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Understanding reproductive loss: Exploring sociological perspectives

Part 1: The social dimensions of reproductive loss

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Pregnancy and childbirth: Happy or unhappy endings?

Pregnancy and childbirth can be an enjoyable and exciting time for women, men, families and the midwives who care for them, but not always. Sociologists, and other social scientists, have noted that the discourses (ways of understanding, thinking and speaking) which surround pregnancy and childbirth focus on positive outcomes and happy endings without acknowledging common, sometimes repeated experiences of reproductive loss. Layne argues:

... emphasis on happy endings, whether believed, to be the result of medical intervention or women's natural inborn powers to reproduce, exacerbates the experience of those whose pregnancies do not end happily. (Layne, 2003, p. 1881)

Of course, whilst most pregnancies end happily and others do not, some women are unable to conceive at all and others only achieve conception after years of infertility or via assisted conception. Look at Box 1, which provides some other examples of reproductive loss.

Box 1 Reproductive loss

infant death
infertility
early/late miscarriage
neonatal death
stillbirth
termination
(un)successful assisted conception

Would you agree that all of the experiences listed in Box 1 could be defined as a 'reproductive loss'? All of these experiences are very different. However, there are similarities, too. For example, each of these creates the potential for grief and bereavement, stimulating demand for particular information and support needs. All of these experiences also subvert the notion that reproduction is, in the modern world, certain and controllable.

Reproduction: Controllable or uncontrollable?

Over the past 40 years, there have been considerable changes and innovations in the way that society aims to manage human reproduction. The contraceptive pill, pregnancy predictor kits, ovulation kits and the increasing availability of the new reproductive technologies are just some of the ways in which women, men and families seek to gain control over reproduction. Some of these innovations can, and do, enable individuals to control if and when they have children but contraceptive failures do occur and reproductive technologies are frequently unsuccessful. Pregnancies fail and babies die and sometimes there is no known cause or explanation. Earle and Letherby (2007, p. 234) argue that, 'reproductive control is merely an illusion...' since experiences of reproduction are mediated by a wide range of social (and other) factors which mean that although some aspects of human reproduction can be controlled some of the time, they cannot all be controlled all of the time. Indeed Hull et al (1985) have described human reproduction as remarkably inefficient!

The concept of the lifecourse is useful in helping to understand the illusion of reproductive control. The life course refers to the expectation that individuals' lives will follow a reasonably linear path based on life phases and that particular events will occur within these phases. For example, children and young people are expected to go to school, complete their education and find work. Adults are expected to stay employed, form relationships, have children and die only when old. Our abiding notion of the family largely rests on being able to support people at different stages of the life course, childhood, youth, adulthood and old age. You can probably think of many other similar life events that are expected to occur at different phases within an individual's life. However, you can probably think of many other examples where life events do not follow a linear path. Cotterill (1994, p. 112) argues that the concept of the lifecourse is problematic since factors such as 'death, divorce, cohabitation and premarital pregnancy [amongst others] disturb the chronological order of the life course stages and create family forms which differ from the ideal'.

Busfield (1987) has argued that having children is a crucial component of the lifecourse, particularly for women although the decision may be made within a complex, even competing discourse:

It appears that it is difficult for young women to make the 'right' reproductive choices; if they become pregnant early, they are easily seen as educational failures and 'welfare cheats', but again, if they postpone motherhood, they are seen as 'selfish' and too career orientated. (Aapola et al., 2005 p. 105)

However, it is increasingly recognised that disruptions to the reproductive lifecourse are significant for men too, as well as for other family members such as siblings and grandparents. SANDS, the stillbirth and neonatal death charity, highlights the special information and support needs of the wider family (see Box 2).

Box 2 Recognising the needs of all family members

Fathers: After a pregnancy loss, mothers are often the focus of attention and sometimes fathers can be ignored. Men often report a feeling of needing to be 'strong' for their partners but this can affect their ability to express their own feelings of grief.

One bereaved father says: *"After our baby was stillborn, friends and family would take me aside and ask me how my wife was, never thinking to ask how I was".*

Grandparents: When a baby dies, grandparents lose their grandchild but they often do not know how to help their own child who is suffering.

One bereaved grandmother says, *"For me the suffering was doubly dreadful for, not only did I have to watch my loved grandson suffer and struggle for life, but I had to stand by and see my daughter completely heart-broken and be unable, perhaps for the first time since I gave birth to her, to help her in any way".*

(Adapted from SANDS (online) 'Special Support', <http://www.uk-sands.org/>)

When pregnancy is not chosen, not achieved, fails or ends unhappily, the life course appears disrupted and the social illusion of reproductive control – where one exists – is shattered.

Reproductive loss and the determinants of health

Sociologists would argue that reproductive loss is a social, as well as a biomedical, issue since the experiences of those women whose pregnancies do not end happily are often socio-economically determined. Poverty and social exclusion remains one of the most important factors in determining women's reproductive health. Access to reproductive health care (and healthcare more generally), such as family planning, maternity care and assisted reproduction, is also determined by social factors. Women of minority ethnic backgrounds also experience marked inequalities in health, as do other groups, such as lesbian women, refugees and asylum seekers. Similar patterns of inequality are evident across the world (Franklin and Ragoné, 1998).

According to the most recent perinatal mortality survey (CEMACH, 2007) there continue to be major maternal risk factors for perinatal mortality, in particular, social deprivation, ethnicity and maternal age. For example, mothers living in the most deprived areas are twice as likely to have a stillbirth compared to women living in the least deprived areas. The babies of women living in the most deprived areas are also 2.2 times more likely to die in the first month of life (see Table 1).

Table 1 Stillbirth and neonatal mortality rates by quintiles of deprivation, England, 2005

| | Live births | Stillbirth | | | Neonatal death | | |
|--------------------|-------------|------------|-------------------|-------------------------------------|----------------|-------------------|-------------------------------------|
| | | Number | Rate ^a | Rate Ratio ^c [95% CI] | Number | Rate ^b | Rate Ratio ^c [95% CI] |
| Total | 607,090 | 3064 | .. | .. | 1726 | .. | .. |
| 1 (least deprived) | 167,684 | 345 | 3.5 | .. | 171 | 1.7 | .. |
| 2 | 129,918 | 421 | 4.2 | 1.2 [1, 1.4] | 224 | 2.2 | 1.3 [1.1, 1.6] |
| 3 | 109,868 | 531 | 4.8 | 1.4 [1.2, 1.6] | 277 | 2.5 | 1.5 [1.2, 1.8] |
| 4 | 100,815 | 714 | 5.5 | 1.6 [1.4, 1.8] | 404 | 3.1 | 1.8 [1.5, 2.2] |
| 5 (most deprived) | 98,805 | 1040 | 6.2 | 1.8 [1.6, 2] | 640 | 3.8 | 2.2 [1.9, 2.6] |
| Missing | .. | 13 | .. | .. | 10 | .. | .. |

^aRate per 1000 total births

Sources: CEMACH PDN 2005, 2006

^bRate per 1000 live births ^cRate ratio using least deprived as baseline

ONS 2005

Note: second or subsequent deaths from pregnancies with multiple losses excluded from this analysis.

(Source: CEMACH, 2007, Table 1, p. 7)

Women from minority ethnic groups are also more likely to experience a stillbirth or neonatal death. For example, in England, women of black ethnicity are 1.9 times more likely to experience a stillbirth and 2.2 times more likely to have a baby die within the first month of life compared to women of white ethnicity (see Table 2).

Table 2 Stillbirth and neonatal mortality rates by ethnicity, England, 2005

| | Live births | | Stillbirths | | Neonatal deaths | | |
|----------------------|----------------------|--------|-------------------|-------------------------------------|-----------------|-------------------|-------------------------------------|
| | Number | Number | Rate ^b | Rate Ratio ^d [95% CI] | Number | Rate ^c | Rate Ratio ^d [95% CI] |
| Total | 613,028 | 3,390 | .. | .. | 2,149 | .. | .. |
| White | 476,900 ^a | 2,302 | 4.8 | .. | 1,476 | 3.1 | .. |
| Black | 28,200 ^a | 331 | 11.6 | 1.9 [1.7, 2.1] | 192 | 6.8 | 2.2 [1.9, 2.6] |
| Asian | 50,800 ^a | 455 | 8.9 | 1.5 [1.4, 1.7] | 246 | 4.8 | 1.6 [1.4, 1.8] |
| Chinese | 2,400 ^a | 10 | 4.1 | 0.7 [0.4, 1.3] | 10 | 4.2 | 1.3 [0.7, 2.4] |
| Other & mixed origin | 18,400 ^a | 177 | 9.5 | 1.6 [1.4, 1.9] | 119 | 6.5 | 2.1 [1.7, 2.5] |
| Not known | 36,500 ^a | 58 | .. | .. | 69 | .. | .. |
| Missing | .. | 57 | .. | .. | 37 | .. | .. |

^aEstimated distribution according to maternity HES

Sources: CEMACH PDN 2005 & 2006

^bRate per 1000 total births ^cRate per 1000 live births

Maternity HES 2004-2005, ONS 2005

^dRate ratio using White ethnicity as baseline

(Source: CEMACH, 2007, Table 2, p. 8)

Women aged less than 20 and above 40 also have a higher perinatal mortality rate. For example, the stillbirth rate for women over 40 was 7.2 per 1000 and the rate of neonatal death was 4.0 per 1000 live births. This is in comparison to the very lowest stillbirth and neonatal mortality rates observed in women aged 30-34 years (3 per 1000 total births). However, women in their teens have the highest rates of neonatal mortality (CEMACH, 2007).

Maternal risk factors and the social determinants of health overlap. For example, women in their teens are at an increased risk of experiencing stillbirth and neonatal death but this group may be more likely to live in socially deprived areas. Reproductive loss is, quite clearly, a social issue since it occurs disproportionately amongst the population.

The harmful consequences of reproductive loss

Reproductive loss – of whatever kind – can have a distressing effect on women and their families with potentially harmful emotional consequences. Writing specifically about miscarriage, Simmons et al (2006) highlight the important role of midwives and other health professionals in reducing these potentially harmful consequences. They argue:

... professionals play a key role in defining some miscarriage experiences
 and thus have an opportunity to reduce the traumatic impact and
 potential psychological sequelae ... (Simmons et al, 2006, p. 1943)

Read 'Laura's story' in Box 3 and think back to the first time you cared for a woman with an unhappy ending to her pregnancy.

Box 3 Laura's story

Laura was a student midwife on a busy labour ward. She arrived on duty one afternoon for a late shift to discover that there had been a stillbirth and that the baby's mother was critically ill following a post-partum haemorrhage. She had just been transferred to the intensive care unit. The staff members on duty were quiet and subdued by the traumatic events of the delivery. The family were still in the visitor's room on the labour ward and had requested to see the baby. Laura's first job was to wash and dress the baby and take her to the family. She had been asked to do this because she was a trained counsellor and she agreed.

As she washed and dressed the baby, Laura talked to her and then took her to meet the other members of her family. There were four people in the room, the baby's father, grandmother, grandfather and an aunt. Laura said 'hello, I have brought the baby to meet you' and lifted the baby girl out of the cot to show her to them. The baby's grandmother stepped forward and took her in her arms. Laura asked the family if they wanted to be alone with her and they nodded agreement and she left them for half-an-hour before returning to see if they needed anything. She noted that the family had returned the baby to her cot and were sitting in silence. With their consent, she took the baby from the room telling the family that they could see her at any time while she was in the hospital. They asked to be taken to the intensive care unit and Laura allocated another member of support staff to go with them.

Laura returned the baby to the small treatment room where she was being kept prior to transfer to the hospital mortuary. One of the midwifery managers entered the room and spoke to Laura. On seeing her, Laura burst into tears. The manager reached out and touched Laura's arm. Laura apologised and explained that she had not realised how distressing this would be – it was her first experience in caring for a woman who was experiencing stillbirth. The midwifery manager said, 'That makes no difference, it never gets any easier.' Laura found this very comforting.

When Laura reflected on this later she knew that she had felt confident that she would be able to respond sensitively to the needs of the family and therefore was not afraid of having to find the 'right' words. However, in the whole of her training as a nurse and so far in midwifery, she had not received any professional development in bereavement care. Without her own development in this area she would have continued to feel unqualified to help.

Normative expectations dictate that pregnancy and childbirth will end happily and with positive outcomes. Experiences which do not conform to these ideals are difficult to reconcile with these positive expectations. How did Laura's experience compare with your own? Where there any similarities or differences between your experiences? Laura's story highlights the importance of ensuring that midwifery education, training and professional development acknowledges the potential for unhappy endings.

Whilst reproductive loss is distressing to women and their families, working in such situations and within settings where endings are often unhappy is also difficult for the people charged with providing the appropriate care, information and support to bereaved families. Writing about the role of healthcare providers within neonatal intensive care units (NICU) Reilly-Smorawski et al (2002, p. 22) argue that: 'Providing care for families of dying infants in the NICU is a uniquely intense and painful experience.' Now look at Box 4 and read Martine's story of working on a special care baby unit.

Box 4 Martine's story

Martine had worked on the special care baby unit for two years. Joseph, one of the babies on the unit, had been born at 25 weeks gestation and the staff had all become extremely fond of him and his mum, Rachel during his long period of recovery. When James was nearly ready for discharge, the staff encouraged Rachel to move into a small en-suite room on the ward and helped her to take over all of his care.

Sadly, Joseph contracted necrotising enterocolitis and deteriorated very rapidly and died despite attempts over several days to keep him alive. Everyone in the unit felt desperately sad and some felt unable to cope with the shock of Joseph's death. Most difficult of all, seemed to be that Joseph had seemed past the dangerous time and was nearly ready to go home. Rachel did not want to spend time with the staff after his death, and despite encouragement to return to the unit or to become a member of the unit's bereavement support group, Rachel did not take up these offers. The staff felt at a loss to know what to do and felt that Rachel's rejection of their support was an expression of blame for his death, or their failure to save him.

Sociologists have argued that the medicalisation of pregnancy, childbirth and early parenting can lead to the illusion of omnipotence – or power – within reproductive healthcare. Many lives are improved and saved through medical, technological and pharmacological advances in healthcare. However, the illusion of omnipotence is difficult to reconcile when things go wrong and places midwives and others in challenging situations within already demanding settings.

Both Martine's and Laura's stories highlight the continuing need to acknowledge and respond to the emotional impact of caring for mothers and babies. Moss and Brannen argue:

Care as a concept and its particular contextualized meanings shape our understandings and interpretations of the world and the ways in which we consider how we and others ought, or expect, to act. At the same time, care is a *social scientific concept*, and as such an analytical tool which provides critical, in-depth insights into social phenomena. (Moss and Brannen, 2003, p. 4-5 original emphasis)

Care is an important concept within midwifery and to be caregivers, midwives have to be care receivers too. Laura's story illustrates the importance of de-briefing and sharing experiences with other colleagues Reilly-Smorawski et al (2002) suggest that knowing what happens in the lives of families after reproductive loss is important since follow-up can help midwives and other caregivers to cope with feelings of sadness, failure, guilt and distress. Laura's story also illustrates the importance of de-briefing and sharing experiences with other colleagues. Some of the literature also highlights the important role of humour, especially when coping with difficult situations. Drawing on her research on gynaecology nursing, Bolton (2005) argues that shared banter, humour and playing practical jokes play an important role within an environment where much of the work is regarded as socially distasteful, difficult and tainted. For example, one staff nurse in her study comments: '*We're well known on here for being a bit mad. We have some brilliant nights out where we really let off steam, but we manage to do that at work as well. We would be mad if we didn't.*' (Bolton, 2005, p. 180).

Mary Sidebotham, Clinical Midwifery Specialist urges all midwives to encourage women within their care to act on their concerns if they are worried and to learn that the worst thing to say to a worried pregnant woman is 'don't worry'. She also suggests:

The midwife has a responsibility to keep herself updated and learning is a constant requirement. We must learn from all situations and that means listening to people carefully. Midwives are encouraged to reflect and put what they have learned into practice. (Sidebotham, online, <http://www.uk-sands.org/>)

In the next article within this three-part series on the sociology of reproductive loss the focus is on the moment of death and it explores the key role of midwives in providing support when a baby dies and immediately afterwards.

Useful resources

- Layne, L.L. (2002) *Motherhood Lost: A feminist account of pregnancy loss in America*, Routledge, London.
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- Open learning materials on living with death and dying: <http://openlearn.open.ac.uk/course/view.php?id=1621>.
- Social aspects of death, dying and bereavement study group, British Sociological Association, <http://www.britisoc.co.uk/specialisms/MedSocDDB.htm>.

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