

## RESEARCH ARTICLE

## Support and destigmatization in early pregnancy loss in Spain

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## Abstract

Early miscarriages are a frequent reproductive event, often silenced and shrouded in stigma. Feminist anthropology has pointed out how such losses challenge the widespread Euro-American social representations of motherhood and pregnancy, as well as societal unease with death. This article draws on a project focusing on the experiences and needs of those who undergo a miscarriage during the first trimester in Spain, based on 580 h of participant observation in ob-gyn care and 60 interviews. In Spain, several grassroots organizations offer peer support and try to act upon silence and stigma around pregnancy losses, with an impact on the biomedical sphere that has led to the development of guidelines for pregnancy loss care. However, in our article we will show that support is mostly built on a grief model, leaving specific support needs for first trimester miscarriages uncovered at both the emotional and medical level. This grief-centered support, overlook the distinct embodied and social experiences of early pregnancy endings, inadvertently deepening the very hierarchy of loss it aims to counteract. In doing so, we address a gap in feminist anthropological research by mapping the stigmatization processes and unmet support needs hidden beneath the widespread call to break the silence.

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## INTRODUCTION

In July 2023, the president of the Autonomous Community of Madrid in Spain, Isabel Díaz Ayuso, announced that she was canceling her attendance at a public event due to a miscarriage she suffered at eight weeks. Her declaration stirred expressions of sympathy as well as antagonistic comments from fellow Spanish politicians across the political spectrum, as well as on television talk shows and social networks. Given that Ayuso's political party, the Partido Popular, has a strong stance against abortion rights, some criticized the politician for weaponizing her personal reproductive history when opposing measures designed to facilitate abortion (Ortiz, 2025). Importantly, after Ayuso publicly discussed her miscarriage on primetime TV, media outlets portrayed her as "breaking the silence" on a taboo topic, noting how other women have shared their miscarriage stories (Arriaza, 2025; Pedreños, 2024).

The generalized statement about the social silence around these early pregnancy losses and the solitude experienced by women constitute both, a popular narrative and a strong political claim about miscarriage (Browne, 2025). Commonly defined as the spontaneous loss of a pregnancy before fetal viability, miscarriage affects approximately between 10 and 20% of all pregnancies (SEGO, 2010). Early losses such as Ayuso's, occurring before the end of the first trimester (SEGO, 2010), should account for 85% of all miscarriages although estimations are indirect (SEGO, 2010), and constitute the focus of this article.

This article draws on qualitative research carried out in Barcelona (Spain) to explore how processes of stigmatization and issues of social support are perceived by pregnant women, their partners, and healthcare professionals. These dynamics often operate beneath a generalized pressure to break the silence—a pressure that, on its own, is insufficient to grasp the multiple social dimensions in which the complexity of early miscarriage is embedded. We focus on the various hierarchies of silencing that shape first-trimester miscarriages at the familial, community, and healthcare levels. Furthermore, we argue that a grief frame frequently works against other dimensions of the miscarriage experience, thereby compromising the quality and appropriateness of the physical, emotional, and social support that individuals require.

Situated within the broader framework of anthropological research on pregnancy loss, our article centers on first-trimester miscarriages, paying particular attention to linear and teleological ontologies of pregnancy (Kilshaw, 2026; Middlemiss, 2024) and their related hierarchies of loss (Middlemiss and Kilshaw, 2023). Most feminist anthropological studies encompass miscarriages across all gestational ages, up to viability, and often examine different kinds of miscarriages together, whereas the specificities of first-trimester miscarriages remain comparatively neglected. We address this gap in feminist anthropological research—the relative neglect of first-trimester losses—by mapping the stigmatization processes and unmet support needs hidden beneath the widespread call to break the silence.

## The anthropology of pregnancy loss and miscarriage

From its beginning feminist anthropology built on a heavily gendered topic such as human reproduction and its politics (Ginsburg and Rapp, 1991; Rapp, 2001). Still, miscarriage, or rather, pregnancy loss (a wider category that encompasses miscarriage and also includes

abortion), has received comparatively less attention than other topics (Layne, 2003; Kilshaw, 2020; Andaya and Kotni, 2022). The field of reproductive anthropology started in the early 1990s, with the work of Linda Layne (1990). Her contribution (Layne, 1996) featured in the first volume on miscarriage in socio-cultural anthropology (Cecil, 1996), and her monograph was the first on the subject (Layne, 2003). Pregnancy loss is indeed a “reproductive disappointment” (Bennett and De Kok, 2018), or “problematic reproduction,” crucial to the understanding of global politics of reproduction (Rapp, 2001, p. 469). It interrogates the socio-cultural, political, and moral meanings of pregnancy, kinship, and parenthood, and overlaps with morally charged topics, such as abortion (Layne, 2003; Kilshaw, 2020; Middlemiss, 2024), disability (Siegl, 2024; Jones, 2025), infertility (Bennett and De Kok, 2018), and the end-of-life (Kaufman and Morgan, 2008). From an approach sensitive to language and definition, Middlemiss (2024) reviews feminist anthropology’s history of discomfort in engaging with pregnancy loss, as the forms of grief this experience takes are often grounded in claims of fetal personhood (see also Layne, 2003). However, acknowledging the complexities of pregnancy loss as an experience is precisely a way to defuse the anti-abortion rhetoric pitting fetal rights against pregnant people’s right to terminate a pregnancy (Layne, 2003; Middlemiss, 2024).

As Kilshaw (2020) reminds us, anthropological analysis of miscarriage provides a window into the uncertainties of reproduction in the era of medical and technological management of reproductive risk (Rothman, 2014) whose moral, physical, emotional and material burden falls, mostly, on pregnant individuals (Hammer and Burton-Jeangros, 2013). For Kilshaw (2020) miscarriage makes visible and subverts boundaries that rituals, technology, medicine, and law contribute to produce and manage. Boundaries between life and death, or between maternal and fetal bodies, but also, boundaries between medico-legal categories (such as miscarriage and stillbirth, baby or fetal remain, viable and non-viable fetus), or social categories (such as motherhood, or kinship).

Feminist anthropology has engaged with the topic of silence and support around miscarriage and pregnancy loss, with silence being linked to stigma. Pregnancy constitutes a liminal status in many cultures, and people who have been pregnant but do not have a living child as a result, remain in a limbo (Layne, 2003; Middlemiss, 2024), which is also a testament to the liminal status of dead embryos and fetuses (Layne, 2003; Morgan, 2009; Giraud, 2020; Middlemiss, 2024). The reproductive governance of the fetal body in pregnancy loss (Middlemiss, 2024) brings forth fluctuating definitions of personhood, kinship, and motherhood that may sharply contrast with lived experience (Layne, 2003; McIntyre, 2024; Middlemiss, 2024; Kilshaw, 2026). Thus, Layne (2003) posits that the taboo surrounding miscarriage and pregnancy loss in general does not stem from the insignificance of this reproductive event. On the contrary, it is a way of managing the extreme relevance this liminality acquires in contemporary societies (Layne, 2003). Crucially, pregnancy loss challenges “narratives of lineal progress” (Layne, 2003) or “teleological ontologies of pregnancy” (Franklin, 1991; Middlemiss, 2024). Both ideologies cast pregnancy as a linear, uninterrupted process of fetal development, leading from conception to the term birth of a living, and, eventually, a healthy baby.

Within this sociocultural framing of pregnancy, Middlemiss and Kilshaw (2023) point out that different pregnancy losses are granted different degrees of social recognition. The degree of closeness to the pregnancy, gestational age (with the correlated stage of fetal development), reproductive history, other losses in one’s social circles, and the circumstances surrounding both the pregnancy and the loss, all contribute to creating “hierarchies of loss” (Middlemiss and Kilshaw, 2023). Such hierarchies have also been noted for Spain (Cassidy, 2021).

Crucially, feminist anthropology has shown that miscarriages are reproductive events shrouded in social silence (Layne, 2003; Kilshaw, 2020). Miscarriage challenges social discourses and practices of motherhood, parental identity, pregnancy, babyhood, and fetal

personhood, while, at the same time, stirring the unease and denial that characterize contemporary attitudes towards death and grief (Layne, 2003; Memmi, 2011; Kilshaw, 2020; Freidenfels, 2020; Giraud, 2020; Middlemiss, 2024).

However, the insistence on breaking the silence has been criticized from feminist theory. Browne (2025) shows how injunctions to break the miscarriage taboo reinforce the idea that miscarriage is an individual's misfortune whose stigma can be eliminated through education. Yet, as Browne (2025) posits, stigma is experienced differently depending on the "social inequalities" (2025, p. 210) that shape the individual's trajectories, as reproduction is fundamentally stratified—encouraged and protected for some groups, delegitimized for others (Colen, 1995). More importantly, Browne argues that miscarriage stigma is actively produced and maintained by neoliberal and patriarchal power structures, as well as enacted through the driving force of institutions and markets. In this article, following Browne's conceptualization (2025), we posit that the silence around miscarriage is part of a wider politics of reproduction (Ginsburg and Rapp, 1991), and actively produced and managed at a social level (Browne, 2025).

## Sociodemographic context of early pregnancy losses in Spain

Over the last decades, Spain has undergone profound demographic transformations that shape the current context in which early pregnancy losses occur. Like other European countries, Spain is deeply affected by the global decline in fertility, reaching one of the lowest figures in the world in the late twentieth century (Kohler et al., 2002; Alvarez and Marre, 2021), as well as one of the oldest first-time motherhood ages globally (32.6 years in 2024). The number of women who become mothers after the age of 40 has doubled over the last two decades, and births to women over 40 have outnumbered those to women aged 27 (Instituto Nacional de Estadística, 2024).

These changes are the outcome of wide-ranging social and cultural transformations over the last decades which include the massive entry of women in the labor market, the expanded access to higher education, the widespread availability of contraception, and the normalization of reproductive choice. Indeed, precarious employment, gendered inequalities in care responsibilities, and the high cost of housing weigh heavily on decisions around whether and when to have children (Alvarez and Marre, 2021). In this context, many people resort to assisted reproductive technologies, to address medical infertility, age-related fertility decline, absence of a partner, or the lack of male gametes in same-sex couples. In Spain, ART now accounts for 12% of all births, and between 45 and 48% of these treatments involve gamete or embryo donation (Sociedad Española de Fertilidad, 2023). Yet, miscarriage rates remain high and age-dependent: after IVF with autologous oocytes, the miscarriage rate is 16.1% in women under 35 and rises to 36.4% in women over 40 (Sociedad Española de Fertilidad, 2023). In a demographic landscape marked by postponed motherhood and widespread recourse to medically assisted reproductive technologies, early pregnancy loss therefore carries a heightened individual and social significance.

In Spain, where our research takes place, the call for miscarriage awareness constitutes a political agenda for grassroots associations (Esku Hutsik n.d.; FEDUP n.d.; Sujoy, 2022; McIntyre, 2024; Petits amb Llum, 2024), and professional corporations (Gómez-Ulla and Contreras, 2022). Awareness actions on the International Day of Perinatal and Neonatal Death (October 15) include projecting light shows on monuments or launching memorial websites that list the names of lost babies (Umamanita n.d.). On occasions, such as during Ayuso's public disclosure of her miscarriage, the media amplify these calls for awareness (Sánchez, 2024), especially at a local level (Redacción Radio Vigo,

2025; Tejero, 2025). Under pressure from grassroots organizations, some cemeteries have now specific corners or spaces for the inhumation of stillborn or memory spaces (McIntyre, 2024).

Miscarriage stigma in all gestational ages reflects, and is strongly related to, stigma concerning voluntary termination of pregnancy. Despite an ostensibly liberal abortion law, abortion in Spain is a highly stigmatised reproductive event (Lucas and Comas d'Argemir, 2016; de Zordo, 2016). Barriers to accessing timely abortion persist, with inequalities between geographical areas (Estévez Jiménez and Cruz Piqueras, 2024; Mundi López, 2025). Most terminations are performed in the first trimester of pregnancy (Ministerio de Sanidad, 2025a). The Spanish model for provision of abortion is based on private clinics, which have traditionally provided the bulk of termination, with fees subsidized, in most cases, by regional taxpayer-funded healthcare budgets (Ministerio de Sanidad, 2025b). In the last 10 years, the percentage of terminations performed in taxpayer-funded facilities, such as public hospitals or local healthcare centres have augmented, albeit with significant inequalities between regions (Ministerio de Sanidad, 2025b).

## MATERIALS AND METHODS

This article is based on an ethnographic research focusing specifically on the experiences and needs of those who experienced an early loss during the first trimester of pregnancy, carried out during 2023 and 2024. The study draws on 600 h of participant observation in a primary healthcare center, and a third-level public hospital in Catalonia (Spain), as well as 60 interviews: 32 with people who had lost at least one pregnancy in the first trimester, 9 with their partners and friends, and 19 with healthcare professionals. For this article, we will rely solely on interviews' data.

Pregnant people identified themselves as women. They were between 31 and 44 years of age, with a majority (17 participants) between 36 and 39 years of age. All the women interviewed lived in Spain at the time of the interview, with a strong prevalence of women living in the autonomous community of Catalonia, specifically, 13 of them in the city of Barcelona and 10 in other parts of the autonomous community. Participants were mostly Spanish except for seven identified as Argentinian, Brazilian, Moroccan, Italian, and Senegalese nationals. The sample was composed mostly of people who had completed tertiary or university education and were holding job positions that allowed them to cover their needs.

As for healthcare professionals, 15 were obstetric/gynecologists and midwives, working in maternity services and maternal-fetal medicine services in hospitals and primary healthcare centers in Catalonia. However, our sample also included two receptionists at healthcare facilities, and two psychologists specialized in perinatal health and losses. Participants were recruited through posters disseminated in healthcare centers and on the social media of our research group. Interviewed participants' consent was either tape-recorded in spoken form or collected in written form. Interview transcripts were pseudonymized.

Data collection was followed by an analysis of semi-structured interviews and field notes using Dedoose software (2023). The analysis aimed to identify participants' expressions regarding the social support they perceived and effectively received from partners and relatives, as well as from their wider social networks, including social organizations and health professionals. We applied a combined inductive-deductive coding strategy. First, an initial set of codes was developed based on the research questions: types of social support, experiences in healthcare, disclosure, and so forth. Then, through repeated readings of the materials, we refined and expanded this codebook to incorporate emergent themes arising directly from participants' narratives. Coding was carried out independently by members of

the research team, and discrepancies were discussed until consensus was reached. This systemic approach made it possible to trace both common patterns and internal variations across participants' accounts.

## FINDINGS AND DISCUSSION

### Good intentions are not enough

Although public discourses increasingly frame miscarriage as a loss that deserves empathy and visibility at all stages, participants' accounts show that early losses occupy an ambiguous place. Many of them described how the early stage of their pregnancies was used by their relatives and friends as an argument to minimize or relativize their experiences. Many participants shared an understanding of early losses as less relevant than later losses in their interviews and they felt that their experience was less life-shattering than a second- or third-trimester loss. However, they stressed the personal and subjective value of these reproductive events (Kilshaw, 2026) and how it was a relevant one for them, nonetheless.

For example, Nadia and Antonia, two unrelated participants, were both told that losing a pregnancy early was preferable to losing one later. In contrast, Marisela was told that "nature is wise." Meanwhile, Teresa's mother-in-law urged her to view her miscarriage as merely "a period," reinforcing the idea that early pregnancy losses are minor reproductive events. These kinds of expressions reflect a widespread, naturalized discourse—one that participants themselves had internalized. Reflecting on her social support, or lack thereof, Teresa says:

"Helping a person who is feeling down is very difficult. I mean, managing sadness or helping someone manage it... Then the comments people make to try and cheer you up are very unfortunate, and they're like: "Come on, it's nothing, I mean, come on, think about the good things you have," and I'm like, yes, that's fine too, but I just want to be allowed to feel bad for a couple of days."

Participants noted that this type of response was not ill-intentioned, but they perceived it as a way of categorizing their experience within a hierarchy in which early miscarriage is located at the bottom. Julia is conciliatory when she discusses how her family and in-laws minimize her loss, as she says they do it out of a desire to protect her; yet this only made her upset with them. Nelo, whose wife had an early miscarriage, attributes his family's disappointing reaction to lack of education:

"Telling the family was an absolutely terrible idea. Precisely for that reason, because of the comments like: "no, it's nothing," "It was no big deal..." Both families behaved badly, from our point of view, out of a lack of understanding."

Silence was, in some cases, an individual choice. Naima did not disclose her pregnancy, nor her miscarriage, "in order not to worry" her family. The idea of miscarriage as unsettling for those who are not living it, has been repeated by Júlia, who had a scan to confirm her pregnancy test after a fertility treatment; the scan, instead, showed that the pregnancy was not evolutive. Júlia had spent the time in the waiting room browsing online catalogues of maternity clothes with her mother-in-law, who had offered to purchase them for Júlia's birthday. After the scan, she felt she was "letting her family down" with her miscarriage, after the happy news of achieving a positive test.

Parents and in-laws are often the bearer of well-intentioned, insensitive remarks or advice. Aina remembers her mother-in-law, on the night of her early miscarriage diagnosis, scolding her and her husband: "I don't want to see one more tear: this was nothing." Some participants complained about the uncanny silence their relatives or friends observed about the miscarriage, failing to ask any question or to mention the event altogether. Others, instead,

were positively surprised by the supportive attitude of relatives or work colleagues, whom they would not have credited with tact or sensitivity, or with whom the relationship was not very close to begin with. Surprise intervened also when research participants who shared their miscarriage with older relatives, become, in turn, recipient of disclosure. Their own parents, parents-in-law, or other elder family members opened up about miscarriages happened decades ago in the family, and never revealed before.

Some research participants recall feeling downright offended by some of their relatives or in-laws' insensitive behavior. Saskia, Aina, and Lia felt taken aback by, respectively, a bad-taste joke, a badly timed pregnancy announcements, and family gossip on another pregnancy in the family.

In general, participants valued positively when friends, family, and colleagues acknowledged the miscarriage and offered material or emotional support in a way that was sensitive to the miscarrying person's needs and privacy. Support was sometimes found among weak ties. Both Saskia and Júlia used social media to share their experiences. Both were overwhelmed by the number of responses by people who they do not know very well, or even not at all, and had gone through the same experience.

## Experiences with peer support groups

Faced with what is perceived by participants as a lack of support and as evidence of a failure to understand their experiences, some turned to peer-support associations. In Spain, perinatal loss associations are present in most of the national territory (McIntyre, 2024). They offer peer support to people experiencing a loss, promote events, lobby in the public sector, and disseminate informative material aimed at breaking silence and stigma around pregnancy losses (Cassidy, 2021; McIntyre, 2024). The presence of grassroots activism is a testament to changes in understanding the meaning of miscarriage. Nevertheless, although these associations publicly emphasize inclusivity and describe themselves as spaces for "perinatal grief" encompassing all losses -from miscarriages at any stage through stillbirth and neonatal deaths-, participants who attended such groups after an early miscarriage often found themselves surrounded by people who had experienced late pregnancy loss or stillbirth. Among those participants, Mónica acknowledges that the other members validated the realness of her loss and her emotions about it, but she felt a gap between her own experience of loss and what other participants told about theirs. In her interview, she explained this legitimization issue:

"I never felt comfortable with [Association Name], because [...] it's like everyone else had lost their babies after many weeks. And in my case, it was in the first trimester [...]. If you lose your baby at six or seven months, it's... Damn, what a tough experience, how hard. And it's really hard. But losing your baby at three months (of gestation) is also hard, you know? So, when they asked me if I had named him, no, I hadn't named him, but that doesn't mean it hurts any less, right? There's no scale of it hurts more or it hurts less. We've all lost our babies."

Similarly, another participant, Martina, noted that she was also satisfied with her experience with the local support group, but other peers in the support group, sometimes, described earlier miscarriages as comparatively insignificant. She recalls:

"But there are people who have had more than one baby who have died—and they talked about the first miscarriages, such as mine, [...] as if it was nothing, you know? But me, of course, my miscarriage, well, how could it be the same? Of course, I was saying: 'God, on top of everything else, I can't even feel it here, not even here'"

Another participant, Marisela, found that attending a group with people who had losses at later stages was helpful for her, precisely for this mixedness. Yet, she felt that it was not her place:

“It was a meeting where the other women’s pregnancies were further along than mine. And of course, I felt that my experience was horrible, but that was because it was my child, and the others were much further along. And I felt like I didn’t belong there.”

These testimonies highlight that peer-support networks, despite their intention to provide solidarity, can also reproduce hierarchies of gestational age. Participants did not describe rejection by others, but a sense of experiential mismatch: their form of loss and how they felt about it seemed to require justification even in settings meant to validate all experiences. These dynamics point toward a larger pattern: early pregnancy loss occupies an unstable position in the moral and emotional landscape of reproduction (Middlemiss and Kilshaw, 2023). Participants encountered a form of double marginality or double stigma (Peel and Cain, 2012; Middlemiss and Kilshaw, 2023): the general stigma surrounding miscarriage combined with the specific minimization of losses occurring in the first trimester. Moreover, this hierarchy was not limited to social interactions or support groups, as it also appeared in participants’ experiences with the healthcare system, as explored in the next section.

## Biomedical categories and clinical minimization

Biomedical discourse constitutes a driving force in shaping common understandings of reproduction and pregnancy (Purdy, 2001; Clarke et al., 2003; Lock, 2004; Rabinow and Rose, 2006), and this phenomenon has been observed for Spain (Imaz, 2010; Cerezuela et al., 2026). Medicalization has shaped discourses and practices on several reproductive events such as pregnancy (Han, 2013), birth (Davis-Floyd, 2001) or aspects of life and body, such as illness and death (Frost et al., 2007). Miscarriage is not an exception. Participants’ accounts show that hierarchies surrounding pregnancy loss depend on the trimester in which it occurs and shaped their encounters in the clinical setting. Many interpreted clinical routines or protocols, waiting times, and biomedical terminology as indicative of their early loss being considered less significant than later ones. This perception was not necessarily attributed to professionals’ individual attitudes, but rather to how miscarriage care is organized and conceptualized within biomedical settings (Colavolpe-Severi et al., [Forthcoming](#); Remorini et al., 2025). For instance, one of the most common experiences was the long time women waited in emergency departments during an early-stage miscarriage. Unlike other countries, as the United Kingdom (Keeney et al., 2022), maternity hospitals in Spain usually do not have specific early pregnancy units. Early pregnancy scans are only offered routinely in the case of assisted reproduction treatments, to confirm positive results in blood or urine tests. Thus, most of our study participants who had a miscarriage confirmed by ultrasound received their diagnosis in emergency wards. Emergency obstetric care in Spain is usually provided by the same team as (and in spaces adjacent to) delivery rooms and birthing units. Raquel expressed emotional discomfort at being seated next to a woman in the emergency waiting room that she defined as “*embarazadísima*” (very pregnant). Suzanne, who had learned she was pregnant only days before her loss, felt out of place surrounded by visibly pregnant people:

“Well, they received me in the maternity waiting room, so it was a bit torturous, because obviously there were a lot of pregnant women there, and I saw women with big bellies, small bellies, large bellies, touching their bellies...”

Pregnancy was not visible on the research participants’ bodies, yet they were aware of being pregnant. These episodes represent the visual and material aspect of metaphorical invisibility. Ariadna echoes this contradiction when reflecting on the kind of resources one can

find in the clinical settings. She underlines these resources are all oriented towards the end of pregnancy, such as breastfeeding or puerperium:

"I was very surprised that there are groups that focus on the end of pregnancy or postpartum and breastfeeding, which I understand is very necessary, but there is nothing else. There is a lack of support for women throughout all stages. There are no groups to talk about menstrual pain. There are no groups to talk about the pain of loss."

## A cumulative event

The medical realm is one of the social arenas where silence and hierarchies of gestational age are most noticed by women living their miscarriage. It also constitutes an arena where comprehensive and holistic care are requested bottom-up (Rowlands and Lee, 2010; Séjourné et al., 2010; Cassidy, 2021). In the medical settings, lack of support can be amplified by insensitive care (Rowlands and Lee, 2010; Cassidy, 2021; Desy et al., [Forthcoming](#); Remorini et al., 2025).

Biomedical classifications in some cases contributed to the minimization of experiences, as the medical framework defines what is considered legitimate evidence of pregnancy and loss (Ellison, 2003; Kilshaw, 2026). Both Raquel and Elisa found themselves negotiating with medical staff over whether their pregnancy, that was lost before first ultrasound detection, counted as a pregnancy, and consequently, if their losses could be considered as an early miscarriage. Raquel explained:

"Yes, it's true that... the doctor was very nice, but there was a comment like: 'How many miscarriages have you had?' And I said: 'I had a miscarriage at three weeks and a biochemical pregnancy'. She said: 'Well, clinically speaking, you've only had one. You haven't had two'. And I said: 'Yes, but I've had two'. And she answered: 'Yes, but I'm only going to record one miscarriage, because the other one doesn't count'. Apparently, biochemical miscarriages are not considered clinical miscarriages."

Similarly, Elisa recalled her reaction to an infertility specialist labelling her pregnancy as "biochemical":

"[The gynaecologist] came to tell me: 'This has happened, but no'. [...] And I said to her: 'Please, don't invalidate my pregnancy'. She said: 'Well, that's the protocol, this is the name'.— 'I don't care what you want to call it, but don't say that this wasn't... that this was a biochemical pregnancy, because it was a six-and-a-half-week pregnancy. I had pregnancy symptoms, and even though you didn't see it and there was no ultrasound with an embryo, I was pregnant. Don't invalidate it' [...]"

Contrasted meanings of the early biochemical losses are all more important if we consider that miscarriages are medically and socially constructed as iterative and cumulative reproductive experiences. After their loss, our participants often hear, from laypeople and clinicians, that one early loss is understood as a normal part of a reproductive history. Instead, from the second, or, more often, the third loss on, specific exams are proposed.

Saskia recalls her checkup with her gynecologist after her second loss: "This time the doctor was a bit more understanding, partly because it was my second loss, so I was given a bit more attention". Mónica felt touched by the doctor who diagnosed her second loss, and reports on her words: "she was the one who said: 'well, let's try to... Normally we don't do this after a second miscarriage, but we will try to have the tissue analyzed to see if we can... find some information.'"

This cumulative effect modifies the politics of silence when more than one miscarriage or other pregnancy losses occurs. Beatriz became more outspoken about miscarriage after her second loss. Nina shared her first loss, in the second trimester, with her family, and was so

aggrieving that she decided to keep the silence over her subsequent first-trimester losses. Elisa, who also had multiple losses, tells us about her mother:

“She does not know the whole story, she knows about the first miscarriage, but the others, I have played them down a lot, a lot, because she got so upset, that... that I felt that I had to... console her, and I decided she was not helpful, she was a burden. And I did not want it to be this way.”

## Grief and hierarchies of loss in clinical care

Across interviews with obstetricians, gynecologists, midwives and perinatal psychologists, the topic of silence and support, as well as the subject of hierarchies of losses, was broached. Often, this issue was linked to “*duelo*” (grief) as an operative framework from clinical psychology. In our interviews, grief condensates both the emotional pain of loss, and the process of overcoming this reproductive event, integrating it in one’s lived experience. Healthcare professionals repeatedly framed pregnancy loss, including early losses, through the language and conceptual tools of grief. For instance, the term “*duelo gestacional*” or “*duelo perinatal*” (gestational/perinatal grief), which is often part of titles and names for peer support groups and associations, was also found within the clinical setting. Some professionals interviewed pointed out experiences of perinatal loss associations, or perinatal therapists, being involved in improving care for miscarriage and, more widely, for loss, in the clinical sector. Within this context, the use of grief as a framework can be seen as the result of this collaboration, as well as a testament of the fact that grief frameworks have gained increased institutional legitimacy across perinatal care in general (Mitchell, 2016; McIntyre, 2024). When discussing losses, healthcare practitioners explicitly pointed out that an understanding of grieving processes and its psychological mechanisms is crucial to a comprehensive care of this reproductive event:

“The losses in the first trimester [...] I think because you know it’s relatively common, and even though you know that the patient may not know this and her grief will be different, well, it’s you, you deal with it differently” (Obstetrician)

“Some women experience it as the loss of a child, while others see it as a formality. So, for me, the balance lies in knowing how to support those who experience it as the loss of a child: asking them how they are or if they had a name for the baby and allowing them to give it meaning. On the other hand, for those who see it as a formality, don’t make them say, “But what you lost was a child!” Sometimes what I say to them is, “Well, this baby, what happened, is part of your family tree.” So put it where you want to put it. Many try to downplay its importance, and if that makes them feel better, that’s fine, but there are those who try to act as if it were nothing, when deep down they are suffering” (Midwife).

Grief frameworks are embedded in some clinical behavior. When asking a reproductive medicine specialist about the timing of resuming treatment after a miscarriage:

“It depends, because for some patients, it helps them to start again and get distracted this way, it is also a way to leave it all behind. Others really need to grieve and sometimes, three, six months... it depends on each patient’s situation. Sometimes six months could have a detrimental impact, depending on the patient, but yes, at least, three months I think are needed” (Gynaecologist)

And one of the gynecologists of maternal-fetal medicine expressed her clinical preferences based on, in addition to other criteria, its positive impact on grief:

“Look, I don’t like curettage. First, because the woman may not be conscious. If you take away her awareness of what is happening to her, I think it makes the grieving process more difficult. In other words, in order to heal from a situation, you have to experience it. If you don’t

experience it, it's very difficult to heal. You're left with a feeling of emptiness, of 'it was there and suddenly it's gone; they've taken it away from me,' and I don't like that part." (Obstetrician)

Within this frame, some professionals acknowledge that grief can look and feel different across different people and there is no one-size-fits-all grief policy, emphasizing the importance of asking and listening to the person who is having the miscarriage. In general, several professionals referenced ongoing efforts to welcome all people experiencing pregnancy loss, at any gestational age, into the broader institutional discourse of perinatal grief.

The grief paradigm was also present in the interviews with women who lost their pregnancy. They use a language of "duelo" (grief), "closure" (*cierre*) or "farewell" (*despedida*), which they sometimes linked to mourning rituals that can take different forms (McIntyre, 2024). When one of the authors met Astrid for her interview, on a weekend morning, Astrid said she had been out late the night before with her friends, because one of them had just broken up with her boyfriend. Interestingly, this is also the kind of outing that Astrid and her friends had chosen to grieve Astrid's pregnancy, some months earlier:

"Me and my friends, I was lucky that... when I explained it to them, they were really supportive, they were there for me, they said if I wanted to do some kind of mourning, of course, it's... something you've lost, right? It's like a family member you've lost, of course, you get your hopes up and all that."

Elvira describes the work he did with her therapist as "grief work." And when Nieves, some months after her first-trimester loss, found herself underperforming at work, her therapist correlates that episode with grief:

"So, I spoke with the psychologist, who asked me what was the expected due date of the embryo you lost nine months ago? And I said: now. She said it was this, that I had changed my grief phase, it is not a pregnancy grief anymore, it is a postpartum grief and it is when these things happen, this is going to change, you are going to see it differently, you will feel like that, because the kind of grief you are going through is different."

Some professionals use grief as an equalizer of hierarchies of loss. An obstetrician recalls how early loss care was improved in their workplace:

"The obstetrics team saw that the pregnancy loss was not being handled well on an emotional level, and that this had a very significant impact on women, and that something had to be done. So, they have given this issue significant importance and now treat these women as they would those in their second or third trimester, that is, they provide support and collaborate with psychologists and psychiatrists." (Obstetrician)

Participants' accounts suggest that while grief-centered approaches offer meaningful language for validating early miscarriages, they do not fully address additional needs that participants articulated but were not captured by this framework.

## Grief and early miscarriage

Most participants we interviewed did articulate their losses through the language of grief, and many indeed expressed the need -often unmet- for psychological support. Beyond this, their narratives also revealed a series of concerns that extended beyond emotional processing. For instance, the psychological support they could access after miscarriage in certain administrative jurisdictions was very limited, non-existent, or submitted to long waiting lists. Complaints also concerned the process of physical management of the miscarriage.

Participants who went for aspiration or curettage, or induction of labor, within a healthcare facility, complained of being clumped together with other surgeries, being let to wait for a long time, and being given few instructions upon discharge. In one instance of a late first-trimester labor induction at a hospital facility, there was also a complaint about the insensitive

and hurtful management of fetal remains. Those who used pharmacological management at home, instead, described feelings of uncertainty as well as doubts. These regarded how to interpret the intensity and duration of their bleeding and pain when they were expelling the pregnancy at home, and in some instances, how to manage the pregnancy tissue they were expelling.

Some resorted to reaching for support among laypeople who have gone through similar experiences. Elisa got in touch with a friend who had the same experience, who gave her advice, including on which kind of sanitary pads to buy. And for Ariadna, the crucial interlocutor was not a friend, but a friend of a friend whom she had just met once:

"In fact, I have a childhood friend who is going through IVF. She was the one who put me in touch with this girl who was going through the same as me, and she just had a miscarriage in [Name of the Hospital]. It was at the same time and the same place. So, I got in touch with her and, since then, we talked about everything. But on that day, when I got in touch with her, we talked on the phone for three hours without knowing each other. I mean, I had seen her at a wedding, but I did not even remember her face."

All along her interview, Bibiana emphasizes the importance of discussing her early loss to break the silence. Her husband, instead, has not shared the physical aspects of its expulsion at home as much as she did:

"The hardest part, expelling it, he did indeed discuss it with some people, because as I had such a hard time, he mentioned it to some very close friends. But he has not divulged about it as much as I did."

Analisa's husband took a day off work to assist Analisa after surgery for an ectopic pregnancy. When Analisa was asked, during the interview, whether her husband had shared in the workplace the reason for his leave, she replied:

"For instance, when I had surgery... the reason, I mean, it was clear, right? But... I realized, had it been an appendicitis, for instance, my husband, when he had to share it at work, he did not know... he did not say what it was, and an appendicitis, he would have shared."

This lack of information about the physical dimensions of early miscarriage is exacerbated by an iron curtain between the experience of miscarriage and the experience of voluntary termination of pregnancy, which obscures the common points between the two.

"For you to understand the taboo, I know there was a woman who had a voluntary termination because they were not able to, whatever reason, financial reasons, who is keeping silent about it in the association. She does not dare to talk about it. So, you see the taboo. Because it is not a safe space either. Within the association, there are first-, second- and third-class women, and first-, second-, and third-class deaths. And in society at large as well." (Nina).

"And then it was after mine that I found out about other people that had also happened to it, and when one of my best friends decided to have a voluntary abortion. It was a super different situation, and in fact she didn't tell me because she thought I would be upset. And obviously I wasn't, because it was a very different process." (Nieves).

The separation between voluntary and involuntary losses, and the application of a grief frame to both, is clear in this interview with a midwife:

"Here we use 'legal' terminations as the ones with a medical reason, or spontaneous, and the voluntary, which are women who did not want that pregnancy. But this is very ugly, it stigmatizes them so much. They're pregnancy terminations. The cause or ground is the least important thing.

Anthropologist: Right. And the consequences can be similar as well.

Midwife 1: Sure, because she does not want that pregnancy, because her conditions are unfavorable, so, it is a grief as well."

The physical aspect of abortion, such as blood or fetal remains, have limited presence within the clinical context (because being carried out at home or in private clinics), which contributes

to its invisibilization compared to other aspects of early miscarriages, such as its diagnosis. As Browne (2025) notes, psychological frameworks often become dominant not because they fully address patients' experiences, but because they align neatly with institutional logics that individualize and delegate reproductive events, placing emotional processing on the patients. In our study, this translated into an environment where the spotlight was on emotional support, and an equalization of all losses no matter its gestational age. This is something our participants asked for and appreciated, but they were left comparatively in the dark about the informational and logistical scaffolding needed to navigate the embodied dimensions of miscarriage.

These concerns resonate with critiques of psychologization in reproductive health, which argue that emotional frameworks can mask institutional shortcomings and divert attention from material inequalities and gaps in care, especially for women (Ginsburg and Rapp, 1995; Frost et al., 2007; Browne, 2025).

## CONCLUSIONS

Our study shows that early pregnancy loss occupies an ambiguous and often marginal position within broadly social and clinical settings in Spain. While public discourse increasingly recognizes early miscarriage as a legitimate loss, participants' accounts reveal something different. Specifically, gestational age hierarchies persist (Middlemiss and Kilshaw, 2023) that shape whose experience is fully acknowledged as a reproductive event, and whose is minimized. These hierarchies were reproduced across interpersonal interactions, peer-support settings, and biomedical encounters, where classifications and comments often conflicted with participants' lived understandings of their losses.

The prominence of grief as the dominant interpretive framework within healthcare settings reflects broader transformations in perinatal care. Moreover, while both grassroots associations and clinical practitioners emphasize umbrella concepts, such as grief, to encompass all gestational ages, the experience of first-trimester loss exposes a further layer of stigmatization. Stigma associated with voluntary termination, its physical processes, and clinical practices, has repercussions on informational gaps and the lack of tailored resources during the physical process of miscarriage. Early losses are framed by healthcare professionals through the lens of grief, a lens that they perceive as the gold standard, because it appears to make no distinction in terms of gestational age. Acknowledging the emotional depths of a first-trimester loss seems to be the antidote to the minimization that this reproductive event receives in clinical encounters and in society in general. However, this approach leaves insufficiently addressed the practical dimensions of care.

By situating first-trimester loss within feminist anthropological discussions of miscarriage stigma, this study highlights how early miscarriage is differentially recognized and re-stigmatized, within broader reproductive regimes.

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## DATA AVAILABILITY STATEMENT

The article does not reproduce material from any other source. The data is not publicly available due to its sensitive and confidential nature.

## ETHICS STATEMENTS

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