AFRICA REGIONAL SEXUALITY RESOURCE CENTRE

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Understanding Human Sexuality Seminar Series

"Culture, Femininity and Sexuality".

When the fruit-bearer does not bear the fruit.

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Feminine =‘of woman’; ‘womanly’

Woman = adult female

Female = “of the sex that can bear offspring or produce eggs; fruit-bearing”

(The Concise Oxford Dictionary of current English, 7th edition)

This paper seeks to explore the synergistic relationship of biological reproduction and cultural femininity. The integration of a woman’s femininity with her role as a sexual being; having the ability, or inability, to bear children.

In other words – what of the woman who does not fit into the socially accepted, expected and endorsed role of motherhood; what is her social identity when she does not, cannot fulfill her perceived primary role of bearing children?

Where does this leave her in the context of femininity as defined in our current world, in our South African society?

Within the parameters that this forum allows for, I will approach the issue from the following perspectives:

- An outline of the woman’s own psychological experience of miscarriage, largely referring to Bowles’s research (2000), supplemented with my own research findings.
- The influence of culture.
- A brief outline of the experience of healthcare services commonly encountered in SA, noting the relationship between South African health policy and woman’s health issues.

Practice experience has shown that often the loss associated with miscarriage goes by unacknowledged, other than in the context of the medical model which views the human body as a biological and clinical organism. McAndrew (in Dominelli 1990:40) suggests that the emotional needs of women are generally not

addressed by the medical practitioners attending to them (Field and Marck 1994:281). Having a child is portrayed as fundamentally a biological and clinical experience which can either be 'put right' following dysfunction or the dysfunction be prevented (Nicolson 1998:3).
In seeking to gain insight into how women experience miscarriage, it is important to consider the context and setting in which these experiences occur.
Social values and perceptions, be they from the medical profession or the value society accords to individuals, all impact on the way women perceive themselves and their value in society.
The acknowledgement accorded by the medical model generally provides little meaning to the particular life experience as a whole.

It would appear that research in the area of miscarriage is noticeably lacking, particularly in the South African context. It has been proposed that one reason why this limitation may exist, generally, is that miscarriages are seen as defiantly resistant to prevention and solution (Hey, Itzin, Saunders and Speakman 1989:60). This, however, does not account for the lack of available information regarding how women experience miscarriage against their background of roles, expectations of womanhood and purpose. Neither does it account for the obvious dearth of supportive resources available. This apparent lack may be viewed as either an assumption that emotional problems do not exist; or possibly, that those individuals experiencing problems are unable to cope (Dominelli 1990:40).

It is encouraging to note the recent increased recognition accorded to women's health issues at international levels (Volz 2000:11). Similar policy development can be followed in South Africa, however, as Klugman cautions, policy is only as good as the capacity to implement it. While existing policy commitments such as 'a caring culture', 'health promotion' and 'community participation' are all cornerstones of the national health policy, they remain dependent on social, economic and cultural relations in society (1999:66).

It is my opinion that while the face-value of South African policy documents 'a caring culture', the reality of mismanagement and seemingly alternate agendas to 'caring' for people is rife. I will support this statement shortly.

The meaning of miscarriage for women would, as in all experiences, be founded on the three pillars of what the individual considers to be knowledge, how the knowledge is used to make sense of the experience and how the experience is then incorporated into their biographies (Nicolson 1998:47).

Given that the general response of society is to avoid dealing with the emotional aspects of miscarriage it can be asserted that women often lack the knowledge they need to make constructive meaning of their experiences.
Consequently, women often suffer in isolation, an element further encouraged by the nature of gender socialisation prevailing in South Africa. Gender socialisation is a crucial determinant in woman's sense of womanhood, role and purpose (Giddens 1989:162). Having children is seen as the crux of this socialisation; the completion of being an adult woman (Phoenix, Woollet and Lloyd 1991: 59).

In South Africa, as is cited in many parts of the world, having a child is seen as a woman's passage into adulthood as a woman. An important step in asserting her womanhood.

Definition of Miscarriage – *"…any pregnancy loss, that is the loss of an embryo or foetus that occurs before 20 weeks gestational age, which is approximately up to the 5th month*."(Hill 1997:1; Turkington 1999: 1; Polaneczky 1999:174) The formal medical term for miscarriage is "spontaneous abortion" (Hill 1997:1).
The debate surrounding the emotive and alienating terminology related to miscarriage is significant. It is not dealt with in this instance.

<u>Psychological Consequences</u>

The psychological consequences of miscarriage were largely ignored until the late 1980's (Reinharz in Zucker 1999:3). Bowles (2000:2) suggests that the situation is still one of sparse availability of scientific literature on conditions related to foetal loss, such as depression, anxiety and prolonged grief.

Clinicians report that for some women the event of a miscarriage can be traumatising.
The psychological consequences for women who have miscarried may vary tremendously depending on genetic makeup, past learning experiences and the extent to which maladaptive changes have progressed (LeDoux 2002: 281).

Individual characteristics, personalities, resources, beliefs, and their resultant cognitions and behaviours, coupled with the situational factors throughout the time of coping are among the strongest determinants of how the individual will fare both psychologically and physically, when faced with stressful experiences (Park 1998:2).
Satisfaction with social support suggests that social resources may enable people to interpret the stressful experience in a less threatening manner because of the positive context. It is also possible that opportunities for individuals to discuss and process the event are provided, thereby decreasing its aversiveness and possibly enabling people to make meaning and identify positive aspects (Lepore, Silver, Wortman, & Wayment in Park 1998:12).
The converse is naturally true of a social setting which alienates the particular women. A study in Mozambique indicated that women reported high maternal reproductive morbidity and immense pressure to bear children during reproductive years while competing for scarce resources, including male support and income. This vulnerability heightens women's perceptions that they and their unborn infants will be targets of witchcraft by jealous neighbours and relatives. As a result prenatal care is often delayed and pregnancy hidden (Chapman 2003).

Attention to the ethnic and cultural differences in expectations and beliefs may result in the development of more supportive social and cultural environment for enhanced coping.

Distress Response Symptoms

Domar (Domar and Dreher 1996:234) provides a comparison of distress scores, Figure 1, including infertility patients. The comparison is not specific to miscarriage but provides a context in which miscarriages frequently occur.

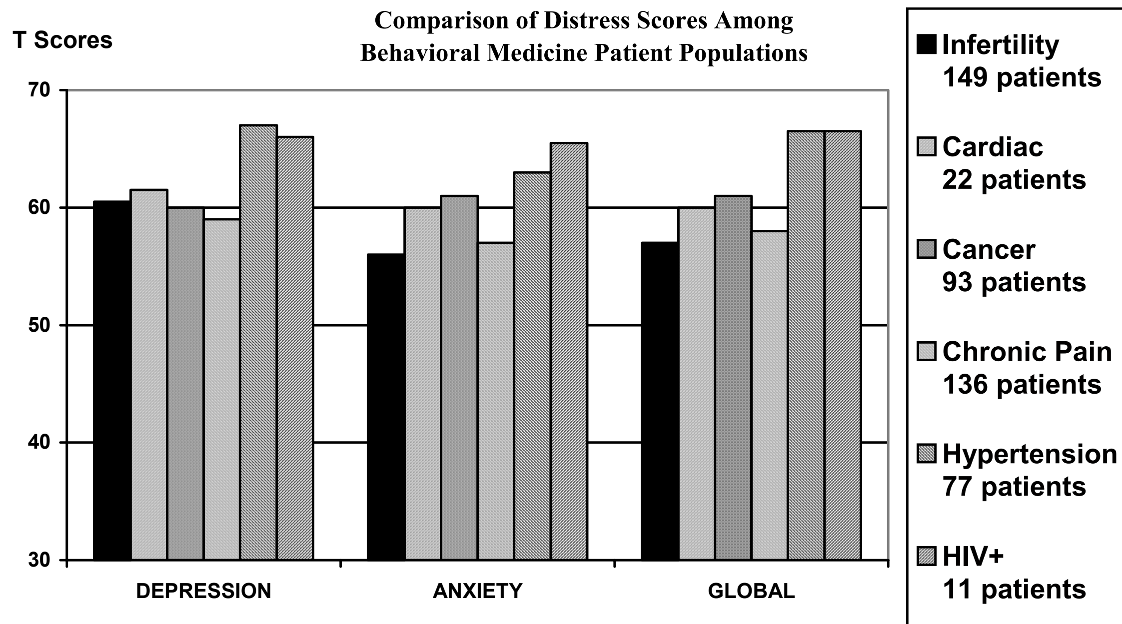

Figure 1

Depression

Depression results from an inability to make the appropriate adaptive response to stress (Duman in LeDoux 2002:280). Recent work has suggested that depressive symptoms and anxiety are common among some women following miscarriage and that generally, miscarriage is often viewed as a traumatic event by the women who experience it (Zucker 1999:3).

A study, conducted by Swanson (2000:191), using a path analysis based on the Lazarus Paradigm to predict Depressive Symptoms after Miscarriage, confirmed that women most at risk for increased depressive symptoms share the following characteristics:

- attribute high personal significance to miscarriage
- lack social support
- have lower emotional strength
- use passive coping strategies

- have lower incomes
- and do not conceive or give birth by 1 year after loss

The Lazarus Theory deals with emotions and adaptation.

Loss - Grief

The authors of the works consulted generally indicated an understanding of the experience of miscarriage as an often-traumatic event, with reference to 'severe grief' and 'severe emotional distress' (Hill in Cooper 1997:3, Turkington 1999:4, Bowles 2000:4). Polaneczky (1999:1-5) notes grief, depression, sense of failure and anxiety about subsequent pregnancy in patients having suffered a miscarriage. She reports that for some a successful subsequent pregnancy can help resolve the feelings; however, for others the loss is mourned forever. The response to a miscarriage is in essence the experience of having responded to the notion of mothering a child; of having responded to the possibility of motherhood (Field and Marck 1994:125).

It is suggested that a miscarriage can cause feelings similar to the loss of a child or other member of the family (Turkington 1999:4). Hill observes that many women grieve as much over the loss of a baby in the first trimester as they do for a stillborn baby or for a child that dies months or years after the birth. Bereavement may be complicated as it is often a mourning of the loss of a future and expectations, not simply of an embryo (Slater 1999:2).

Guilt

The miscarriage may also trigger many personal issues about a woman's fertility, her identity as a parent or her relationship with her partner, and her own attitudes to life and death (Patton and Wood 1999:1).

Guilt and self-blame are reported as common emotions following a miscarriage (Regan 1997:247). Knowing why can become an obsession, which can in turn lead to the search to place blame somewhere specific. Often the individual places the blame on herself. Self-recrimination is nurtured as woman often report the

view of miscarriage being seen as a punishment for ambivalent feelings related to the pregnancy (Hey et al 1989:69).

Disorders

Bahtia (1999:7) proposes that the grief reaction related to miscarriage is usually self-limited. It is, however, suggested that if the reaction persists beyond eight weeks and self-esteem is reduced, the patient should be evaluated for an adjustment disorder with depressed mood or major depression. Bowles (2000:1) identifies that when the distress response persists up to four weeks a diagnosis of acute stress disorder (ASD) be considered. Symptoms persisting beyond four weeks should alert consideration of a diagnosis of post-traumatic stress disorder(PTSD).

The Four Domains of Spontaneous Abortion Symptoms

Bowles (2000:5) notes the striking similarities between descriptions of grief-related behaviours in miscarriage and those of ASD or PTSD after miscarriage. They are only distinguishable by careful review of the diagnostic criteria in the DSM-IV.
A comparative review of the criteria of ASD/PTSD and the Distress-Response symptoms following miscarriage indicate the following, **Figure 2**:

<u>The Four Domains of Spontaneous Abortion Symptoms:</u>

Emotions/feeling states

Shock[*]

Numbness[[section]]

Guilt[[section]]

Anger[*][a]

Anxiety[a]

Depression

Self-blame[*]

Derealisation[*][sections]

Depersonalisation[*][sections]

Isolation[*][sections]

Physical symptoms

Empty feeling inside stomach[*]

Tightness in chest or throat[*]

Shortness of breath[*]

Weakness/fatigue[*]

Sweating[*][a]

Cognitive effects

Intrusive thoughts about foetus[*]

Hallucinations of a baby's cry/visual images of baby[*]

Phantom foetal movement[[section]]

Difficulty with concentration and decision making[a]

Fantasies about foetus[[section]]

Dissociative amnesia[[section]][sections]

Diminished situational awareness[[section]]

Behaviours

Difficulty sleeping (nightmares)[*][a]

Loss of appetite

Social withdrawal[sections]

Substance abuse/use[sections]

Avoiding medical facilities/personnel, pregnant women, children, etc., to prevent reliving the event[*][sections]

Impaired social and occupational functioning[||]

The symbols denote the criteria areas of acute and post-traumatic stress disorder characteristics:

[*]--Reexperiencing the trauma.

[[section]]--Dissociative symptoms.

[a]--Increased arousal.

[sections]--Avoidance of trauma-producing stimuli.

[||]--Poor social and occupational functioning.

(Adapted by Bowles from Moscarello R. Perinatal bereavement support service: three-year review. J Palliat Care 1989(5):14 in Bowles 2000:13 and 14)

The symptoms of distress response after miscarriage include psychological, physical, cognitive and behavioural effects. It should be noted that patients with distress response after miscarriage often do not meet the criteria for acute or post-traumatic stress disorder.

Geller asserts that women who have had a miscarriage are eight times more likely to develop an episode of obsessive-compulsive disorder in the following six months than are women in the general population (in Johnson 2000:1-2).

There was no increased risk of developing any other anxiety disorder, such as panic disorder or phobia. All the women in Geller's study were interviewed at least once in the six months following their miscarriage. The Centre for Epidemiological Studies Depression Scale and the Diagnostic Interview Schedule was administered. The findings of the research were consistent with what was noted in clinical situations with women who have miscarried. Similarities existed in anxiety symptoms, nervousness, and obsessive thoughts about self-blame and concerning not being able to conceive again. Geller reported a commonality among the research participants to feel the need to participate in rituals and compensatory compulsive behaviour to placate their feelings of loss and to prevent future loss.

Similar themes emerged from a study conducted in the Eastern Cape, South Africa in 2003 (Watson 2003). The themes correlate with those from other parts of the world and it would seem that there is little difference in the experiences cited by the women.

Key responses identified were as follows:

Negative impact on self-image:

Sense of inadequacy in role of woman, wife and mother. Disappointment to husband and greater family.

Sense of failure as a person. Unworthiness and inferiority.

A sense of being physically and emotionally 'empty'.

Guilt

Self-blame and self-reproach pervading all areas of life.

A sense of being punished for being ‘bad’.

Anger

Bitterness and frustration toward self and others.

A sense of being cheated.

Anger toward self, others and God. Bargaining with God.

A sense of being punished; injustice and retribution.

Social withdrawal

Avoidance of pregnancy related subjects, people and situations.

Feeling inadequate and actively avoiding social interaction.

A sense of isolation and the feeling of being unsupported.

Anxiety and fear

Particularly during subsequent pregnancies.

Shock

A sense of physical and emotional numbness.

Depersonalisation

Denial

Depression

Repression of emotion and detail of events.

Loss

Feeling physically and emotionally empty and hopeless.

The women interviewed attributed high personal significance to having children and consequently the miscarriages. This was evident in the perceptions of feeling inadequate and useless as a woman; failing in the role of woman, wife and mother; to feeling like a social outcast as a result of being childless.

Influence of Culture

Gender socialisation is a crucial determinant in woman's sense of womanhood, role and purpose (Giddens 1989:162). Having children is seen as the crux of this socialisation; the completion of being an adult woman (Phoenix et al 1991: 59). Giddens further illustrates this by referring to children's classic storybooks, "Women who were not wives and mothers were imaginary creatures like witches or fairy godmothers" (1989:163).

There is a broad consensus amongst anthropological literature regarding the definition of a witch. A witch is a traitor, representative of all that is anti-social and unnatural to a particular society. To be labelled a witch is to be placed in an antagonistic relationship to the rest of society (Ritchken 1989).

Oakley suggests that, "cultural femininity and biological reproduction are curiously synonymous in the proclamation of medical science about women" (in Nicolson 1998:2). The norm in female socialisation does not allow for deviation from this framework, thereby prolonging the process of coming to terms with the loss (Phoenix et al 1991:48-55, Ireland 1993:153). Field and Marck (1994) report of numerous findings of women referring to themselves as "outsiders" by virtue of not having children. The valuative meaning attached to a miscarriage is consequently strongly influenced by this view. A participant in one such study reported the following perception about pregnancy regarding maturing and gaining entry into the adult world:

> "*It is important developmentally for an adult to have children, to go through recognised stages, rites of entry or passage in our society. If you don't enter those, there's a sense of being an outsider. Children are really important to have a sense that we're part of the mainstream and help us feel that we've come of age, reached a level of maturation."*

It is this clash between social pressure to reproduce and the experience of miscarriage, amongst other reproductive difficulties, that may lead to a variety of psychological phenomena (Zucker 1999:1).

Ethnic and cultural environment largely dictate the expectations, beliefs and values of all participants in any experience. Bloom (in Mirkin 1994:292 and 293) draws attention to relatively recent western medical history. In 1931 medical experts attributed the causes of sterility to “modern women who transgressed the laws of nature”. The American population crisis was said to be the responsibility of “fat women, academicians, public women, detached women and social corsairs.” 19th century experts cast “women’s failures” as “psychological aberrations”. Infertility was depicted as a maladaptive disguise for the fear of, or hostility toward reproducing. As recently as the 1940’ and 1960’s the notions of “hypofeminity” and “female masculinity” emerged. Miscarriages were attributed to “habitual abortions” and “hostile mucus”. Bloom finds that childless women in this era constituted a discarded group who were accused of selfishness. Literature suggests that this group were shamed in bringing their womanhood and character into question.

Rozario (in Ram and Jolly 1998: 154) highlights the experience of women in rural Bangladesh, whose culture views miscarriages, among other reproductive difficulties, as the result of evil spirits.
In the rural North Eastern part of South Africa, in Bushbuckridge, as in many such areas, childbearing is celebrated as a symbol of achievement and success.
Here a mother is addressed with respect and acquires the status of an adult thereby leaving behind her virginal status (vuntombi), which is characterised by subordination and uncertainty (Harnett, Kahn, Shivambo and Mnisi 1996).
In the Xhosa culture, dancing is used as part of the ritual to ensure the fertility of a friend before she married or to restore her fertility if she had trouble bearing children after the marriage. Here again, a strong example of the pressure to conform to the status quo and produce. The value of the woman is in producing children and caring for a family.

In South Africa the title of mother is a crucial indicator of women’s strength and social standing. Lewis comments that for Black South African women, the title of ‘mother’ has little to do with individual women’s experiences, but rather becomes a validating term which embodies the essence of their social standing (in Agenda 40 1999:39).

Baruch (1999:94) similarly suggests that women who internalise the social norms expressed by the dominant gender roles often view themselves as defective against the pressure of trying to live up to a mythological image. For many women infertility then carries a shrouded stigma borne of shame and secrecy.

The traditional Afrikaans culture in South Africa is also strongly patriarchal and in this context the women often experience great pressure to bear a son.

The notion of discussion regarding reproductive issues or difficulties from the woman's perspective is not within accepted parameters of many cultures. Several studies have reported that communication between men and women about reproductive health ranges from minimal to non-existent. (in Agenda 40 1999:40).

> *Sex and sexuality are often the exclusive preserve of the African husbands, and if a wife initiates a discussion of family planning, she may threaten her husband's sense of control and generate mayhem within the family*.

(Biddlecom and Fopohunda in Maharaj Agenda 1999:39)

A belief in witchcraft, based on envy and close proximity, is an integral part of many African cultures. Pregnant women are most vulnerable and must take care to appease the ancestors. The first trimester is regarded as a period of particular vulnerability to bewitchment and is shrouded in secrecy. Most women do not make decisions regarding health-service attendance themselves. Such decisions are made collectively by members of her family, and if she is married, by her husband's family. (Harnett et al 1996).

There are other cultures which place great emphasis on the meaning of miscarriage, as in the case of the Pulana and Kgaga cultures in Mpumalanga, South Africa:

Hammond-Tooke (in Ritchen), writing on the Kgaga, states that sexual intercourse with a woman who has had a miscarriage results, according to both Pulana and Kgaga culture, in illness and even death (Ritchken 1989).

Until recently, literature in developed countries concerning women's emotional well- being and meaning accorded to experiences has been scarce, especially the history of emotion, psychology and interpersonal relationships. Manderson (in

Ram and Jolly 1998:27) comments on the added difficulty in drawing on these experiences of non-literate and often silenced women, in order to understand their experiences.

The Impact of Healthcare Services

Ample evidence exists of patients' dissatisfaction with doctors' communication skills. Despite increased availability of information, many women still want to know more than that which is told by the doctor. Freeling identifies the patient's need to have an "absolute, uncritical confidence in their doctors' skills" (Freeling 1998:1). A study (Jewkes 1998) on the quality of care in family planning clinics in the Eastern Cape, South Africa, found that staff were equipped with sound clinical knowledge of procedures and processes but that poor attitudes prevented them from providing a good service (Klugman Agenda AGE Monograph 1999:52). Klugman cites various findings of women users of health services repeatedly reporting poor health worker attitudes as their main problem.

The South African government's White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997) recognised that access to services requires improvements in service quality.
The White Paper commits the government to promoting a 'caring ethos'. In an effort to instil this a Charter of Community and Patient's Rights was defined, with health workers being rewarded for 'compassionate and caring service'.
Linked to the general campaign within the civil service called 'Batho Pele – People First'.
The White Paper's objectives focused on, among other aspects, the improvement to the psychological well-being of people and communities (Klugman 1999:57).

However, this very same Department of Health, between 1996 and 2003 failed to properly account for 81.9% of its budget allocation.
The Eastern Cape Department of Health failed to spend 19.4% of its infrastructure budget between 1999 and 2004. None of the department's annual strategic plans for this period were found to contain accurate, time-bound and costed capital expenditure and maintenance plans.

None of the Dept's strategic plans for the 2000 – 2004 period were found to contain accurate information on the Eastern Cape public health service delivery environment and needs to be met by the department. These plans did not contain any evidence of effective consultation with the department's external and/or internal stakeholders. There was also a manifest lack of internal financial control measures, a lack of financial records and the failure to properly record all financial transactions. The national Auditor General found in 2003 that the Minister of Health and the national Department of Health had no monitoring mechanisms in place to ensure the proper use of funds disbursed to provinces in the form of conditional grants (Allan, Overy, Somhlaba, Tetyana and Zepe 2004).

It would seem that attention, support and acknowledgement of women's health issues are simply not priorities. The above figures, in my opinion, bring into question the priorities of the state health system.

I reiterate, policy is only as effective as its implementation and refer again to Oakley's notion that, "cultural femininity and biological reproduction are curiously synonymous in the proclamation of medical science about women" (in Nicolson 1998:2).

The complexity of delivering a health care/healing service relevant to all South African's is immense. It is impossible to do this without approaching health system development on a local level.
The best intentions do not help when there is dualism between the government's presented-self (policy, papers, documents) and the people's real-self.

Martin (in Lykke and Braidotti 1996:116 - 117) describes the essence of health as: a sense of non-dualism, interconnectedness; caring for the whole person including all positive and negative aspects without judgement; a healthy organism connected with its environment. To Martin, health care implies healing not exclusively of body-mind, but also of the eco-social environment. An approach which views the boundaries separating people's concern for spiritual, psychological, physical, interpersonal, social, political or environmental well-being as arbitrary.

Kriel suggests that profound transformation of the medical clinical method is needed if it is to address the whole complexity of the human person as a self-conscious living system. A new understanding of science, the nature of reality, and of the nature of consciousness is needed (2000:3).

Several studies have sought to establish the precise nature of the relationship between healthcare professionals and women who have miscarried. Women who report greater satisfaction specifically with the support and comfort provided following their loss also exhibit fewer depressive symptoms (Murray and Callen in Paton et al 1999:3).

Robinson's (2001:3-12) research similarly noted a wide range of physician reactions to patients presenting with emotional distress or potential mental health problems. Some physicians apparently failed to recognise the emotional component. Physicians appeared to either actively ignore this problem, gloss over it, or actively manage the distress. When not explicitly focused on the feelings and emotions of the patient medical carers often miss them (Kriel 2000:139).

Similar reports can be found in South African studies. The Transformation of Reproductive Health Services Project (TRHSP), which was run over two years in three rural provinces in South Africa, reported the following:

> *Health care workers themselves believe that they deliver sub-optimal care to clients. They describe themselves as rude, uncaring, insensitive, and note that they treat clients selectively, providing better treatment to educated and well-off women and to men and worse treatment to illiterate or poor women* (Fonn et al in Klugman 1999:52).

Given the context of South Africa's lack of infrastructure, poor social services, reality of poverty and general inequality in respect of gender and race, particularly prior to the government change, the well-being of the majority of women was undermined. This doubtlessly impacted on the care and treatment of women experiencing miscarriage.

In 1994 the Women's Charter for Effective Equality (WCEE) was adopted at a national convention of the Women's National Coalition. Its presentation on health stated the following:

> *Equal, affordable, accessible and appropriate health care services, which meet women's specific health needs and which treat women with dignity and respect, shall be provided. Women should be made aware of their rights in relation to health services. Health services must be appropriately oriented to meet women's health needs and priorities …*

Kriel proposes that it is insufficient to appeal to doctors to be more sensitive or to include additional training in ethics, communication skills or the social sciences. To transform the science-based clinical method he suggests that a model is needed which recognises more ways of knowing the world and ourselves than the one of the sciences. He advocates that such a move will create dialogue between the insights of the human and social sciences and the scientific clinician (2000:45).

While each specialised field is without a doubt necessary and useful, it is the inescapable interconnectedness which is emphasised as being the essence of true health care.

Despite being close on seventy years ago, a 1934 publication of the Lancet resonates with an uneasy echo:

> *"…the expectant mother is not an ambulant pelvis, but a woman with human needs, whose soul and body are closely interlocked…let us not forget the mother"*
>
> (Lancet, 7 July 1934, p.1198 in Oakley – the Captured Womb)

Conclusion

What then of the 'non fruit-bearing fruit bearers' ?
The link between biological reproduction and a woman's sense of social self is clearly a strong and carefully constructed one. The intention is not to randomly deconstruct this, but rather to create an awareness and understanding among health care workers, and related professions that concerns do exist. Solution is not

the issue as is acknowledgement and affirmation of women, as valuable and worthy human beings, regardless.

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