- yes, I had that at that time. I mean I had that at that time .. and.. what also

was .. I mean, why, why always me, I mean, this feeling was so strong, always me, me, always, there have already been incidents, for instance surgeries or something like that … just .. *yes .. as if I would have to be punished, that was my impression.*

The subject (W 4) mentions self-blame, "She worked too much, did too much and could not relax." She regretted that she did not change her behavior during her pregnancy but managed her life in the same way as usual. By searching for a reason for those incidents she had the impression that she was the one who had to suffer. She had several surgeries, some of them in connection with getting pregnant, but also personal problems in life that she thought would only happen to her. To make sense of the feeling that so many unfortunate happenings occurred to her, she had the impression that she must be punished for something she had done in a previous life (an idea she had). Layne also makes moral failing a subject of discussion that can be related to IPL. Having a healthy child can be considered "moral achievement, the result of self-discipline and labor," and consequently, "the inability to bear children is oftentimes attributed to moral failing on the part of the woman" (148). Sandelowski elaborates on the fact that conception can be willingly controlled, that is planned, or prevented; not being able to conceive or bring a child to full term equals "a kind of failure of will" (qtd. in Layne 148).

There are also other forms and examples of self-blame and guilt that I did not try to identify in my research because of lack of sufficient evidence. For instance,

> Many parents review in their minds the times they had sexual intercourse during their pregnancy, wondering if this had an effect. A mother may

> think about the medications she swallowed, the alcohol or diet soda she drank, the extra trip she took, or the possibility that she was exposed to harmful chemicals. Parents scrutinize every activity, looking for a clue. They study every news item reporting the discovery of possible causes of damage to unborn children. (Borg and Lasker 21)

Reasons such as environmental poisons and hazards were not mentioned in my interviews. One woman (W 7) had light chemotherapy shortly before she was pregnant with her first baby, which she lost twenty weeks after conception. This was the only example which comes close to what Borg and Lasker found. Many people assume that increasing environmental hazards probably cause most of the reproductive losses.

Going through a period of grief after an IPL can put a great strain on a couple. They can make each other responsible for what has happened. Borg and Lasker summarize their findings:

> Even when there are no obvious disagreements, there is the potential for a man and woman to blame each other for their loss. In these cases the anger can be overwhelming. He thinks that perhaps she was not careful enough during her pregnancy and shouldn't have worked; she blames him for urging her to make love or for arguing and upsetting her. (93)

This tension can also be a moment when unspoken anger comes to the surface. None of my participants mentioned that their husband blamed them or vice versa. On the contrary, two of my participants (W 7 and W 10) stated that grieving together with their husbands saved their marriage and strengthened their relationship.

5.3 Guilt of Not Functioning Properly as a Woman

As discussed in the previous section, self-blame and guilt can have different faces. In one of my interviews, a woman (W 2) felt guilty after two reproductive losses (both of them before week twelve) for not functioning properly as a women.

Example 8:

W 2: I mean, after the second time, I mean, yes, I did [feel guilty], but we also talked about, *I mean my husband started to talk about adoption right away, and that it would not be a problem for him at all, I mean, hey, it should in a way*, yes, I did have such feelings, *what did I do that was wrong* .. yes ..

The subject (W 2) miscarried her first two pregnancies she and her husband concluded that she was not able to have children of her own. Without medically supported or confirmed proofs, the couple accepted the woman's reproductive failure. Example eight illustrates that the ignorance about reproductive loss can lead to false conclusions and new options—in this case the suggestion of adopting children. Pragmatically speaking, the sentence, "I mean my husband started to talk about adoption right away, and that it would not be a problem for him at all," can be understood as, "I don't blame you for not being able to carry out a pregnancy" or "It is not a problem that *you cannot* have children, we may have children through an adoption," which again burdens the women with the feeling of being incapable of having a child.

Referring back to example eight from the interview (W 2), the question of "what did I do that was wrong" clearly indicates that she believes that she must have done

something. Actually in all of my interviews there was never a question whether the reproductive function of a male could have caused the premature death of a child. In fact, throughout my research and in popular culture, I never came across an instance where people turned their attention to the father as the possible cause for the failure of pregnancy. In cases of infertility, both men and women can be 'held responsible,' even though women usually are 'blamed' and medically checked before men.

Many of the participants referred to the reassuring comments by their doctors stating it wasn't their fault. Example nine, (which is a continuation of example eight) the participant (W 2) who was afraid that something was wrong with her, restates her physician's explanation:

Example 9:

W 2: I did have these feelings-[it was my body's failure] even though the physician always said, *this does not* ..[come from riding horses or from a health-related cause] anything at all, most of the time it [the IPL] *happens because it* [the child] *would not be healthy,* then it is a good reaction, if it goes away

Example nine (as well as the context from which this excerpt is taken) illustrates that the subject questions her physical qualities for bearing a child. Even though women were told by physicians and books that their IPL wasn't their fault, they still have feelings of guilt.

A further reason for feeling guilty, mainly imposed through media and society, is a mother's age. Lifestyles of women have undergone major changes in the last two generations. A government substituted high-quality education system and the women's

movement made it possible that today more than half of the students at Swiss universities are women. Women who take advantage of this opportunity are getting married at an older age than their mothers and grandmothers and consequently postpone their pregnancies. As I mentioned in chapter two, in Switzerland, the average age of women who give birth to their first child is around thirty-one years. If a woman wants more than one child, her second pregnancy is likely to be around age thirty-four or thirty-five, an age of which it is said to be exposed to a higher risk of IPL (American Pregnancy Association).

One woman (W 1) was thirty-nine years old at the time when I conducted the interview. She did not pursue a tertiary degree but worked in her profession for many years. She had her first child at the age of thirty-three. One year later, she had her first IPL. At the age of thirty-six, she had her second child. At the time of the interview, the subject (W 1) was in her third trimester and worried about this pregnancy, since she lost two children when trying to get pregnant with her third child at the age of thirty-eight. She mentioned doubts about her age but also offensive comments by other people whenever she mentioned her wish for having a third child. Peggy Orenstein recounted her personal experience of IPL and refers to the same problem. She writes that

> Some women also may be reacting against a newly punitive atmosphere toward older mothers. Miscarriage rate increase with maternal age and those of us who have pushed their attempts at childbearing to the furthest frontiers of time worry that we'll be blamed for our losses, that we'll be harshly judged for 'waiting too long.' Sometimes we feel that judgment towards ourselves. (par 11)

Age is certainly a factor that has to be taken into consideration when talking about guilt. An independent lifestyle, a university education, a professional career, or simply the decision to postpone motherhood to a later age, can be turned against women who lose a child during pregnancy. A contemporary lifestyle can be interpreted egotistical, career-oriented, or selfish. A postponement of childbearing, regardless of the reasons behind it, makes women vulnerable to harsh critique from society. Sandelowski observed similar findings in her study about infertility where women were held responsible for their lifestyle, which not only includes a career, but also their eating habits, as well as frequent sexual contact and multiple sexual partners (qtd. in Layne 148).

One participant (W 7) experienced eight reproductive losses. Six of them occurred between weeks twelve and sixteen mostly through spontaneous abortion and the two others—her very first and the one before her last child—ended in week twenty and thirty, respectively. In terms of grief, her last reproductive loss in week thirty was even more difficult because she and her husband had to decide during labor what kind of life-saving measures they wanted to take in case the child was not able to survive on her own. In example ten, she (W 7) recounts her experience:

Example 10:

W 7: Well the grief has also gone in a way .. but what I still have is- it was in a week- there are so many shows on TV [6]- and last time there was a great article in the Beobachter [a critical and consumer-oriented magazine] and they always say very clearly "twenty-eight weeks, no problem" [children who are born in week twenty-eight would be able to survive] … and *that gets me then somehow because I*

always remember ourselves making the decision [of not wanting other life-saving measures other than oxygen]=

I: Mhm.

W 7: =the decision for us, for the child- I'm still convinced it was right, I can always say to myself when I don't feel good 'we let her decide' and I'm still happy about that … *and on the other hand the guilt of- it's a problem even though I know-* [it was the right decision] *it's still a problem*

I: Yes.

W 7: *And the question did we make the right decision? ... This is something that churned me up inside.*

5.4 The Child's Decision to Live or Die

Further explanations are probably needed to culturally contextualize the subjects' statements. In Switzerland, physicians of State Hospitals tend to encourage parents to let the child decide whether it wants to live or not. They do, however, provide life-saving machines and drugs to keep a child alive, but they also tell parents that a child has its own "will to survive" or not.

Since there is modern technology that can determine in an early state of gestation whether a fetus is 'normal' or not, women are expected to have 'normal' and 'healthy' babies, in contrast to a baby with a disorder of some sort. In the case of signs of a potential disorder, doctors usually recommend a selective abortion (even in a very late stage of gestation) in cases of genetic or other disorders. Women who choose to abort a possibly disabled child (which despite advanced medical technology is not one hundred

percent proven) might suffer guilty feelings in a different way and accompanied by other feelings. Borg and Lasker explain that "In cases of selective abortion, there is grief for a wanted child, questions about the characteristics of the baby—not usually seen by the parents—worries about future pregnancies, ambivalence about abortion itself, and guilt—terrible guilt" (57). This guilt is intensified because no one can foresee the actual condition of the child and because there is always the chance of a wrong diagnosis (this is important for expecting parents).

The notion that a child decides whether it "wants to come or not" or whether it "wants to live or not," as discussed in the last example, is widespread in Switzerland. Birgit Schmid, a Swiss journalist who lost her son Luis after eight months of pregnancy in utero, writes,

> During the discussion of the autopsy report in December 2004, the physician explained to us that in six out of a thousand cases, there are stillbirths after the twenty-third week. And to be even more precise, our child belonged to the three cases, in which the cause of the death remains unknown. The doctor said that the positive side of it was that one could exclude a genetic defect. (19)

The exclusion of a genetic disorder was not a relief in her case, because the cause remained unknown. She writes further,

> We [Schmid and her husband who is a physician] were further looking for possible reasons. Was it the glass of wine, which I drank at my birthday party during the third month of pregnancy? Did Louie realize when we had a row? Was he tired of the ultrasounds?" (19).

Schmid recalls the glass of wine but also the fight with her partner.

Schmid's statement adds to this notion that the child decides whether it wants to live or die and implies that mothers-to-be can influence the child's decision by providing a welcoming and conflict-free environment. Consequently, in Schmid's rationalization, the child decided not to come to that particular mother because his or her future parents did not provide the conflict-free space a child would have wished. In the previous example Schmid stated, "Was he tired of the ultrasounds?", which indicates that she reasons that her frequent pregnancy checks might have upset her son and therefore caused the death. She allows herself to be blamed for having too many ultrasounds. This idea sounds rather strange, but many of the participants come to similar conclusions.

5.5 Bodily Failure and Lack of Control vs. Acceptance of Responsibility and Guilt

Layne aptly describes the dilemma that women experience after an IPL in their emotionally turbulent state of making sense of what occurred. She writes,

> Either they accept responsibility for the pregnancy loss and therefore blame themselves for the death of their "baby," or they must admit that the loss was a bodily event over which they had no control. Despite the much-discussed dominance of the Cartesian split between mind and body, this is still experienced as "I'm/was out of control." This alternative of acknowledging that one was not in control of oneself is hardly more palatable that self-blame. (151)

In the interviews this dilemma of admitting that they could not control their pregnancy and feelings of guilt was often expressed by my subjects. One subject (W4), a

mother of two, lost one of her twins after twenty-six weeks of gestation. The child died in utero, and she had to carry the death and a living child until she gave birth in week thirty-two. It was her first pregnancy. By searching for possible reasons—because there were no medical explanations for the death of one of her twins—she questions her body by concluding that her body was probably not made to carry to term two children (see excerpt below). Later in the interview, she explains that she was looking for possible reasons and blamed herself for working too long, etc.

Example 11:

I: What went through your head? What was later? Was it important to you to know a reason?

W4: Yes, we said that we would really like to know what it was. And they said that they could not find any medical reasons. Often time, the umbilical cord is around their neck or something like that but the doctors- they couldn't find out anything. Or it wasn't a heart defect either. Brain- I mean that something was wrong with the brain … they really did- they said that they could not find that out anymore. Because there has already been a certain state of decay. It was well covered that you could not find that out anymore. I tell myself today, it had to happen. She just couldn't have a sibling for some reason and *I also tell myself, perhaps I am not made for twins. My body is not, maybe strong enough for that.* Destiny. You have to come to term with that just like that. Some things you just have to take it [...]

Example eleven illustrates the participant's perception of her physical constitution, which she interpreted as not allowing her to carry twins. From a medical perspective, there was no evidence for her assumption. Later in the same interview she (W 4) was looking for possible reasons other than her supposed failure of not being strong enough to carry twins. The two excerpts clearly illustrate the dilemma that Layne was explaining: A woman either accepts that it was a shortcoming of her body over which she had no control or—as the subject (W 4) states in the example below—she feels guilty of having done something that caused the death of the unborn.

Example 12:

I: A lot of women are looking for explanations or have a sense of guilt. I am responsible for=

W 4: =yes, I did always have that- I always had a lot to do and I thought maybe *I did something wrong.* On the other hand I had to say, it was just not meant to be. *But at the beginning I always thought, now I am guilty, I did something wrong I went too early .. I did not work out like crazy but at my workplace, I should have reduced my working hours earlier.*

The previous two excerpts (example eleven and twelve) from the interview with the participant (W 4) not only exemplify the question of their reproductive capacity but also that women always search for reasons in themselves. This is not an isolated example. In fact, all of my participants gave reasons with regard to their behavior, their health constitution or both.

Another aspect of the feeling of guilt or responsibility for the IPL is connected with what I have just explained: the notion of motherhood is closely linked to the role of the protector. When a pregnancy does not end happily, women might feel that they failed to protect their child. This triggers feelings of guilt and a sense of responsibility. Hsu et al. state that "Stillbirth or perinatal loss challenges a woman's image of and preparation for motherhood. She can no longer project the role of protector, resulting in acute guilt and causing conflict between perceptions of herself and her body" (410). None of my participants worded their notion of motherhood as the role of the protector, but their comments implied a certain sense of the helplessness of not being able to prevent the child from premature death. From a medical perspective, none of the IPLs of the participants in this study could have been prevented. IPLs happen. The excruciating self-questioning and self-blaming could have been prevented through a better understanding of the frequency and unpredictability of IPLs and a professional support system. The following section briefly outlines the consequences of the lack of and the need for knowledge about IPL.

5.6 The Need of Knowledge about Involuntary Pregnancy Loss

The lack of information about IPLs amplifies the feelings of guilt and possibly the notion of a bodily failure. Self-blame, self-doubts, and feelings of guilt hinder or prolong a healthy grieving process and burden a woman in addition to the grief about the death of her child. (Gray and Lassance 124). A better understanding of IPL, including favoring factors (age, alcohol, drugs, etc.) and possible reasons of pregnancy loss, but above all facts such as the frequency and randomness of IPL, would certainly exculpate women

who have lost one or more children. There are few books that explain IPL from medical, social, and, psychological perspectives in an accessible but still sophisticated manner. In her book, Avoiding Miscarriage: Everything You Need To Know To Feel More Confident In Pregnancy, Susan Rousselot, a physician, shows by means of an example how important knowledge about IPL is. Telling Melinda's story, she writes,

> The hospital doctor was great. She told me 'you have no idea how many women have miscarriages—it's really, really common.' That made me feel much better. There was still that 'Oh God, what's wrong with me? It's all my fault' voice in my head, but it did feel better. (14)

This example clearly shows that the knowledge about the frequency of IPL could ease a woman's self-blame and guilt. The feeling of being the only one who experiences IPL creates the idea of not functioning properly as a woman or having deficits in their own reproductive ability because "everyone else's pregnancy goes well." Apart from feeling isolated and "incomplete," a woman is also excluded from "the motherhood-club." Citing Melinda again probably summarizes the need for knowledge about IPL. She says, "Learning more about miscarriage made all the difference. When I found out how common it really is I felt this liberation" (14).

5.7 Summary

This chapter has discussed the forms of self-blame and feelings of guilt after an IPL. It also explored the different reasons for IPL expressed by my participants, namely medical reasons, unsolved personal issues, and lost chances, as well as the child's will to live. Pregnancy loss not only implies the sudden end of a developing identity associated

with motherhood, resulting in grief and sadness, but also triggers feelings of guilt and responsibility for the death of the unborn. There are many factors that contribute to the emergence of guilt. Probably one of the most crucial factors is the lack of knowledge and understanding of IPLs. Neither women who suffer IPL nor their friends, family, and acquaintances know how to handle such a traumatic situation. Bereaved mothers feel that they could not fulfill their roles of the protector and therefore feel a sense of responsibility for the death of their child. Popular culture as well as the women's movement equates pregnancies as individual achievements which propose that they can be controlled. The advances in antenatal medicine suggest that pregnancies always end happily and an involuntary ending must have reasons, such as failure or malfunction of the women's reproductive ability or unsafe behavior. Women often find themselves in the dilemma of either having the impression of having done something that might have caused the death of the child or admitting of not having any control over their bodies. In both cases, women unnecessarily carry the burden of guilt and responsibility. However, the cause of most of the IPL remains unknown and is neither related to behaviors on behalf of the woman, nor to health-related issues. In light of my analysis of this chapter, I strongly believe that an open discussion and education about pregnancy, including (the frequency of) pregnancy loss, can greatly relieve self-blame and feelings of loss.

NOTES

[1] Since there is modern technology that can determine in an early state of gestation whether a fetus is 'normal' or not, women are expected to have 'normal' and 'healthy' babies in contrast to a baby with a disorder or some sort. As I have experienced it myself,

doctors recommend a selective abortion in cases of genetic or other disorders. Women who choose to abort a possibly disabled child (which despite advanced medical technology not 100% proven) might suffer guilty feelings in a different way and accompanied by other feelings. Borg and Lasker explain that "In cases of selective abortion, there is grief for a wanted child, questions about the characteristics of the baby—not usually seen by the parents—worries about future pregnancies, ambivalence about abortion itself, and guilt—terrible guilt" (57). This guilt is intensified because no one can for sure foresee the actual condition of the child and because there's always the chance of a wrong diagnosis (this is important for expecting parents).

[2] There was a curtailment of her cervix uteri (neck of her uterus) that might have caused an early opening of the os uteri (uterine orifice).

[3] W 7 had to remove a fallopian tube before the age of 24 and had additional problems with her womb and stomach area since the age of 12.

[4] See subchapter 2.4.1

[5] In Switzerland, Kinesiology, also know as "Psychokinesiology" (psycho-kinesiology) is a special form of therapy which operates through muscle tonus. Kinesiology is an alternative and holistic method to cure physical and psychical problems. More information about kinesiology, see http://www.kinesiologieverband.de (European association of Kinesologists) and on the webpage of the International Association of Specialist Kinesiologists http://www.iask.ch/v4.html.

[6] On TV, there are many health programs. Some of them show new reproductive technologies for couples who have difficulties to conceive but also report of premature

births in which children survived. If children are prematurely born in week twenty-six, it's medicinally possible to keep them alive.

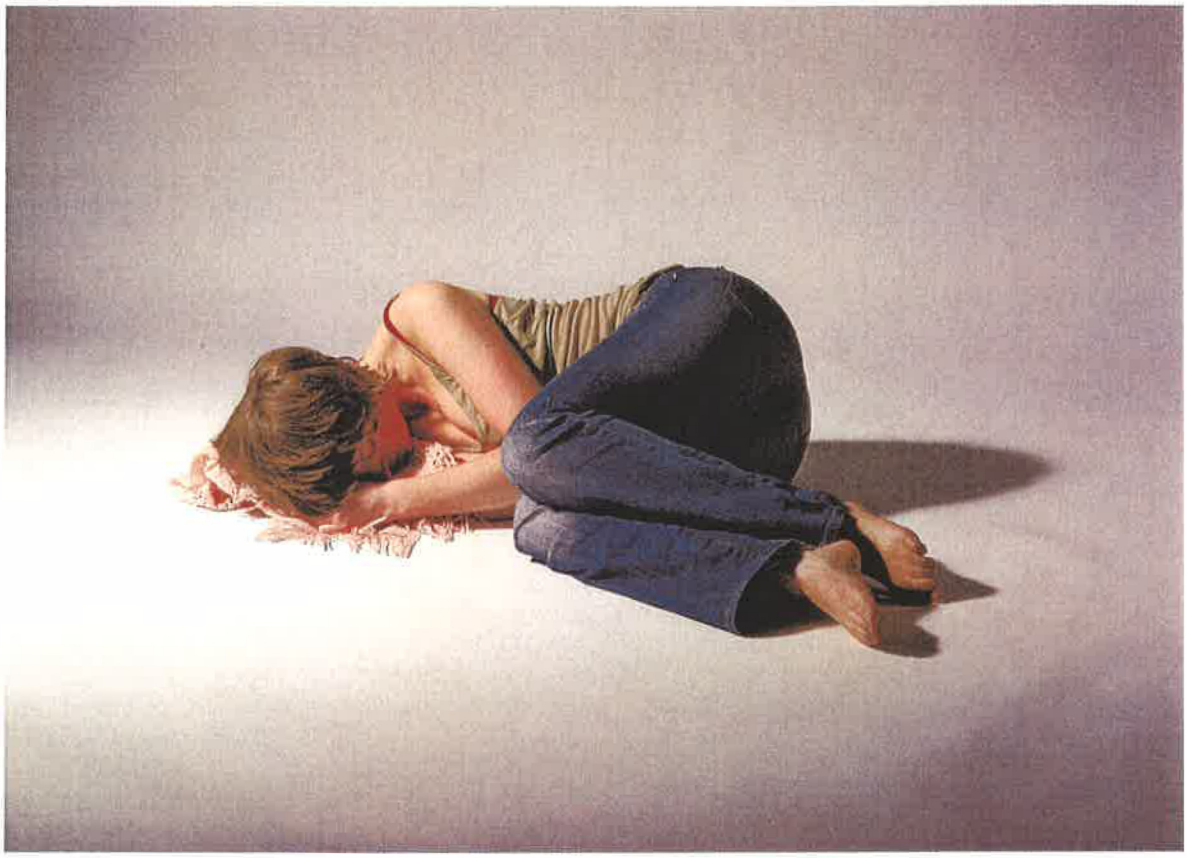

Fig. 7. Photographical Exploration of Reproductive Loss: Emptiness. Subject (W 8):"I was incredibly sad- .. exhausted and empty." (Menzingen, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

CHAPTER VI

CONCLUSION

To talk about reproductive loss means sharing very intimate information. Although the participants agreed to engage in a conversation where a delicate subject was discussed, there might be additional factors, of a psychological (repression, anxieties or simply character trades), social, or cultural nature that impede the successful unfolding of the conversation. Regardless of the participants' culturally mediated cues, which certainly help them process the flow of information by offering frames, schema, and scripts, the interviewee might still be unwilling or reluctant to fully disclose important details and facets pertaining to the experience of reproductive loss.

These factors, which do not have anything to do with shared knowledge or culturally mediated concepts associated with pregnancy and childbearing, cannot be explained by discourse theories nor are they predictable. They are mainly conditioned by psychological and situational factors. It might be useful to briefly look at these factors in order to indicate the complexity of the various layers involved in each conversation.

First, in more than half of the interviews, the contact between the interviewer and interviewee was a fairly recent one. The interviewer was acquainted with four of the participants before the interview, but met six participants for first time at the interview. Any lack of intimacy might be held accountable for the speaker's hesitancy of fully disclosing the impact of the traumatic experience. Second, the speaker may not trust the

interviewer for one reason or another and refuse to fully engage in the conversation. Third, the retelling of traumatic experiences may trigger an upsurge of emotion again which, given the nature of the conversation, might overwhelm the speaker. For the sake of self-protection, the speaker remains within controllable boundaries of emotional reaction. Lastly, and this occurs entirely unconsciously, the psychic apparatus complicates the process of retrieval of the traumatic event for the purpose of causing no further harm to the subject in question.

All these factors constituted a frame that could not be controlled by the interviewer and was not taken into consideration when analyzing the data.
Apart from these factors mentioned above, the participants seemed to feel comfortable during the interview, for there were no obvious signs that one of the above mentioned factors would have negatively influenced their openness.

One crucial reason for the participant's openness was that the interlocutor was probably perceived as part of a conversation about IPL rather than merely an interviewer because she experienced reproductive loss herself and shared this information with the participants. The sociolinguistic interviews, at some point, felt more like a conversation than collection of data for a linguistic research, especially in interviews in which the interviewer and the interviewee knew each other before (see example one in the endnotes of this chapter). But also during interviews in which the interviewer and the interview saw each other for the first time, feelings of friendship and commonness prevailed and the participants shared intimate information.

The most striking features and at the same time the most important finding of this thesis is that when women talk about their experience, the retelling is somewhat scattered

and, at first glance, almost incomprehensible. Throughout the interviews, there are very few passages where a description of a happening is recounted in a straightforward manner. Grice advises to "make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged" (45). As illustrated in numerous examples in chapter four, narration about a very personal topic, such as pregnancy loss, obviously needs background knowledge in order to process and understand (see endnote 1 for an example). The interviewee leaves out crucial information and expects the interviewer to fill in the gaps. Applying one or more maxims would not be enough to obtain meaning.

If a conversation can only be deemed successful, that is, if both speaker and listener cooperate in the verbal exchange by applying one or more maxims, then one might add to this that the participants oftentimes rely on background information. Background information does not explicitly surface in the, but it constitutes the context, linguistic and otherwise, in which the conversation is held. Therefore, the cooperative principle deemed instrumental in the functioning of a conversation must be revised on the grounds that contextual information (referential field) becomes even more relevant when the explicit content of the conversation touches upon traumatic experiences or tabooed subjects. My observation confirms the hypothetical claims stated for this research.

My findings show that the cooperative principle not only applies to the explicit mode of narration but also and probably more importantly, to the implicit forms that subtend the conversation at the same time. Socially sanctioned and culturally conditioned concepts enter the picture at various moments and inform the course and the direction of the conversation itself. Since a taboo is something that ought not to be stated, it becomes

evident that these concepts might be held accountable for the form of narration itself, which, disorganized, scattered, and unintelligible as it appears at times, reflect the cultural and social ramifications at large. However, my research shows that Grice's cooperative principle and the conversational implicature are certainly important when processing narration but inadequate with tabooed subjects such as IPL. The crucial factors as to why the interlocutor is able to fill in the gaps and to fully understand the content of the discourse about IPL lies in the fact that both the participant and the interlocutor have a particular and unique mutual knowledge, namely IPL. The fact that I have my own story of pregnancy loss constituted a common ground on which they could rely on and vice versa.

This mutual knowledge constitutes a narrow frame that is tightly bound to a cultural and historical context.

Lastly, I had the impression that at least some of the women who participated in this study, evidently felt the need and urge to voice what they had experienced. Considering the amount and content of the information collected, I realize that these women wanted to share their experiences for different reasons. First, because discourse about IPL is still considered a taboo which impedes the naturalness of sharing information about reproductive loss with others. Second, there is no public organ to grieve, process, or discuss IPL (as in Japan, for instance). Third, because the interviewer's own experience of IPL allowed establishing a special form of woman talk and provided a welcoming and friendly room for a discussion about a unique feminine experience (Coates 232). Losing a child during pregnancy makes a women feel helpless and guilty. Finding a community or setting where there is mutual understanding to relate

traumatic events and showing willingness to do so might be an invaluable contribution to a growing understanding of what it means to endure the ordeal of stillbirth or miscarriage.

NOTES

Example 1:

W 7: Yes, he [a man] misses out on some things [in terms of pregnancy]. For instance being able to carry a baby in your womb. And I clearly state that [unborn] children belong to both [mothers and fathers] and- and also the process afterwards both have to carry a great deal in term of emotion

I: Hmh Hmh. I agree.

W 7: The only difference is that it's in our belly

I: Yes, you as a woman feel it physically

W 7: Yes but if a man wants he get a lot out of a pregnancy

I: Yes, I think so, too .. Did your understanding of life or death change in a way? [/?/]

Example 2:

I: From the diagnosis to the birth, this is often the time, in which everything stands still. Do you still remember your thoughts or feelings at that time?

W 2: This *was evening and at seven o'clock* we went down [geographical location of the doctor's praxis], yes, I mean, somehow-.. I think- *..I have been crying for the whole night*=

I: =Yes

W 2: =*With the second* [child], I was already prepared somehow, yes sure, I was disappointed and sad, but not in the same way like I was with the first *one* [child]

I: Do you think, the duration was [decisive?]

W 2: [Perhaps this] as well and you were somewhat more prepared, you did think about this could happened again, but with the first one, I never imagined something like that to happen.

I: =Yes

W 2: =Yes

I: =You had one day in order to realize what happened and until the child went away.

W 2: =Yes, she actually already told me *down there*, that *it* is gone, that *it* was not there anymore and, yes, but, until *it* was fully away- it took then-…how long did it go? .. *the next day*, I was at home and the day after, I had to go *down*- .. and on the one hand I was also glad in a way, because I knew, now *everything is out* of me. She told me, *it* would take for sure one week until everything w*ould go away* and then I was actually glad that *everything* went away at once.

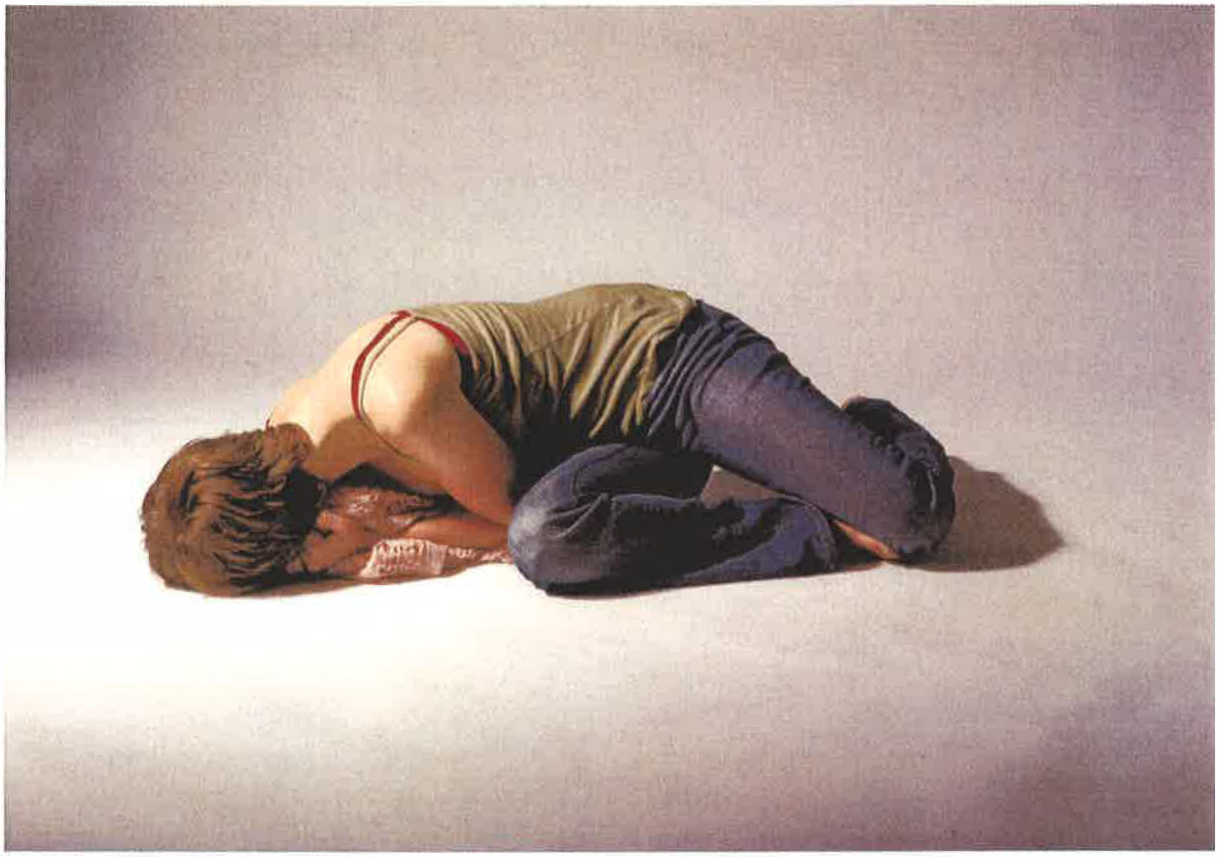

Fig. 8. Photographical Exploration of Reproductive Loss: Sadness. Subject (W 2):"This was evening and at seven o'clock we went down, yes, I mean-, somehow-, I think I have been crying for the whole night." (Menzingen, 2006); Hauser, Barbara, Photography Project For The Master of Arts Thesis (Aarau, 2006).

APPENDIX A:

SCHEDULE OF INTERVIEW QUESTIONS

The schedule of the interview questions used for this research consists of three parts: the questions of the first part ask for information before, the questions of the second part ask for information during, and the questions of the third part for information after the moment in which the IPL occurred.

Before the miscarriage or stillbirth happened

1) Who knew about the pregnancy?
2) Was it a planned pregnancy?
3) Did you have health problems during your pregnancy, and if yes, what kind of problems where they?
4) Did you know about the frequency of reproductive loss?
5) Did this influence you?

Indicators of the impending miscarriage/stillbirth and moment of miscarriage/stillbirth

6) How did the child's death become apparent?
7) What happened between the diagnosis and the actual birth?
8) How did you experience the birth?
9) Do you still remember your thoughts and feelings of those moments?

After the miscarriage/stillbirth

10) Did you try to come up with an explanation?

11) How important was it to have a reason for the sudden death of the child?

12) Did you have feelings of guilt?

13) What was the reaction from your friends and family?

14) To whom did you talk about it?

15) Did you talk to women who lived through the same experience?

16) What value does this occurrence have for you, today?

17) Did the notion of death or life change?

18) Do you want to add something, which is or was important in your eyes that I did not ask?

APPENDIX B:

TRANSCRIPTION CONVENTIONS

The following transcription conventions based on Schiffrin (1987a) and Tannen (1989a) printed in Schiffrin (1994), with slight changes.

I: Interviewer

W: Interviewee. W stands for woman.

. falling intonation followed by noticeable pause (as at end of a declarative sentence) but it does not necessarily have to mark grammatically the end of a sentence.

? Rising intonation followed by a noticeable pause (as at end of a interrogative sentence) but it does not necessarily have to be at a interrogative sentence.

, Continuing intonation: may be a slight rise or fall in contour (less than "." or "?") followed by a pause (shorter than "." or "?")

! Animated tone as at the end of an exclamatory sentence but it does not have to be an exclamatory sentence

../... Noticeable pause or break in rhythm without falling intonation (each half-second pause is marked as measured by stop watch. Two dots mark a noticeable pause of one second)

(2 sec) pauses, longer than ...

- Self interruption with glottal stop

: Lengthened syllable

Underlining emphatic stress

= In order to simplify my data transcription I used = whenever there was not noticeable pause between the interviewee and the interviewer

[ ] When speech from interviewer and interviewee overlapped.

APPENDIX C:

NOTES ON TRANSLATION

All women I interviewed speak Swiss German as their mother tongue. We have different dialects, but there are no difficulties whatsoever in fully understanding each other syntactically, semantically, or in terms of vocabulary. Since Swiss German is not a written but only a spoken language, I transcribed the data into English. A graduate class in translation (Translation of Texts: Theory and Practice) that I took during the summer semester 2006 provided the necessary theoretical and practical knowledge for the translation work. Despite theoretical guidelines, it is often difficult to translate – I tired to convey the meaning and the mood as accurately as possible. From my own experiences with foreign languages, I understand that every language has certain ways of expressing feelings. Compared to other data I have seen, such as in Deborah Tannen's work, Talk Among Friends, Swiss people often make sounds to support each others' speech (as listed in appendix B), while the other person is still talking. This behavior is not to be confused with an interruption, but this peculiarity occurs in most Swiss German dialects. The person who talks does not perceive such sounds as disturbing at all.

APPENDIX D:

CONSENT FORM

Information about the Consent to Participate in the Research of How Women Talk about Reproductive Loss.

WHO IS THE PRIMARY INVESTIGATOR AND HER ADVISOR?

The principle investigator of this research is Barbara Hauser. This research is part of her thesis requirement to earn a Masters of Arts degree in Linguistics at the University of North Dakota (UND) in Grand Forks. Dr. Xiaozhao Huang, professor form the English department at UND is her thesis advisor. Both Dr. Huang as well as Barbara Hauser are available to answer any questions you have about this research. You are welcome to ask any questions regarding this research or about your rights at any time of this study. If you have questions about this research, please call Barbara Hauser at 001-777-9281 (USA) or 041 820 4110 (Switzerland) or Dr. Xiaozhao Huang at 001-777-3321. If you have any other questions or concern, call Research Development and Compliance at 001-701-777-4279.

WHAT IS THE PURPOSE OF THIS STUDY?

You are invited to participate in a study of how women talk about reproductive loss, a subject which is still a taboo. Many women feel that they were the only ones having experienced a loss of a child during pregnancy, even though one in four pregnancies end in miscarriage or stillbirth. Barbara Hauser will conduct sociolinguistic interviews, that is, the interview is more similar to a conversation than an inquiry and the participant is encouraged to ask questions as well. Her method of research will be open-ended questions with women who have experienced stillbirth or miscarriage. Every participant can provide as much information as she wants. Barbara Hauser expects the results to be a study of language use in discourse in which a woman, who suffered reproductive loss, talks about her experience. This study can be an important contribution to the understanding of reproductive loss.

WHO CAN PARTICIPATE AND WHAT ARE THE PROCEDURES OF THIS STUDY?

Subjects who participate in this study have suffered one or more miscarriages or stillbirth. The investigator will conduct interviews with ten women from her circle of friends or

women who answered the information sheet in Romy Hauser's shiatsu practice in Beckenried, Switzerland. This means that there are two groups of subjects. One group consists of women whom she personally knows and one group of women whom she does not knows before the interview. If you participate in this study, there will be only one interview which will last approximately one hour. The interview will be conducted either at your home or in a different place suggested by you—wherever you feel most comfortable. Barbara Hauser would like to observe how women retell their experience of reproductive loss and what kind of information women share with the investigator respectively, or what is said and what kind of information is left out because it is assumed that the interviewer is able to draw upon mutual knowledge. There will be three sections of open-ended questions (what was before, during and after the loss of the child) and you can provide as much information you want. The investigator will not ask for more information than you want to share. She will tape-record all interviews with the written consent of the subject. This is necessary to ensure accuracy of the data.

RISKS AND BENEFITS OF PARTICIPANTS

No physical, psychological, or financial risks are anticipated that could harm you during the study. The investigator will provide you with a list of all the questions that she will ask you during the interview. If you feel these questions will harm you emotionally or psychologically you are highly encouraged not to participate. The questions of the interview are open-ended, that is, you can provide as much information you would like to share, but no more. You have the right to withdraw from the interviews at any time including the analysis of the data without consequences and statement of specific reasons. There is no penalty, as agreed on the signed consent form. When you decide to withdraw from this research all the data collected related to you will be destroyed (transcriptions will be shredded and tapes will be destroyed). The investigator ensures privacy and anonymity. All materials related to the research will be stored in a locked drawer. Data (tape-records and transcriptions) and consent forms will be stored in two different places that can be locked. The only two persons who have access to the original data will be Barbara Hauser (primary investigator) and Dr. Xiaozhao Huang (advisor). If you mention names or places, the investigator will change such information that could identify you, including the data which is possibly obtained. The original data remains confidential.

Your participation in this study may result in a better understanding of reproductive loss. The ways in which a woman retells her experience gives insights into what she expects the investigator to know.

If you accept the idea of this research and decide to participate in it, you will receive a copy of this the signed consent form. The investigator will also provide you with a handout consisting of all the questions that will be asked during the interview in advance. Please feel free to ask any questions you have concerning this research before during or after the interview. Questions may be asked by calling Barbara Hauser at 001-777-9281 (USA) or 041 820 4110 (Switzerland) or Dr. Xiaozhao Huang at 001-777-3321.

AGREEMENT TO PARTICIPATE

I have read and understood this form and the research procedures. All of my current questions about my participation in this study have been answered, and I was informed and encouraged to ask any questions I may have concerning this study in the future.

I, _____, have read all of the above and willingly agree to participate in this study as explained by Barbara Hauser.

_____

Signature Date

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