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Resisting disenfranchized grief in the context of perinatal death: A qualitative study on the social labor of bereaved mothers

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ABSTRACT

Perinatal death remains socially unevenly recognized, despite important changes in practice and culture. This qualitative study examines how bereaved mothers negotiate everyday (non) recognition across interactional settings. Using a grounded theorizing approach, we conducted in-depth interviews with 23 mothers in Québec and analyzed how expectations of recognition shape social action. We identify a threefold, explanatory typology of social labor: anticipatory (guarding against likely non-recognition), reactive (countering or eliciting recognition amid present non-recognition), and proactive (activating existing recognition or disclosing the loss absent mismatch). Non-labor occurred when perceived effort outweighed emotional capacity or the likelihood of a positive outcome (e.g., formal/administrative non-recognition, certain workplace and medical contexts). Rather than portraying parents as passive, our analysis complements existing literature by specifying the interactional mechanisms through which recognition is negotiated in daily life, while not presuming these efforts' efficacy or generalizability beyond the Québec context.

Perinatal death, occurring during pregnancy, delivery, or within 28 days postpartum (Institut national de santé publique du Québec, 2019), affects millions worldwide, with low-income countries being disproportionately impacted (Flenady et al., 2017). While neonatal mortality rates have declined, stillbirth rates remain stable or are rising in some regions (Flenady et al., 2016). Although official statistics are lacking in Canada, estimates suggest that approximately 100,000 families experience perinatal loss annually (de Montigny et al., 2017).

Beyond its economic burden, perinatal death has far-reaching psychosocial effects (Riddle et al., 2023), influencing marital, familial, and social dynamics (Heazell et al., 2016). Despite its significance, it remains underexplored in grief research compared to other forms of loss (De Montigny et al., 2015). The concept of disenfranchized grief (Doka, 1989, 2002), which describes grief that is unacknowledged or socially unvalidated, has been instrumental in highlighting the lack of recognition surrounding perinatal grief (Charmaz & Milligan, 2006). Research on perinatal grief has largely focused on this lack of recognition, through a close examination of its socio-historical evolution and manifestations (Bacqué & Merg-Essadi, 2013; Gélis, 2015; Walter, 1994), as well as its psychosocial repercussions (Brierley-Jones et al., 2014; Soubieux, 2013). Another body of literature has explored how rituals help address non-recognition (Brin, 2004; Layne, 2000; Walter et al., 2012), shedding light on evolving social responses to perinatal grief.

While this scholarship has been crucial in legitimizing perinatal grief, we extend it by specifying under-examined aspects of how recognition is negotiated in everyday interaction. First, alongside important accounts of historical change, synchronic variation within contemporary societies remains less fully described (Zeghiche, 2019). Second, the focus on non-recognition can obscure the fluid interplay of recognition and non-recognition across time and space (Zeghiche et al., 2020). Third, while many studies richly document impacts on parents (Brierley-Jones et al., 2014; Hazen, 2006), our contribution is to complement this work by analyzing the interactional mechanisms of parents' social labor – their (necessarily fluid) efforts to elicit, protect, or withhold recognition in concrete encounters. Finally, research on bereavement rituals often catalogues practices

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(Blood & Cacciatore, 2014; De Vries & Rutherford, 2004); we foreground how these practices are embedded in wider social interactions where legitimacy remains negotiated. We also acknowledge recent expansions in public memorialization and peer support; consistent with Godel (2007), we treat these advances as a micro-culture that has not fully diffused into everyday social life, where parents still encounter routine instances of non-recognition.

Agency outside ritual is well documented in institutional and peer contexts – e.g., hospitals with perinatal-death protocols (King et al., 2021), bereavement support groups (Hazen, 2006), and advocacy movements (Davidson, 2011). By contrast, the everyday, informal negotiations of recognition beyond these structured settings remain comparatively under-specified. This study addresses this gap by examining the forms of social labor that bereaved mothers engage in to navigate perinatal grief. Using Goffman's interactional approach to stigma and recognition, we explore how mothers actively challenge, negotiate, and cope with non-recognition in their daily lives. We introduce a typology of social labor (anticipatory, reactive, proactive) emerging from our analysis and discuss its implications for understanding perinatal bereavement as a dynamic and interactional process.

Framing (non)recognition

Goffman's interactional framework offers valuable tools for understanding the complexities of (non)recognition in disenfranchized grief. By examining interactions between the "stigmatized" and the "normal," Goffman (1963) highlights how social actors actively manage stigma. Rather than passively enduring stigma, individuals who are *stigmatized* or *stigmatizable* actively respond through various strategies. These may include concealing the source of stigma – whether partially or entirely, temporarily or permanently – maintaining a low profile, or, conversely, adopting a stance of defiant bravado. Some individuals navigate stigma by avoiding specific places or situations, while others confront it directly, embracing their stigmatized identity with composure and openness.

While Goffman's model has been widely applied (Link & Phelan, 2001), some scholars critique its limitations. Riessman (2000) argues that it assumes stigmatized individuals internalize dominant beliefs rather than actively resisting them. Following this perspective, we conceptualize bereaved mothers' responses not merely as reactions but as acts of resistance. Resistance need not be public, organized, or overt; it can manifest in silence, avoidance, or subtle disruptions of social norms (Collins, 2000; Scott, 1985).

This study examines how bereaved mothers enact resistance across different social spaces, including medical, familial, and professional contexts. We employ the concept of social labor – adapted from Kurasawa (2007) and López (2018) – to describe the ideational, discursive, material and embodied practices that fuel normative and political struggles for social justice. We retain from Kurasawa (2007) and López (2018) the idea of *labor* as a process of ongoing, often invisible effort oriented toward moral or social recognition. However, rather than applying it to collective or transnational struggles for justice, we relocate it within the micro-social dynamics of everyday interactions surrounding perinatal bereavement. This adaptation is informed by Goffman's (1963) interactional model of stigma and Scott's (1985) notion of *everyday resistance*, which together highlight the subtle, individual, and processual forms of negotiation through which bereaved mothers resist non-recognition. Thus, *social labor* in our framework denotes an array of ideational, material, and embodied practices through which mothers seek, elicit, or protect themselves from recognition, without presupposing organized activism or overt resistance. This use of the term emphasizes the laborious, continuous, and relational nature of these efforts, positioning them as both reactive and constitutive of social interactions.

Method

The analysis in this study follows the grounded theorizing approach, as outlined by Paillé (2011). This methodological framework is particularly effective for examining social phenomena, as it emphasizes understanding the underlying processes at play. The empirical data serve as both the starting point for analysis and the continuous thread that informs the resulting explanatory model (Lavoie, 2019). Theorization is deeply rooted in the data collected, evolving and being validated through direct engagement with "observed reality." This iterative process allows for ongoing refinement as data collection and analysis occur simultaneously, particularly in the initial stages of the research.

In this approach, the interview questions evolve in response to the emerging insights, making it more of a dynamic questioning process than a static one aimed at codifying an already established corpus of data. Grounded theorizing is also marked by the absence

of a fixed research question at the outset. Instead, the study begins with broader, exploratory questions about the contours of a social phenomenon, with more specific research questions emerging and becoming clearer as the analysis progresses (Fortin & Gagnon, 2016; Kaufmann & de Singly, 2016; Paillé, 2011).

Participants and recruitment

Following grounded-theory principles, we used theoretical sampling to recruit mothers with direct experience of perinatal loss (second trimester to 28 days postpartum) and iteratively sought conceptual variation (time of death, unit of care, institutional level) until theoretical saturation (Charmaz, 2014; Paillé, 2011). We restricted recruitment to mothers to maintain analytic homogeneity (Clavandier & Charrier, 2015; Murphy, 2009) and feasibility (Murphy &Thomas, 2013), acknowledging the documented, yet distinct, experiences of fathers/partners (deMontigny et al., 2017; Obst & Due, 2019). Eligibility criteria included: (1) being 18 or older, (2) experiencing perinatal death from the second trimester to 28 days post-birth within the last five years, and (3) residing in Quebec City, Montreal, or Outaouais[1].

We limited inclusion to the past five years to maintain socio-temporal homogeneity in the social regulation of perinatal death and bereavement. Studies without a time limit often pool experiences spanning 10–30 years (e.g., Brierley-Jones et al., 2014; Hazen, 2003, 2006; Murphy & Thomas, 2013; Pollock et al., 2020), which is valuable for historical breadth but less suited to our aim of a synchronous analysis of social (non)recognition. We focused on this window to examine how (non)recognition varies by time of death, unit of care (e.g., ED vs. maternity), and institutional level (primary vs. tertiary), while maintaining categorical and spatial homogeneity in clinical/interactional contexts. We did not include first-trimester losses because they frequently occur outside hospital settings and because tangibility is configured differently there, yielding qualitatively distinct dynamics relative to our aims.

We use termination for medical reasons (TFMR) (Fr. *IMG*) to denote procedures undertaken due to maternal health risk and/or serious fetal diagnosis; elective terminations without medical indication were not eligible and were not included. Although we initially considered excluding TFMR given their specificities (Legros, 2001), early interviews showed that (non)recognition issues were comparable to other loss types (late miscarriage, stillbirth, neonatal death), so these cases were retained. This approach allows us to acknowledge differences and similarities across perinatal deaths without conflating them into a single undifferentiated category (Murphy, 2009) or undertaking formal causal/gestational contrasts.

Ineligible cases comprised first-trimester losses and elective terminations; four prospective participants were screened out (loss before the second trimester or outside the 5-year window). Recruitment concluded at $N = 23$ when additional cases no longer contributed new conceptual leverage (theoretical saturation). This strategy prioritizes analytical adequacy over statistical representativeness (Kaufmann & de Singly, 2016).

Ethical approval was obtained from the University of Ottawa (04-17-06), and data collection took place from January 2018 to July 2019.

Recruitment strategies included outreach through community organizations, online support groups, and professional networks, along with limited snowball sampling. The study included 23 mothers, aged 18–39 at the time of loss. Most were in relationships ($n = 21$), employed full-time ($n = 18$), and had household incomes above CAD 75,000 ($n = 18$). Causes of perinatal death included TFMR ($n = 9$), stillbirth ($n = 7$), neonatal death ($n = 4$), and miscarriage ($n = 3$).

Data collection

Interviews followed a comprehensive, nonhierarchical approach (Kaufmann & de Singly, 2016), prioritizing participant agency and trust (pre-contact by email/phone; explicit reminders of consent/withdrawal options); conducting interviews in participant-chosen settings (home, campus, phone, videoconference); and iteratively refining a structured yet flexible guide. Topics covered aspirations for parenthood, pregnancy experiences, medical and social interactions surrounding perinatal death, and long-term bereavement practices. The interviews were not designed to catalog or analyze material culture per se (object types, makers, imagery), nor did we collect visual artifacts or service histories (e.g., Poussières d'ange Québec – a photography service offered for parents who lost their baby). References to photographs, prints, tattoos, urns, keepsake boxes, and home displays arise as participants described how such items were used to invite acknowledgment or to resist silence; our analysis remains focused on these interactional uses, not on the objects' formal properties. Interviews lasted between 50 minutes and three hours, with most participants interviewed once. Two were re-interviewed to address gaps

in workplace-related experiences. Interviews were recorded, and transcribed for analysis.

This approach generated detailed, situated narratives suitable for theorizing the social labor involved in navigating perinatal bereavement. The following section details our analysis and findings.

Data analysis

Following Paillé's (2011) six-stage grounded-theorizing sequence, we treated *social labor* as a sensitizing concept rather than an a priori code. In open coding, we tagged segments on mothers' expectations of recognition, instances of (in)congruence, and responses, including labor and non-labor. Categorization differentiated active/passive recognition, active/passive non-recognition, and separated labor types from non-labor. Through linking and modeling, we integrated these into a process chain: expectations → (in) congruence → labor *or* non-labor → outcome, which yielded a threefold typology of labor (anticipatory, reactive, proactive) and non-labor, depending on whether inaction reflected satisfaction with recognition, acceptance/anticipation of non-recognition, or temporary inability/low expected efficacy. Theorization specified the interactional conditions under which each response arises (e.g., setting, timing, formal vs. informal non-recognition) and their differential likelihood of restoring congruence (more assured for proactive labor under passive recognition; uncertain for reactive labor; absent or variable for non-labor).

Results

We present the findings from the full corpus of 23 interviews, foregrounding patterns that recur across participants while attending to variations by type of loss, time since the event, and interactional setting (medical, familial, social, workplace). To protect confidentiality and maintain readability, we include a curated set of quotations that are representative of each theme rather than exhaustive, and we provide approximate indicators of prevalence (e.g., "about half," "roughly two-thirds") to convey proportionality. All personal identifiers are replaced with pseudonyms.

Expectations regarding the recognition of perinatal death and bereavement

The first question our data analysis aimed to illuminate concerned the conditions under which mothers' social labor unfolds. The findings show that this labor largely stemmed from incongruence between mothers' lived experience and their expectations regarding (non)recognition. In other words, when lived experience did not align with expectations, labor ensued; conversely, when experience and expectations aligned, there was no labor. Before deepening this first observation, it is important to pause on the notion of expectations. The mere presence (or absence) of recognition does not, by itself, explain bereaved mothers' (non-)labor. As we noted in a previous article (Zeghichhe et al., 2020), it is not enough to map the social (non)recognition of perinatal bereavement; we must also take into account bereaved mothers' expectations regarding it. The notion of expectations is therefore central to the phenomenon under study, since it is from this that (non)congruence with lived experience – and, in turn, the (non-)deployment of labor – follows.

This notion, which is difficult to grasp empirically, was operationalized through mothers' positive, neutral, or negative assessments mothers made about the words and actions of those involved in their perinatal death experience, including healthcare providers, family, and friends. These expectations were articulated in statements such as: "(My gynecologist) is a gem … impeccable … really very kind … it was very, very focused on my needs" (Pascale, TFMR of pregnancy, 26 weeks); "(The doctor) was very gentle, very present … it helps a lot" (Vanessa, TFMR of pregnancy, 26 weeks); You're left to your own devices … you're a bit rushed … "… there was a real lack of resources … it becomes so hurtful" (Audrey, stillbirth, 41 weeks); "The worst experience I've ever had … I had the impression that I was a heavy case" (Anne, neonatal death, 1 day postpartum).

For nearly, all the women (21 of the 23 participants), these expectations were underpinned by a shared belief that their loss was legitimate and deserving of recognition. Several arguments were presented to justify this perceived legitimacy, including the maternal attachment to the baby, the baby's personhood, the stage of pregnancy, and the lived experiences associated with parenthood (e.g., having given birth, touched, carried, or rocked the baby). In cases of neonatal death, the fact that the baby had survived for hours or days also contributed to the sense of legitimacy:

> It's someone you've lost. You carried it (this baby). From the moment it was inside you, you knew it even if you didn't want it (…) so it's a part of you. Love is created, bonds are created. You give birth to this baby (…) So it's a real pain, even in your flesh.

> You feel as if your heart is being ripped out of you (…) It's really as if (…) your arm is being taken and they want to pull it out, rip it out of you with a sharp blow (…) It's a real loss. (Noëlla, stillbirth, 39 weeks)

While most mothers (roughly three-quarters of participants) grounded the legitimacy of their bereavement in their emotional attachment to the baby (among other factors), regardless of the number of weeks of gestation, some participants invoked a perceived hierarchy of death to assert the legitimacy of their grief. For instance, when the topic of miscarriage was raised in comparison to late perinatal death, some mothers strongly objected: "No, it wasn't a miscarriage that I had, I lost him at 34 weeks" (Aurélie, stillbirth, 34 weeks). Others take offense at this hierarchy, as Virginie (TFMR, 20 weeks) did: "It's crazy how a one-day-old baby is a recognized loss – it's a tragedy – but a month earlier, it's nothing."

Only two participants questioned the legitimacy of their loss: one following an early second-trimester loss with no tangible memories of the baby or the death, and another who, as a single, nulliparous woman, voiced self-doubt about whether her loss "counted."

Having addressed the notion of expectations, we now detail the two configurations at the core of our explanatory model: congruence and incongruence between mothers' expectations and their lived experience of (non)recognition.

Congruence between (non)recognition received and (non)recognition expected

In cases of congruence, two scenarios were possible: either expected recognition matched actual recognition, or non-recognition matched what was not expected. Starting with the first scenario (congruence between expected and actual recognition), this occurs in contexts of active recognition, where actual recognition precedes or anticipates expected recognition. In these situations, mothers do not need to verbalize expectations for them to be met; the recognition process is set in motion upstream of mothers' expectations. A telling example of active recognition lies in the rituals organized in medical settings after the baby's birth. Here, mothers do not even need to express their expectations. The established protocol may even exceed what they anticipated. Several mothers, for example, were particularly struck by the use of the symbol on the door or by the preparation of the memory box. Recognition thus precedes expectation. In other cases, mothers' expectations are anticipated and proactively probed – they are asked whether they want to see their baby, hold the baby, photograph the baby, etc. Consequently, mothers do not have to expend social labor to elicit recognition; they can be carried by the current of recognition induced by the hospital protocol, which allows them to reaffirm their status as mothers, the baby's personhood, and the legitimacy of their grief.

But recognition does not stop at the hospital setting. In this study, we also observed instances of active recognition in family and social spaces, albeit more frequently in the short term. These take the form of expressions of sympathy, physical presence, and participation in (para)funerary rituals, etc. Again, mothers do not have to expend social labor to elicit recognition from those around them. One mother, for example, explained that her parents took turns being with her and her partner and helping with daily tasks. Another said she was pleasantly surprised by the support from a friend she had known for only a few months: "She supported me emotionally. She checked in on me and made sure I was okay" (Chantal, miscarriage, 16 weeks).

The second scenario involved congruence between non-recognition and non-expectation. Some mothers (about one-third) explained that they were not upset when certain people refused to see photos of the baby because they expected this and did not try to correct the situation – they accepted it as it was. Others said that the absence of official documents attesting to their baby's existence did not affect them because such documents did not carry symbolic weight for them: "(The birth certificate) is not something I absolutely care about. For me, it's simply a piece of paper. I did everything I could, (…) so the certificate is really secondary for me" (Sylvie, TFMR, 32 weeks). In all these cases, mothers did not expend labor to try to shift the situation because it aligned with their expectations. Consequently, expectations are not always oriented toward recognition. This shows that not all signs of recognition have the same value, either from one person to another or from one object of recognition to another.

Incongruence between (non)recognition received and (non)recognition expected

The second configuration observed was when mothers' lived experience did not align with their expectations. Here, too, two patterns emerged. The first involved recognition that was received but not expected/desired. On several occasions, the presence of parents or other family members at the hospital was not wanted, or

their request to be present was explicitly refused by the mother. A couple of mothers even refused to let their parents see the baby at the hospital or in photos or attend the funeral.

> The whole family came [to the hospital], and there was a bit of a debate because they wanted to see my daughter. I didn't want to, nor did my husband (…). My mother asked me several times to see the photos, which I never showed anyway, just because it's ours. It's ours, it doesn't belong to anyone else. (…) Even the funeral – no one came. It was just me and my partner because, in the end, that's what united us. (Amélie, stillbirth, 34 weeks)

At times, even expressions of empathy from family and friends were misunderstood or poorly received.

> What bothered me was when people started crying too much. That really upset me. My father-in-law said to me, 'We're really sad about this' (…). But I remember, at the time, I told him off in my mind because I thought, 'I don't give a damn about your grief. You have no idea how destroyed I am.' (Caroline, TFMR of pregnancy, 33 weeks)

Even after returning home, some mothers (about a quarter) refused visits from parents or friends and explicitly asked to be left alone. In most cases, this request was sufficient to readjust relatives' and/or friends' attitudes to the mother's expectations. Sometimes, however, this readjustment proved more difficult in the family space; either because family members insisted on having their request granted, or because the request itself was perceived by the mother as intrusive and insufficiently respectful of her needs. In all the cases mentioned, mothers expended labor to bend the situation to their expectations.

In a few rare instances (five cases), the expectations themselves were contradictory. In other words, a mother might ask not to be called but then take offense at the silence.

> When I sent the email to my boss, (…) I said, 'I don't want people to bother me, I don't want them to write to me to find out what happened.' (…) But at the same time, I got no message, no bouquet of flowers, nothing. (…) Afterwards, I thought to myself, 'Come on! They could have done something.' (Amélie, stillbirth, 34 weeks)

> I was disappointed that they [my friends] didn't write to me to say, 'I'm thinking of you.' I didn't want to manage them, but I still wanted their love. (Anne, neonatal death, 1 day postpartum)

These experiences highlight the complexity of bereaved mothers' expectations: neither homogeneous nor predictable, and sometimes even contradictory.

The second pattern involved recognition that was expected but not received. It emerged that, depending on the type of (non)recognition (active or passive), certain nuances appeared in the kind of labor undertaken and its aim. The analysis therefore proceeded to unpack and refine the explanatory model by focusing on these nuances and on the resulting typology of labor.

Aims of social labour

In cases of passive recognition, where recognition existed implicitly, mothers' expectations were neither anticipated nor probed. However, once the expectation was articulated, it was readily met. Several mothers (approximately one-third of participants) described situations where their relatives did not spontaneously; ask to see photos of the baby but were pleased to receive them once the mother offered; or hesitated to inquire about the baby, yet once the mother initiated the conversation or offered photographs, the response was positive: "People wait a little while for me to mention it first, but as soon as I do, I am well received." (Anneli, neonatal death, 2 days post-partum). In these instances, labor aims at stimulating recognition or activating latent predispositions. Once set in motion, the process no longer requires fueling; congruence occurs automatically.

On the other hand, cases of passive non-recognition – such as silence, forgetfulness, or avoidance – required mothers to engage in labor aimed at either countering the non-recognition or actively encouraging recognition. Some mothers responded by rejecting the silence surrounding their loss: "(My family) didn't talk about it so much, but I did." (Aurélie, stillbirth, 34 weeks). Others moved beyond discomfort to normalize the subject: "I was so hard-headed, I didn't want it to become taboo, that even if I saw that people were uncomfortable, I talked about it." (Anne, neonatal death, 1 day postpartum) In a few cases (around four participants), this labor was delayed. One mother, for example, refrained from responding immediately to a family member's silence but later felt compelled to address the situation. She recalled:

> I called [my mother-in-law] and said, 'This will never happen to me again. We're going to talk about my daughter and we're not going to pretend that nothing happened, and what we've just been through, we're not going to bury it ten feet under'. (Audrey, stillbirth, 41 weeks)

Labor can also target forgetfulness among relatives, as illustrated by the mother who, during a family gathering, corrected a family member who had failed

to acknowledge her baby during a tribute to deceased family members: "I was so insulted that they didn't name him, as if he hadn't existed." (Laure, TFMR of pregnancy, 18 weeks)

The third aim of labor is less about denouncing non-recognition than about fostering recognition. This includes mothers' efforts to keep conversation going: "(I brought up the topic) so that people would simply get used to talking about it and hearing about it" (Paméla, TFMR, 21 weeks); and the placement of symbolic objects[2] in visible places at home – photos, the urn, footprints, ornaments. Tattoos are another way to counter the lack of tangibility and the tendency toward invisibilization: "Sometimes (…) it's (my tattoo) that makes me talk about it, too. You know, a child asks me about my tattoo (…) well then I explain" (Hélène, miscarriage, 17 weeks). This is a way, among others, to remind people of the baby's existence, reaffirm the baby's place in the family, and compensate for the lack of tangibility underpinning non-recognition.

However, unlike passive recognition, the transition from expected to actual recognition in cases of passive non-recognition, is neither immediate nor guaranteed. As one mother put it: "No matter how much I talk about it, if the other person isn't receptive, there's nothing I can do" (Paola, miscarriage, 17 weeks). Faced with persistent silence and forgetfulness from loved ones, some mothers eventually opted to forgo recognition from others altogether, especially on occasions like Mother's Day, which they marked independently by purchasing gifts or celebrating with their partner. Over time, most mothers (around two-thirds) found that rituals were increasingly confined to their nuclear family and seldom involved extended family or friends. One mother reflected: "The first few years, my mother would call me on the anniversary of the baby's death. But it will be five years this January, and now we mark it only within our immediate family – and that suits me." (Pascale, TFMR of pregnancy, 26 weeks). As expectations for external recognition diminished, a growing need for self-recognition emerged, as mothers began to celebrate their loss and their baby independently.

Finally, in cases of active non-recognition, where explicit words or gestures of dismissal occurred, mothers engaged in labor to either counteract or protect themselves from the non-recognition. Some mothers expressed disapproval directly, such as when a mother defended her decision to perform rituals in honor of her deceased child, responding to a friend's criticism: "No, but you'll never say that to me again … it doesn't make sense what you've just told me … when you give birth and see your child, you'll think of me with my dead child in my arms." (Audrey, stillbirth, 41 weeks). Others employed more protective strategies, such as isolating themselves to avoid discomfort or declining invitations to events where they anticipated non-recognition: "[Declining an invitation to a family get-together] was my way of telling my mother-in-law that (the loss of my baby) isn't 'resolved' for me" (Caroline, TFMR, 33 weeks). Still others tried to better control how the death is announced, including a photo and accompanying text to underscore the tangibility of the loss and prevent further misunderstandings. Yet, in all forms of labor, nothing guaranteed the desired congruence.

The issue of disclosure of perinatal death: a case apart

In contrast to the previous discussions where the concept of *labor* emerged in response to the non-recognition of perinatal death or bereavement in social interactions, the situation surrounding the disclosure of perinatal death presents a distinct dynamic. In these cases, the labor was exerted *upstream* rather than downstream. Specifically, when a mother was confronted with the question, "How many children do you have?" and the death of her child had not yet been disclosed, she faced a dilemma. The decision was whether to reveal the perinatal death or to conceal it. The choice lay between denying the existence of the baby – thereby contributing to the silence surrounding perinatal death – or sharing a deeply personal experience, exposing herself to discomfort and potentially hurtful responses. Sometimes, the need for acknowledgment eclipses others' discomfort. As Maxence (TFMR, 27 weeks) noted: "At the first team meeting (after I returned to work), I said what had happened. People were uncomfortable, but I was relieved." For many women (roughly two-thirds of participants), the decision to disclose or conceal depended on the context, as certain situations were less conducive to revealing such intimate and painful experiences. When the interaction was brief or casual, mothers often chose not to disclose: "I don't feel like explaining in every conversation" (Jennifer, neonatal death, 1 day postpartum). However, in rare cases (two participants), mothers consistently concealed the death. One mother, having lost her baby early in pregnancy (at 16 weeks), did not feel legitimate in discussing her loss, even though she personally regarded the child as part of her family. In contrast, another mother found concealment unacceptable, stating:

> I feel bad for days [if I hide the existence of my baby]. I did it once, and I'll always remember it, so I'll never do it again (…) I'd rather say that she's dead

> outright, that she's dead and create discomfort than say that she doesn't exist. For me, it's unthinkable (Audrey, stillbirth, 41 weeks).

About half of the mothers were more inclined to disclose the death when it was recent, while others waited until a certain amount of time had passed before sharing their loss. This variability underscores the importance of context and the personal significance of the decision to disclose or conceal perinatal death. However, our data also show the laborious nature of social interactions in the context of perinatal death, even the most mundane. Indeed, a question as seemingly innocuous as "How many children do you have?" can be a source of worry and apprehension for mothers. As one participant said: "It takes energy to answer these questions (…) when you talk about it, you have to be strong enough to absorb all the comments you're going to hear." (Vanessa, TFMR, 26 weeks)

Typology of labor

At the end of this analytical component, a typology of labor emerged as a function of the conditions of its deployment and its aims. Labor can be anticipatory, reactive, or proactive. Anticipatory labor aims to prevent active or passive non-recognition or to shield against it; it seeks future congruence on the basis of a past incongruence. Reactive labor aims either to elicit recognition or to counter non-recognition (passive or active); it thus arises in response to a present lack of congruence that it seeks to correct. Finally, proactive labor involves taking the initiative without it being a reaction to a lack of congruence – for example, when recognition exists passively and simply needs to be activated, or when the perinatal death is unknown to interlocutors and the mother decides to disclose it.

This typology informs us about the aims of social labor but also its outcomes. Thus, only proactive labor in contexts of passive recognition (where the move from expectations to lived experience is almost automatic) and anticipatory or standalone proactive labor (e.g., avoiding certain people/situations or seeking recognition by and for oneself) are assured of congruence between expectations and experience – that is, of a positive outcome. By contrast, reactive labor in contexts of non-recognition (passive or active) does not necessarily produce congruence; its outcome is uncertain. Moreover, anticipatory labor does not aim to counter non-recognition, but merely to guard against it or avoid it. In such cases, there is no external outcome per se, but this does not invalidate the labor. Although avoidance strategies underlying anticipatory labor do not directly tackle the issues of non-recognition, they can be necessary.

Obstacles to social labour

While the lack of congruence between expectations and lived experience of (non)recognition explains a substantial part of social labor, there are exceptions: incongruence can exist without labor. We therefore extended the analysis to understand what distinguishes non-labor situations from labor situations. To do this, we considered the intensity of labor, its outcome, and the fit between the two (intensity and outcome).

Intensity refers to the level of effort expended to bring lived experience into alignment with expectations. Intensity is relative and depends on the person's emotional energy at time t (the fewer reserves one has, the more even a small effort feels intense; sometimes out of reach), on the type of (non)recognition faced (formal/informal, active/passive), and on the presence or absence of intermediaries. Within the typology of labor, intensity clearly increases as one moves from passive recognition to passive non-recognition and then to active non-recognition, or from informal to formal non-recognition. Moreover, intensity is higher for reactive labor, since it confronts other actors who may act as obstacles. For anticipatory and proactive labor, intensity is lower because recognition is set in motion without a direct intermediary or because recognition is latent (in the proactive case).

Turning back to non-labor, we found that it occurs when the perceived intensity of possible labor appears too high – either relative to one's emotional state at time t, or relative to the probability that labor will lead to a positive outcome. Thus, around the time of death, non-labor may occur due to the mother's emotional state. One participant, for example, explained that she could have ordered her baby's birth certificate, but neither she nor her partner felt able to undertake the steps: "In the first weeks, we were really devastated (…) Thinking about ordering (the birth certificate) was more than we could manage." (Anne, neonatal death, 1 day postpartum) Here, the probability of a positive outcome was high (the baby died after birth), but the mother's emotional state made even minimal labor feel insurmountable.

Non-labor also occurs when the probability of a positive outcome is perceived as very low or nil. We observed this in cases of formal non-recognition and

in two of the four spaces examined – namely, the medical and workplace settings. Most mothers (about two-thirds) lamented not being able to obtain administrative recognition of their baby's existence; yet, because this formal non-recognition was considered a fait accompli against which they could do nothing, expectations were real but no labor followed to bring lived experience into alignment. Many also regretted not receiving workplace recognition through, for example, maternity leave (for losses before 20 weeks) or a phased return. Mothers often reported feeling saddened, even offended, by this state of affairs: "The fact that nothing exists (administratively) is like he didn't exist (…) it still hurts." (Noëlla, stillbirth, 39 weeks) Yet none of the mothers interviewed undertook labor to change this.

Beyond the type of non-recognition, non-labor also depends on the space in which the interaction occurs. We found that when interactions took place in the medical or workplace space, women rarely reacted. Very few instances of labor were identified in these two spaces. In the medical space, we recorded some examples of passive and active non-recognition, but in almost all cases (20 out of 23), mothers lamented the situation without attempting to influence it. The same held for the workplace, where numerous instances of passive and active non-recognition were reported.

In addition to the spatial context, non-labor depends on the temporal context. Thus, the two ends of the bereavement continuum are characterized by an almost absence of labor, but for opposite reasons: the acute pain of the short-term paralyzes and condemns to inaction (non-labor), while long-term easing of the loss allows distancing from external signs of recognition.

Discussion

The findings from this study nuance several elements about the non-recognition of perinatal death and bereavement. First, our analysis reveals that mothers experiencing perinatal loss often have clear expectations about how they wish to be treated – expectations that they perceive as legitimate. Our data extend accounts that emphasize internationalization of social norms around perinatal death by showing how expectations of legitimacy and situated acts of resistance emerge alongside it. For instance, Brierley-Jones et al. (2014), in line with Goffman (1963), describe mothers who have lost a child as "normal deviants," individuals who internalize a stigma due to society's rejection of their loss. However, our findings indicate that mothers' clear expectations of recognition challenge the notion that such norms are entirely internalized. This resonates with the work of Adkins (2004) and Ming-Cheng (2015), who argue that marginalization processes do not lead marginalized individuals to fully adopt the norms that sustain their marginalization. The mere presence of these expectations suggests a sense of legitimacy, however fragile and unstable, and a refusal to accept non-recognition. In other words, the feeling of non-recognition does not stem from a total absence of recognition, but from recognition deemed insufficient (Lazzeri & Caillé, 2004). In this regard, our findings align with Riessman (2000), who speaks to hidden, private spaces of consciousness that allow individuals to resist dominant norms.

While some mothers may internalize societal norms about perinatal death – such as the normalization of miscarriage or early pregnancy loss – this internalization does not undermine their inherent sense of legitimacy. As Goffman (1963) explains, stigmatized individuals may compare themselves to others who are more visibly stigmatized, thus positioning their experiences in ways that reinforce their own sense of legitimacy. For instance, some mothers took offense at comparisons between their late-stage perinatal loss and a miscarriage. Although this reflects an internalization of the perceived hierarchy between early and late pregnancy losses, it simultaneously serves as a means of distancing oneself from that very hierarchy by projecting it onto others. This indicates that while some aspects of social norms may be internalized, they do not entirely silence or invalidate the mothers' claims to recognition. However, although differences in gestational timing or medical cause can influence how recognition unfolds, our previous work (Zeghiche, 2020) suggests that these variations are mediated by social tangibility – the extent to which the baby's existence becomes materially and socially visible to others. Tangibility is not given; it is often negotiated and reasserted through practices such as viewing, naming, and commemorating the baby. Recognition can therefore be accorded before birth, when attachment and social anticipation are established. Conversely, it can be withdrawn after birth if the death disrupts the social narrative of parenthood. In this sense, the apparent "hierarchy" of perinatal deaths reflects uneven social processes that construct and sustain the baby's visibility rather than intrinsic differences between trimesters or causes.

Second, the resistance strategies employed by bereaved mothers go beyond simply managing the discomfort of stigma, as Goffman (1963) suggests. Rather, these women actively choose to speak out,

rejecting silence and striving to preserve the memory of their child. They employ material culture (such as photos, tattoos, and other objects) to assert the reality of their loss and its significance. Our findings align with work showing that material traces can scaffold parental grief and public acknowledgment (e.g., historical poetry and personal memorial forms in *Centuries of Solace* (Simonds & Rothman, 1992); the consolatory and legitimating work of mortuary photography (Bacqué et al., 2018). In our sample, objects functioned less as ends in themselves than as interactional levers: photographs or hand/footprints were shown to relatives to "make real" the baby's existence; tattoos and home displays served as durable prompts that normalized talk; and, for some, social-media posts extended recognition beyond the immediate circle.

Other mothers withdraw from situations that might lead to non-recognition, thus gaining some control over their interactions. This finding challenges Hazen's (2006) assertion that silence in the face of perinatal death renders mothers powerless and marginal. In contrast, speaking out and resisting silence emerge as forms of resistance. As Riessman (2000, p. 126) argues: "Talking back challenges stigma by reallocating fault: the problem lies in the values of the accuser, not in the woman herself." Even when silence and withdrawal may lead to isolation, they can also provide mothers with a safe space to protect themselves from further reification and criticism (Collins, 2000; Riessman, 2000). Kärki (2018) also identifies "resistant withdrawals," which can have societal effects, even though they are often overlooked in resistance studies due to their non-activist nature.

Regarding the issue of disclosure versus concealment of perinatal death, our findings suggest a more complex dynamic than Goffman (1963) described. While concealment can be a strategy of avoidance, it is not solely motivated by a desire to maintain social acceptability. Rather, it can stem from a desire to avoid uncomfortable interactions or to protect oneself from the discomfort of others. In some cases, the emotional cost of concealment outweighs the cost of disclosure, indicating that mothers do not always prefer concealment. Thus, while concealment is a strategy employed by some, it is not universally adopted, and its use depends on the context and personal preferences. Where Goffman's (1963, pp. 85–86) analysis does align with our data is in the laborious nature of social interactions, even the most mundane:

> (E)ven very fleeting relationships can constitute a danger, since the small talk suitable between strangers who have struck up a conversation can touch on secret failings (…) What are thinking routines for normal can become management problems for the discreditable.

Our analysis also reveals a typology of social labor performed by mothers. This labor can be anticipatory, reactive, or proactive. Anticipatory labor aims to prevent non-recognition or to prepare for potential non-recognition based on past experiences. Reactive labor seeks to counteract current non-recognition or to elicit recognition in response to passive or active non-recognition. Finally, proactive labor is when mothers take the initiative to disclose their loss, whether in contexts where recognition is already present or where the perinatal death is not yet known. Our analysis shows that social labor is contextual – hence variable and structured – both in its aims and its outcomes. As Ming-Cheng (2015, p. 128) puts it, "the resources for covert resistance are neither ubiquitous nor idiosyncratic." In other words, our threefold typology is explanatory, not just descriptive: it specifies *when* each form is likely to be mobilized, *how* it operates (avoid/guard vs. counter/solicit vs. activate/disclose), and *why* the probability of aligning expectations with lived experience differs across forms (highest where mothers control exposure and framing; lowest where recognition depends on others' immediate uptake).

While this study nuances the perspective of those who emphasize the overwhelming non-recognition of perinatal death and bereavement, it does not suggest that all efforts to gain recognition will necessarily lead to change, either on an individual or societal level. As several scholars (e.g., Kurasawa, 2007; López, 2018) have noted, social denial can be persistent, and the labor performed by individuals may not always lead to systemic change. Even though these forms of resistance are preferable to resignation (Gordon, 1993), they are not guaranteed to overturn societal norms or lead to emancipation (Riessman, 2000). These strategies can be ineffective due to their uncoordinated nature or even counterproductive (Scott, 1985). In some cases, they may reinforce the very patterns of non-recognition they seek to resist. Furthermore, while labor does not necessarily indicate a lack of recognition, it does reveal a gap between expectations and reality, leading to a sense of non-recognition (Robson & Walter, 2013). Ultimately, although labor reflects the fluid and reversible nature of non-recognition, it also underscores its persistence and the challenges that lie ahead.

Finally, our analysis sought to understand what distinguishes non-labor situations from labor

situations, beyond the question of congruence between expectations and lived experience, by looking at reasons for these choices in the interactional situations themselves. The analysis allowed to show that no labor was performed when its intensity was perceived too great compared to the person's emotional state at the time of the interaction, or to the likelihood of it leading to a positive outcome. Non-labor can relate to the specifics of the "crisis" that perinatal death/bereavement represents (Zeghiche, 2020). It thus refers to the "engagement moratorium" described by Mazade (2011), i.e., a temporary inability to enter a timetable of actions, not by power relations or social norms that condemn one to silence or inaction. Moreover, non-labor can also be explained by the type of non-recognition in question. In cases of formal non-recognition, only collective, activist, sustained action can confront it. Indeed, the kind of labor in question cannot address the structural and systemic roots of non-recognition (Collins, 2000; Riessman, 2000; Scott, 1985).

Alongside the time of the interaction, and the type of non-recognition, the analysis showed that non-labor depended also on the space in which the interaction occurred. The medical and work spaces appeared as two spaces allowing fewer instances of labor. The explanation lies in the limited latitude these spaces afford for labor to unfold. In the medical sphere, this is unsurprising: as Walter (1994) and Brierley-Jones et al. (2014) explain, health professionals set the terms when life ends (and, in perinatal death, when it both begins and ends). There is very little room in hospital culture for bereaved people's claims (Thompson et al., 2016). In the workplace, the scarce space accorded to emotions and the emphasis on productivity help explain why silence is harder to counter (Meunier et al., 2021; Zeghichhe et al., 2020). Hazen (2006, p. 241) also highlights the public/private divide at work:

> The division between public and private makes what is personal nearly unspeakable in a public setting such as the workplace. Perinatal loss has to do with women's unpaid labour in the family and has no place in the public space of paid labour. Silences and silencing are used to separate the unproductive reproductive experiences of women from productive interaction in the workplace.

But even when non-labor occurs, this does not necessarily imply internalization of the norms underpinning non-recognition. As Ming-Cheng (2015) argues, the passivity of "marginalized" actors does not preclude a reflective habitus; not reacting to non-recognition does not mean accepting it.

Conclusion

This article set out to identify the social labor undertaken by mothers who lost a baby in the perinatal period – labor aimed at eliciting recognition or countering/avoiding/shielding against non-recognition. Building on prior work that documents the non-recognition of perinatal bereavement, our analysis highlights everyday instances of resistance, without presuming their efficacy, and situates them within an interactional process.

The analysis proceeded in three steps. First, we examined the conditions under which this labor unfolds. We found that when expected recognition did not align with lived experience, women undertook labor to rectify the situation; by contrast, when there was congruence – either between expected and actual recognition, or between not expecting recognition and not receiving it – no labor occurred. Second, we refined this initial finding by considering types of (non)recognition (active vs. passive). Depending on the type, labor served distinct aims, yielding a typology of reactive, proactive, and anticipatory labor. Third, we asked what distinguishes labor from non-labor – that is, why incongruence does not always prompt labor. We thus considered the conditions of non-labor: no labor was undertaken when its perceived intensity was too high relative to a mother's emotional state or to the probability of a positive outcome. Moreover, depending on timing, type of non-recognition (formal/informal), and the latitude that each social space affords (or withholds) for labor to unfold, the initial pattern may not apply and incongruence may lead to non-labor.

The article's main contribution is to show that both non-recognition and struggles for recognition are embedded in structured social spaces: institutional (medical, family, social, workplace), temporal (before, during, after perinatal death), and interactional (the dynamics arising from the encounter between mothers' expectations and their lived experience of active or passive (non)recognition). In other words, the point is not simply that bereaved mothers resist (or not), but that their various forms of (non)labor must be understood in light of the interactional spaces in which they unfold.

In conclusion, this study underscores the significance of individual and unorganized acts of daily resistance within a context that has been relatively underexplored in academic research: perinatal death and bereavement.

Limitations

This qualitative study used theoretical sampling and a single-jurisdiction frame (Québec) with the INSPQ

definition of perinatal death; findings are therefore analytically transferable rather than statistically generalizable. The sample ($N=23$) was not designed to test gestational/cause-of-death contrasts; we explicitly refrained from causal comparisons. We excluded first-trimester losses, which may limit applicability to early miscarriage contexts. Recruitment was concentrated in three Quebec urban regions, which may under-represent rural/remote experiences and some sociodemographic groups. Since findings are situated in Québec's health and social-service system, where hospital protocols (e.g., memory boxes, door symbols) and community organizations (e.g., Parents Orphelins) have expanded recognition, while mid- to long-term support remains uneven, these cultural–structural features may shape both opportunities and obstacles for social recognition. Readers should consider this when applying the typology in other jurisdictions. Data derive from self-reported interviews conducted within a five-year recall window, which can introduce recall and social-desirability biases; we did not triangulate with observation, records, or interlocutors' perspectives (e.g., partners, relatives, clinicians, employers). Finally, interviews were cross-sectional; we cannot infer change over time within individuals.

Directions for future research

To address these limits, we suggest (a) comparative designs across gestational timings and causes of death, (b) cross-jurisdictional studies linking recognition practices to policy and institutional contexts, (c) longitudinal follow-ups to track how labor and expectations evolve, (d) inclusion of multiple stakeholders (partners, extended family, clinicians, managers), and (e) mixed-methods approaches (e.g., diaries/observations, digital ethnography of online memorial cultures) to triangulate self-reports and examine mechanisms suggested by our anticipatory/reactive/proactive typology.

Notes

1. Semi-urban region in south-western Quebec.
2. Because our focus was on everyday uses of material traces to negotiate recognition, we report objects only insofar as participants described deploying them in specific interactions (e.g., showing a photo to a hesitant relative, placing footprints in a visible room, posting commemorations online).

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Ethics statement

Ethical approbation for this study was granted by the University of Ottawa's Research Ethics Board (04-17-06).

Author contributions

SZ conceptualized and led the research project (recruitment, data collection and data analysis). JL and FdM supervised the research project. SZ wrote the first version of the manuscript. JL, FdM and M.-R.L revised it before the whole team further refined the manuscript.

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Data availability statement

The data that support the findings of this study are available from the corresponding author, [SZ], upon reasonable request.

References

Charmaz, K., & Milligan, M. J. (2006). Grief. In J. E. Stets & J. H. Turner (Eds.), *Handbook of the sociology of emotions* (pp. 516–543). Springer US. https://doi.org/10.1007/978-0-387-30715-2_23

Davidson, D. (2011). Reflections on doing research grounded in my experience of perinatal loss: from auto/biography to autoethnography. *Sociological Research Online*, *16*(1), 1–8. https://doi.org/10.5153/sro.2293

De Montigny, F., Verdon, C., & McGrath, K. (2015). Perinatal death and grief in Canada. In J. Cacciatore & J. DeFrain (Éds.), *The world of bereavement* (pp. 179–208). Springer International Publishing. https://doi.org/10.1007/978-3-319-13945-6_11

Flenady, V., Wojcieszek, A. M., Ellwood, D., Leisher, S. H., Erwich, J. J. H. M., Draper, E. S., McClure, E. M., Reinebrant, H. E., Oats, J., McCowan, L., Kent, A. L., Gardener, G., Gordon, A., Tudehope, D., Siassakos, D., Storey, C., Zuccollo, J., Dahlstrom, J. E., Gold, K. J., … Silver, R. M. (2017). Classification of causes and associated conditions for stillbirths and neonatal deaths. *Seminars in Fetal and Neonatal Medicine*, *22*(3), 176–185. https://doi.org/10.1016/j.siny.2017.02.009

Fortin, M.-F., & Gagnon, J. (2016). *Fondements et étapes du processus de recherche: Méthodes quantitatives et qualitatives* (3e édition). Chenelière Éducation.
Gélis, J. (2015). Comment faisait-on autrefois le deuil de l'enfant mort-né? Le rituel du «sanctuaire à répit». *Le Carnet PSY*, (1), 32–37.
Godel, M. (2007). Images of stillbirth: Memory, mourning and memorial. *Visual Studies*, *22*(3), 253–269. https://doi.org/10.1080/14725860701657159
Hazen, M. A. (2006). Silences, perinatal loss, and polyphony: A post-modern perspective. *Journal of Organizational Change Management*, *19*(2), 237–249. https://doi.org/10.1108/09534810610648933
Lavoie, K. (2019). Médiation procréative et maternités assistées: Vers une approche relationnelle et pragmatique de la gestation pour autrui et du don d'ovules au Canada. Université de Montréal.
Lazzeri, C., & Caillé, A. (2004). La reconnaissance aujourd'hui. Enjeux théoriques, éthiques et politiques du concept. *Revue du MAUSS*, *23*(1), 88–115. https://doi.org/10.3917/rdm.023.0088
Legros, J.-P. (2001). L'arrêt de vie in utero ou l'errance des fœtus: Un deuil possible. *Etudes Sur la Mort*, *119*(1), 63–75. https://doi.org/10.3917/eslm.119.0063
Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363
Mazade, O. (2011). La crise dans les parcours biographiques: Un régime temporel spécifique? *Temporalités*, *13*(13). https://doi.org/10.4000/temporalites.1472
Ming-Cheng, M. L. (2015). Conceptualizing "unrecognized cultural currency": Bourdieu and everyday resistance among the dominated. *Theory and Society*, *44*(2), 125–152. https://doi.org/10.1007/s11186-015-9249-4
de Montigny, F. D., Verdon, C., Lord-Gauthier, J., & Gervais, C. (2017). *Décès périnatal: Le deuil des pères*. Éditions du CHU Sainte-Justine.
Paillé, P. (2011). L'analyse par théorisation ancrée. *Cahiers De Recherche Sociologique*, *23*(23), 147–181. https://doi.org/10.7202/1002253ar
Riddle, J. N., Hopkins, T., Yeaton-Massey, A., & Hellberg, S. (2023). No baby to bring home: Perinatal loss, infertility, and mental illness – Overview and recommendations for care. *Current Psychiatry Reports*, *25*(11), 747–757. https://doi.org/10.1007/s11920-023-01469-x
Simonds, W., & Rothman, B. K. (1992). *Centuries of solace: Expressions of maternal grief in popular literature*. Temple University Press.
Walter, T., Hourizi, R., Moncur, W., & Pitsillides, S. (2012). Does the internet change how we die and mourn? Overview and analysis. *Omega*, *64*(4), 275–302. https://doi.org/10.2190/OM.64.4.a
Adkins, L. (2004). Reflexivity: Freedom or habit of gender? *The Sociological Review*, *52*(2_suppl), 191–210. https://doi.org/10.1111/j.1467-954X.2005.00531.x
Bacqué, M.-F., & Merg-Essadi, D. (2013). Des corps immémoriaux … Devenir du corps de l'enfant mort autour de la naissance. Deuils social et psychologique des parents. *Corps*, *11*(1), 57–67. https://doi.org/10.3917/corp1.011.0057
Bacqué, M.-F., Sani, L., Rauner, A., Losson, A., Merg, D., & Guillou, P. (2018). Mort périnatale et d'un jeune enfant. Histoire des rites et des pratiques funéraires en Europe issus de l'expression affective et sociale du deuil. Première partie: De la Préhistoire aux Lumières. *Neuropsychiatrie De L'Enfance Et De L'Adolescence*, *66*(4), 240–247. https://doi.org/10.1016/j.neurenf.2018.03.001
Bacqué, M.-F., Sani, L., Rauner, A., Losson, A., Merg-Essadi, D., & Guillou, P. (2018b). Mort périnatale et d'un jeune enfant. Histoire des rites et des pratiques funéraires en Europe issus de l'expression affective et sociale du deuil. Deuxième partie: Des Lumières à aujourd'hui. *Neuropsychiatrie De L'Enfance Et De L'Adolescence*, *66*(4), 248–255. https://doi.org/10.1016/j.neurenf.2018.04.005
Blood, C., & Cacciatore, J. (2014). Parental Grief and Memento Mori Photography: Narrative, meaning, culture, and context. *Death Studies*, *38*(1–5), 224–233. https://doi.org/10.1080/07481187.2013.788584
Brierley-Jones, L., Crawley, R., Lomax, S., & Ayers, S. (2014). Stillbirth and stigma: The spoiling and repair of multiple social identities. *Omega*, *70*(2), 143–168. https://doi.org/10.2190/OM.70.2.a
Brin, D. J. (2004). The use of rituals in grieving for a miscarriage or stillbirth. *Women & Therapy*, *27*(3-4), 123–132. https://doi.org/10.1300/J015v27n03_09
Charmaz, K. (2014). *Constructing grounded theory* (2nd edition.). Sage.
Clavandier, G., & Charrier, P. (2015). La naissance en mutation, un enjeu pour la sociologie? *Recherches Familiales*, *12*(1), 165–174. https://doi.org/10.3917/rf.012.0165
Collins, P. (2000). *Black feminist thought*. London Routledge.
De Vries, B., & Rutherford, J. (2004). Memorializing loved ones on the world wide web. *OMEGA - Journal of Death and Dying*, *49*(1), 5–26. https://doi.org/10.2190/DR46-RU57-UY6P-NEWM
Doka, K. J. (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Research Press Pub.
Doka, K. J. (Éd.). (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington Books/D.C. Heath.
Flenady, V., Wojcieszek, A. M., Middleton, P., Ellwood, D., Erwich, J. J., Coory, M., Khong, T. Y., Silver, R. M., Smith, G. C. S., Boyle, F. M., Lawn, J. E., Blencowe, H., Leisher, S. H., Gross, M. M., Horey, D., Farrales, L., Bloomfield, F., McCowan, L., Brown, S. J., … Goldenberg, R. L., Lancet Stillbirths In High-Income Countries Investigator Group. (2016). Stillbirths: Recall to action in high-income countries. *Lancet (London, England)*, *387*(10019), 691–702. https://doi.org/10.1016/S0140-6736(15)01020-X
Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.
Gordon, L. (1993). Women's agency, social control, and the construction of "rights" by battered women. In S. Fisher, & K. Davis (Éds.), *Negotiating at the margins: The gendered discourses of power and resistance*. Rutgers University Press.
Hazen, M. A. (2003). Societal and workplace responses to perinatal loss: Disenfranchised grief or healing connection. *Human Relations*, *56*(2), 147–166. https://doi.org/10.1177/0018726703056002889
Heazell, A. E. P., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., Dang, N., Das, J., Flenady, V., Gold, K. J., Mensah, O. K., Millum, J., Nuzum, D., O'Donoghue, K., Redshaw, M., Rizvi, A., Roberts, T., Toyin Saraki, H. E., Storey, C., … Budd, J. (2016). Stillbirths: Economic and psychosocial consequences. *The*

Lancet, *387*(10018), 604–616. https://doi.org/10.1016/S0140-6736(15)00836-3

Institut national de santé publique du Québec. (2019). *Décès périnatal – Surveillance et définitions*. Institut national de santé publique du Québec. https://www.inspq.qc.ca/sante-perinatale/surveillance/deces-perinatal

Kärki, K. (2018). Not doings as resistance. *Philosophy of the Social Sciences*, *48*(4), 364–384. https://doi.org/10.1177/0048393118767093

Kaufmann, J.-C., & de Singly, F. (2016). *L'entretien compréhensif* (4e éd). Armand Colin.

King, M. Q., Oka, M., & Robinson, W. D. (2021). Pain without reward: A phenomenological exploration of stillbirth for couples and their hospital encounter. *Death Studies*, *45*(2), 152–162. https://doi.org/10.1080/07481187.2019.1626936

Kurasawa, F. (2007). *The work of global justice: Human rights as practices*. Cambridge University Press.

Layne, L. (2000). He was a real baby with baby things: A material culture analysis of personhood, parenthood and pregnancy loss. *Journal of Material Culture*, *5*(3), 321–345. https://doi.org/10.1177/135918350000500304

López, J. (2018). *Human rights as political imaginary*. Springer International Publishing. https://doi.org/10.1007/978-3-319-74274-8

Meunier, S., de Montigny, F., Zeghiche, S., Lalande, D., Verdon, C., Da Costa, D., & Feeley, N. (2021). Workplace experience of parents coping with perinatal loss: A scoping review. *Work (Reading, Mass.)*, *69*(2), 411–421. https://doi.org/10.3233/WOR-213487

Murphy, S. (2009). *Parenting the stillborn: Gender, identity and bereavement*. University of Surrey, Surrey, United Kingdom.

Murphy, S., & Thomas, H. (2013). Stillbirth and loss: Family practices and display. *Sociological Research Online*, *18*(1), 27–37. https://doi.org/10.5153/sro.2889

Obst, K. L., & Due, C. (2019). Australian men's experiences of support following pregnancy loss: A qualitative study. *Midwifery*, *70*, 1–6. https://doi.org/10.1016/j.midw.2018.11.013

Pollock, D., Pearson, E., Cooper, M., Ziaian, T., Foord, C., & Warland, J. (2020). Voices of the unheard: A qualitative survey exploring bereaved parents experiences of stillbirth stigma. *Women and Birth: Journal of the Australian College of Midwives*, *33*(2), 165–174. https://doi.org/10.1016/j.wombi.2019.03.002

Riessman, C. K. (2000). Stigma and everyday resistance practices: Childless women in South India. *Gender & Society*, *14*(1), 111–135. https://doi.org/10.1177/089124300014001007

Robson, P., & Walter, T. (2013). Hierarchies of loss: A critique of disenfranchised grief. *Omega*, *66*(2), 97–119. https://doi.org/10.2190/OM.66.2.a

Scott, J. C. (1985). *Weapons of the weak: Everyday forms of peasant resistance*. Yale University Press.

Soubieux, M.-J. (2013). Le berceau vide: Deuil périnatal et travail du psychanalyste. (Éd. Revue et actualisée). Érès éd.

Thompson, N., Allan, J., Carverhill, P. A., Cox, G. R., Davies, B., Doka, K., Granek, L., Harris, D., Ho, A., Klass, D., Small, N., & Wittkowski, J. (2016). The case for a sociology of dying, death, and bereavement. *Death Studies*, *40*(3), 172–181. https://doi.org/10.1080/07481187.2015.1109377

Walter, T. (1994). *The revival of death*. Routledge.

Zeghiche, S. (2019). Entre convergences et complémentarité: Revue de la littérature en sciences sociales et psychologie/psychanalyse sur le décès et le deuil périnatal. *Études Sur la Mort*, *152*(2), 125–142. https://doi.org/10.3917/eslm.152.0125

Zeghiche, S. (2020). *La (non) reconnaissance sociale du décès/deuil périnatal: Variations spatiales, temporelles et interactionnelles* [Thèse de doctorat inédite]. Université d'Ottawa.

Zeghiche, S., de Montigny, F., & López, J. (2020). Les variations spatio-temporelles de la (non) reconnaissance sociale du deuil périnatal: Réflexion critique autour du concept de « deuil non reconnu » (disenfranchised grief). *SociologieS*. https://doi.org/10.4000/sociologies.12700