

Understanding Reproductive Loss: exploring sociological perspectives

Part 3: A social insight into bereavement and reproductive loss

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The final article in this 3-part series offers a sociological insight into bereavement following reproductive loss. The first article focused on the social dimensions of reproduction loss, exploring the way in which such loss is a social issue, as well as a biomedical one. The second article in the series focused on the moment of death and, drawing on the sociology of emotions, explored the implications for practice. But what happens to parents when they leave hospital and go home? How can midwives help parents to cope with their bereavement? Are feelings of grief, the resulting emotional reaction to loss, experienced in similar or diverse ways by different people?

In this article we consider traditional sociological approaches to grief and challenge the often held assumptions that the process of ‘letting go’ or severing the bonds with those who have died is the most appropriate means through which to resolve grief. More recent approaches to grieving take account of individual differences in ways of managing grief and coping with bereavement. A sociological perspective can offer practitioners a further insight into the needs of grieving and bereaved families. Here we consider what this means for practising midwives when a baby dies.

A sociological perspective on grief and bereavement

Most of the literature on grief and bereavement is rooted in psychodynamic and psychological theories. Key influences within this body of literature include the work of Freud (1913), Bowlby (1979) and Raphael (1984) who all agree that the aim of grief is to achieve resolution and recovery; in other words, after a period of grieving, the bereaved individual is expected to ‘let go’ and ‘move on’. The main criticism of this model of grief is that it can become *prescriptive* rather than *descriptive* and when an individual’s

experience and expression of grief falls outside of this model, then it is likely to be defined as abnormal or pathological.

It is only relatively recently that sociologists have begun to study the experience of grief and bereavement, offering new approaches which focus attention away from the individual, towards one which locates grief within social and cultural contexts. One of the key proponents of a new model of grief is Walter (1996), who argues that the process of grief involves the renegotiation of identity for the bereaved person. This is particularly significant in relation to reproductive loss since bereaved parents may need first to legitimate their identities as ‘mothers’ or ‘fathers’ when a baby is stillborn or dies before or shortly after birth. In a qualitative study exploring men’s grief following reproductive loss, McCreight (2004, p. 335) highlights this ambivalence in identity, arguing that men ‘questioned their identity as fathers, uncertain as to their right to the term “father”’.

In his exploration of the culture of grief Walter (1999) draws on the work of Parkes to highlight the way in which society frames the experience of grief. Parkes (1996) has likened grief to sex in that it is disapproved of if done in public. Certainly, Walter argues that there is no longer *one* way of grieving but much more freedom to express individual diversity within grief.

But, where does this leave practitioners who need to help people to cope and recover at times of loss? The guidelines that are available need to be helpful and not constraining but, as Walter argues, Western societies seem to be at a point where opinion is divided on whether dead people should be let go or kept with us. There is also the tension between the notion of each experience of grief being entirely unique and the need for people to share common experiences and know that whatever he or she is feeling is ‘normal’, rather than abnormal or pathological. This tension suggests that practitioners might be caught in a Catch 22 situation.

Read the following case study and consider how you would respond to the needs of Ann and her grief experience.

Box 1 Ann's story

Kate described her work as an agency community nurse and her visits to one of her regular clients called Ann. Ann was a 91-year old woman who lived in a granny flat attached to her son's house, where she had lived for 10 years since her husband's death. She lived mainly independently but needed assistance with bathing and getting dressed.

Ann was suffering from short-term memory loss and found it increasingly difficult to remember the recent past. Every day as Kate helped her with her bath, Ann would tell the story of how her baby died: *'Oh! Oh dear! I had a son, you know. He died. He was beautiful and he died. I don't know why and no-one ever explained it to me. They just took him away and I could not see him.'* She would cry and become very upset. This sad memory and the pain of Ann's loss had lasted for almost 50 years. Ann would begin the conversation about this loss in the same way almost as a daily ritual – but the pain that Ann experienced as she told this story did not seem to diminish. Kate felt that in caring for Ann she had a duty to listen and acknowledge this pain.

When Ann's son remarried Ann was transferred into a nursing home. Kate continued to visit Ann and was dismayed although not surprised that Ann's condition deteriorated and she died just six months after admission to the home. At the funeral, Kate recounted the story of Ann's grief for her son's death, only to find that close family members there were unaware that Ann had been experiencing this pain and talking about her loss. It seemed to be something that she kept from her son and grandchildren.

The example of Ann and other women like her who never recovered from the pain of stillbirth and neonatal loss suggests that they were not helped at the time in a way that would have allowed them to cope more effectively with their loss. It is important to recognise that some women who will have been treated in the same way will *not* have continued to experience pain.

The longer term consequences of reproductive loss

Sociological theory and research offers insights into patterns in the expression of grief and can highlight how differences are mediated by social and cultural contexts. It can also chart changes in the responses to grief and explore how institutions – which are charged with providing care within the context of allocating scarce resources – need to be

able to define the level of professional help needed to support people at a time of vulnerability.

It is not unusual for older women at the end of their lives to talk about stillbirth and neonatal loss (Sidell et al, 1999). The head of one nursing home here expresses a view that is typical of accounts from other heads of care homes for older people:

Quite often women begin to imagine that they can see the baby they have lost when they are near to death. One woman was so distressed about the need to have her baby close to her that we put a little crib that one of the staff loaned to us, next to her bed and that seemed to make it a bit easier. I've heard women talk about being reunited with stillborn babies – more often than being reunited with a husband. For men they want their wives when they are dying, for women children and their mothers are the first choice. (Komaromy, 1999, unpublished research data).

In a Belgian study, Bleyen (2007) has charted historical changes in practice following the death of a baby before, during or shortly after birth. In particular, he notes the move away from hiding the bodies of dead babies in favour of an approach which encourages mothers and/or fathers to hold, cuddle and dress their babies. Emphasising the importance of practice in the construction of identity, he argues that without the opportunity to meet their baby, parents could not be given the opportunity to form or construct an identity for that child.

In this final example you will see how, over the longer term, the impact of responses to loss can be profound.

Box 2 Marcia's story

Marcia was a 17 year-old woman who came to the hospital with her mother for a scan when 26 weeks pregnant. This was an unplanned pregnancy for Marcia and she was going to be a single parent. However she really wanted to be a mother, and she was delighted and looking forward to this very much. On one of the antenatal checks at her home, the midwife was concerned about the growth rate of the baby and thought that either Marcia was not as

advanced in her pregnancy as she thought, or that there was some foetal growth retardation. She referred Marcia to the clinic for a scan that day.

While the scan was being performed, Marcia became worried by the reaction of the ultrasound technician and, when told to wait a few minutes, she became extremely anxious. The technician returned after about 5 minutes and apologised for leaving Marcia, whom she could see was clearly upset, and her mother waiting. She told them that she was concerned because she could not find a foetal heart beat on the scan and would like the consultant to 'have a look'. The consultant arrived a few minutes later and she could not find a foetal heart beat either. She said, 'I am really sorry but there is no foetal heart.' Marcia did not fully understand what this meant. Did it mean that she did not have a baby or that her baby did not have a heart?

The consultant left and the technician asked Marcia and her mother to go with the clinic midwife who would explain what would happen next. The midwife at the ante-natal clinic where the ultra sound had been performed, escorted Marcia and her mother to a quiet room with a few armchairs and attractive décor. Marcia identified this as the sort of room where bad news would be delivered and braced herself. The midwife explained that she could choose to go home and come back the next day for a scan, or she could go to the antenatal ward, returning for a scan the next day. She then said, 'The scan is to make sure that your baby has died and we will have to induce labour after the scan.' At this point, Marcia's heart sank and she felt sick. Tears began to run down her face and her mother reached out and touched her hand. The midwife said, 'I am so sorry, Marcia.' They all sat in silence. It is a memory that is imprinted upon Marcia's brain and a scene she relives every night before she goes to sleep.

Marcia wanted to go home. Deep down she felt convinced that there had been some mistake. Although she knew that her baby had not moved at all that day, she was not too concerned because he had been very active the night before and so she thought he might be tired. She knew it was a boy and had already chosen a name. Marcia's baby was delivered as stillborn two days later.

Two years later she has not talked to anyone about this experience. She spends a lot of time at the grave where his ashes are kept, but does not want to share her baby or her grief about her baby with anyone else and neither does she expect anyone to understand her grief. To Marcia, the whole thing was treated by the professionals as if it was just one of those things, even

though everyone was very kind to her. For Marcia it felt devastating and like her world or her future had ended and she needed others to see that too. Her midwife made several visits to Marcia at home and was kind to her, but Marcia did not feel she really understood. She knew that she had children of her own any way and so believed she had no way of understanding. Marcia had wanted to take her baby home for one night but did not ask and no-one offered. She was saving her money to buy a special memorial for Matthew. She did not know what this would be yet.

Memorialisation after a baby dies

Rather than adopting the view that parents should ‘let go’ and ‘move on’ after a baby dies, memorialisation offers parents and other family members the opportunity to keep alive the memory of a baby who has died if they so wish. Drawing on the work of Walter, and extending the sociological critique of a traditional model of grief, Exley (2004, p. 116) argues that:

maintaining meaningful bonds (and relationships) with those who have died should not be seen as ‘pathological’ grief, but rather as part of the reflexive construction of self-identity and relationships engaged with on a daily basis.

The practice of memorialisation is not new and has commonly taken the form of permanent memorials, for example, in cemeteries. However, there are many different types of memorialisation and, writing about this in the *Guardian* newspaper, Joan Bakewell (2004) argues that ‘the new mantra of consumer choice now even applies to death’. After a baby dies, common forms of memorialisation include post-mortem photography, taking hand and footprints, or keeping a lock of hair, often storing these – together with other keepsakes – within a memory box. Most recently sociologists and other social scientists have also noted the growing trend for online memorialisation. Veale (2004, online), for example, argues that in increasingly fragmented societies where families and friends are often separated by distance, cyberspace offers ‘a holistic approach to memorialisation [which] has successfully improved upon memorialisation practices in areas such as timeliness, cost, accessibility, creativity, and enabled the sharing of grief and bereavement ...’ Of course, whilst not all scholars would agree with

this interpretation, it is certainly true that online memorialisation offers distinct opportunities for expressing grief following reproductive loss. The website *Empty Cradles* (www.empty-cradles.com), for example, offers a message board service and repository for posting letters, as well as other forms of memorialisation. In their online poll on memorialisation 20% of the 2882 bereavement parents who responded stated that they had created an online memorial. Other websites offer similar services.

The role of midwives and other practitioners

Sociologists have made an important contribution to the understanding of grief and bereavement by focusing on how practitioners can make a difference to the way in which individuals can express their grief and maintain, or create, their identity. It also questions traditional approaches to grief which define the need to hold on to memories, rather than letting go, as abnormal and unhealthy. In ways such as these, the sociological perspective can support midwives to reflect on their experiences and their practice.

Lang et al (2001) suggest that the loss of a child is the most difficult loss that a person can experience in their life and argue that the associated grief ‘...is particularly severe, long-lasting, and complicated’ (p. 498). As such, Rich (2000) – and others – argue that bereaved mothers and fathers have unique needs. As we explored in the first part of this series, it is also important to remember that reproductive loss is not equally distributed across the population and there is considerable inequality in service provision. However, knowing the best way to support someone who has lost their baby and to get it right – every time – is not easy.

SANDS, the stillbirth and neonatal death society, has had a huge impact on the way that midwives and other health practitioners respond when a baby dies. Writing about the new Sands Guidelines in the *British Journal of Midwifery*, Schott and Henley (2007) explore the evidence-base for current practice. Box 3 outlines some of the key issues for practising midwives.

Box 3 Some principles of good practice

- There is no conclusive evidence to show that parents should hold and see their baby and no evidence which justifies telling parents that they will benefit from this but neither is there sufficient evidence to show that this is harmful.
- Parents should not be expected to behave in a 'certain way' but should be given choices to enable and empower them.
- Perinatal mortality is higher among Black, Asian and Chinese women as well as among Gypsies and Irish Travellers; however, respecting women and their families means not stereotyping, labelling or making assumptions based on ethnicity.
- It is important to reflect on how your own values may affect your response to parents who have different values, ideas and wishes.

Useful resources

Babyloss (<http://www.babyloss.com>)

Cruse Bereavement Care (<http://www.crusebereavementcare.org.uk/>)

Ectopic Pregnancy Trust (<http://www.ectopic.org/>)

Foundation for the Study of Infant Deaths (<http://www.fsid.org.uk/>)

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Midwives Online (<http://www.midwivesonline.com/index>)

National Bereavement Partnership (<http://www.natbp.org.uk>)

S.P.R.I.N.G. (Support for Parents and Relatives in Neonatal Grief)
(<http://www.springsupport.org.uk>)

Tommy's (<http://www.tommys.org/>)

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