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Reclaiming a moral identity: stillbirth, stigma and 'moral mothers'

Abstract

Objectives: to understand the effect of expectant motherhood discourses on parents who suffer a stillbirth.

Design: a qualitative, exploratory study using in-depth interviews to understand parental experience of stillbirth.

Setting: interviews took place in the homes of bereaved parents across several English health authorities.

Participants: 10 couples and 12 mothers who had experienced a stillbirth.

Findings: mothers were keen to distance themselves from behaviour that might be seen as stigmatising, that is, smoking, drinking, etc., while pregnant. Fathers, while keen to stress that their partners had behaved well in pregnancy, made no such claims.

Key conclusions: stillbirth constitutes a threat to a maternal 'moral' identity which results in a differential experience of loss for mothers than for fathers.

Implications for practice: comprehending that the experience of stillbirth might lead the mother to feel that her identity as a 'moral mother' is under threat is essential in understanding the maternal experience of stillbirth.

Introduction

Stillbirth¹ in the United Kingdom is a relatively rare event. In 2009, the stillbirth rate in England and Wales was 5.9 deaths per thousand births (ONS, 2010). While the rate is relatively low, the numbers of stillbirths that year ran into the thousands – there were 3688 deaths, which left a significant number of parents bereaved. Although we may consider experiences of stillbirth to be highly individualised, societal influences on such events may be observed at both macro and micro levels. For example, a mother’s ethnicity and/or social class affects the likelihood of experiencing such a loss while, in day-to-day interaction, the support that parents receive is dependent upon their social networks (Rajan and Oakley, 1993), as well as the recognition afforded their bereavement (Murphy, 2009). This paper reports on data gathered from in-depth interviews that explored parental experience of stillbirth and argues that these accounts illustrate that the gendered discourses that exist around parenthood, particularly motherhood are integral in the framing of the experience. It argues that the unintended consequences of such discourses render the loss differential for men and women because of social perceptions of the ‘moral mother’.

Literature review

Previous research around stillbirth has identified how it involves both tangible and intangible losses. The tangible loss is of a baby and contemporary practices around stillbirth – seeing and holding the baby – reinforce the reality of the loss. Prior to this, the practice of ‘hiding’ the stillborn from the parents,

¹ Defined as the death of a child born after 24 weeks’ gestation and “...which did not at any time after being completely expelled from its mother breathe or show any other signs of life” (Confidential Enquiry into Stillbirths and Deaths in Infancy [CESDI], 2001:12).

prevalent up until the early 1980s, was argued to render the loss 'intangible' for them (Lewis, 1976). There are, however, intangible losses associated with stillbirth such as the loss of parental hopes and dreams for their child (Jones, 2001) and, for first-time parents, the perception that others will view them as having lost their putative roles of mother and father (Murphy, 2009).

The social categories of mother and father are not neutral ones: they hold particular meanings and significance across time and place and this is particularly relevant to the identity of mother due to the embodiment of pregnancy. Indeed, all societies seem to have had various taboos around pregnancy (Rothman, 1989), in pre-industrial societies, such taboos would have been based upon superstition and would demand a compliant mother-to-be. Western industrialised societies may be seen to be no different. The concept of the 'moral mother' can be identified to the beginning of capitalist society (Chodorow, 1978; Westwood, 1996) and in late modernity, she is in existence still: her overriding guiding ethic is the proper care of children (May, 2008). Copelton (2007) claims that the moral mother is an identity to be taken on before birth, indeed at conception or earlier, and that there is now an ideology of the 'expectant mother'. This, Lowe *et al.*, (2010) maintains, is a consequence of the creation of a 'public foetus'. Women are now required to be consciously aware of what the foetus needs and learn how to protect and nourish it (Rothman, 1989). What sets late modernity apart from other societies is that the advice given to women by medics resides in the discourse of science and is thereby privileged by late modernity but such taboos are,

arguably, a postmodern manifestation of those earlier strictures that were based in religion or superstition.

The 'rule-following' mother

Like many other societies, much of the advice given to pregnant women centres on the care they need to take with substances claimed to either harm or protect the foetus (Petrou *et al.*, 2001). With regard to the ingestion or otherwise of particular substances, the expectation is that the pregnant woman will modify her behaviour. Such discourses, to be found in ante-natal advice, parenting magazines and books, as well as government health campaigns, have the power to create a consciously self-regulatory mothering identity (Lowe and Lee, 2010). Disseminating and encouraging particular forms of behaviour are government-funded health campaigns that are not only targeted at behaviour modification but which also effectively label mothers 'good' or bad' (Oaks, 2000). These campaigns have led to an ideology of the 'expectant mother' (Copelton, 2007). Looking, for example, at nutritional intake, Copelton (2007) argues that

[c]onsuming a nutritious diet in pregnancy, then, becomes part of the cultural expectations of the good mother and women construct positive identities as good mothers by attempting to manage their prenatal diets (p. 490).

More recently, however, diet has also focused on moderation: the 'good mother' is now one who is not obese (McNaughton, 2010). Neither does the 'good mother' smoke (Oaks, 2000) or drink (Kukla, 2010). The moral

pregnant mother, then, is summed up by Oaks as "...one who is self-sacrificing, nurturing, and compliant with medical advice" (Oaks, 2000: 77), and held to higher standards of risk management than the rest of the population (Kukla, 2010). Kukla (2010) notes that there has been a failure to find a link between light-to-moderate drinking and foetal harm, yet total abstinence is recommended. Markedly absent from discourses of foetal protection are those who constitute the mother's social circle, with there being little advice on "...how foetuses may be put at risk by the behaviour of fathers or others" (Kukla, 2010: 325). Prevalent in western cultures, then, is an idea that it is the mother rather than anyone else who, from conception onward, has to develop "...a notion of 'maternal competence', a sense that they *are* able to protect and foster the growth of their children" (Ruddick, 1980: 344).

In contrast to the stance of the 'moral/good/responsible mother' is an 'immoral/bad/irresponsible mother'. This may be effected by drug addiction (Radcliffe, 2009), alcohol misuse (Armstrong, 2003) or smoking (Oaks, 2000). Inasmuch as such mothers fail to live up to the societal ideal of pregnant mother, they run the risk of stigma (Goffman, 1963). Goffman's influential work charts the relationship between an individual's 'virtual social identity', that is, the expectations one might have of an individual, and their 'actual social identity'. Where there is a disparity between the two, the individual's identity may be 'spoiled' and the individual is "...reduced in our minds from a whole and *usual* person to a tainted, discounted one" (Goffman, 1963:12) and is thus morally discreditable.

Meanwhile, although men are encouraged to take part in pregnancy in a way that they have not been before (Draper, 2003), the embodiment of pregnancy

is such that any understanding of fatherhood is necessarily different to motherhood (Lupton and Barclay, 1997). While 'maternal competence' might be a normative identity that the 'good mother' will willingly embrace during pregnancy through taking on board and acting upon medical advice, paternal competence, can only really be performed after birth. Therefore, it can be seen that, beyond the idea of a loss of a baby, issues of identity might be at stake during pregnancy and that stillbirth not only brings the likelihood of the loss of 'mother; but particularly the loss of the identity of 'moral mother'. With this loss comes the potential for stigmatization regardless of the reality of the mother's behaviour.

While the advice given to pregnant women might have the perceived best interests of the foetus at its centre, such advice may be seen, then, to have both intended and unintended results. For those women whose pregnancy outcome might be seen as less than successful, that is, the pregnancy does not result in a healthy child, such advice may have a detrimental impact, particularly when enclosed by normative notions of motherhood. Considering her research participants whose children were born disabled, Landsman (2000) has noted that

[mothers]... hold themselves or feel they are held accountable by others for the failure to produce a normal child despite their access to expert medical knowledge (p. 173).

While to follow medical advice might enable women to feel in control of their reproductive lives, the discourses that demand health-promoting behaviour for both mother and foetus can be seen as potentially problematic for women

who have had a stillborn baby, just as they were for those women who participated in Landsman's (2000) research. In exploring parental accounts of stillbirth this paper presents the difficulty such discourses present for women following a stillbirth and how, during the interview, they performed 'identity work' in order to delimit any potential stigma.

Methods

This research took an exploratory approach and used in-depth interviews to produce a theoretical framework through the application of grounded theory (Strauss and Corbin, 1990). Indeed, I undertook this research from a symbolic interactionist perspective that was concerned to understand the meanings that men and women brought to their experience. I sought and was given ethical approval for the research by my local NHS Research Ethics Committee and the University of Surrey.

Recruitment and sample

Men and women who had experienced a stillbirth since 1993, and not less than six months prior to the interview, were eligible to take part in the study. This time frame was put in place so that parents would have had time to adjust to the initial loss and be able to give an account, not only of the experience itself, but also its longer-term ramifications. My decision not to interview anyone who lost a baby prior to 1993 was based on the fact that this was the year when the legal definition of stillbirth moved from a loss after 28 weeks' gestation to 24 weeks' (Sands, 2008: online).

Recruitment was not easy. Initially I approached hospitals to see if they could assist with recruitment. Of the thirteen maternity units in the south-east of England that I approached only two were willing to do so, but no parents actually came forward to take part. I then focused on networking as a method of recruitment: I gained one or two interviewees through personal contacts as well as through groups associated with childbearing, that is, the NCT, the Birth Trauma Association and Babyloss.com (the latter two hosted adverts for participants on their website). By far the most productive route of recruitment was through support groups run by Sands. I also gained some participants through snowballing and the Sands online forum.

In the event I interviewed the parents of 22 stillborn babies. I interviewed both parents of ten of the babies as well as 12 mothers whose partners were unwilling to take part. All participants were heterosexual. The interviews took on average two-and-a-half hours, with the shortest interview being one-and-a-half hours and the longest four hours. In the main, parents came from a spread of classes, though most could be classified as being in the highest three social classes, and were mostly white. The characteristics of both class and ethnicity were probably a consequence of my recruitment methods: self-help groups tend to consist of middle-class participants (Allsopp *et al.*, 2004). Given the method of recruitment it must be borne in mind that these parents are probably atypical of the population of interest.

At the beginning of the interview parents were asked to tell the story of their stillbirth from the moment they found that they were pregnant or when they

decided to try for a baby. Once they had told their story, we discussed in more depth various aspects of the experience including the understandings they had of pregnancy and of motherhood and fatherhood.

The analytical approach to the interview data was informed by grounded theory (Strauss and Corbin, 1990). All the interviews were recorded and transcribed in full with any identifiers being removed and pseudonyms given to all participants. While later interviews were taking place, the first interviews were being analysed using the data software program Atlas-ti. From this early analysis, initial concepts were generated that informed the later interviews. During the open coding, hundreds of concepts were isolated which were then grouped into categories. Once categories were isolated, using the process of axial coding, subcategories were set up to explain them. Thus, the category 'expectations of success' which related to the idea that pregnancy for the parent interviewed would necessarily end with a live, healthy baby, was explained by the four subcategories of 'medicine', 'bodily integrity', 'competency' and 'silence'. This is helpful as an example of the way in which macro-structures can begin to be understood from micro-analysis (Strauss and Corbin, 1990). The themes presented here, while not generalisable, offer an insight into parental experiences of stillbirth and how ideas around how women should behave in pregnancy have unintended consequences for those who suffer a stillbirth.

Findings

Analysis of the accounts collected suggested that women and men expected that the pregnancy would end with a live, healthy baby because of four core beliefs. These were: a trust in the capabilities of medicine; multiple silences

around stillbirth, for example, in their social networks; a sense of bodily integrity; and, of particular interest here, maternal competency. There were two main aspects to maternal competency: the first was 'rule-following' and the second was more abstract but akin to an instinctual 'knowingness' that mothers should be imbued with. This resonates with Lupton and Barclay's (1997) 'essentialized' aspect of motherhood. The data presented here, however, concentrates on the 'rule following' aspect. It also deals with how, in the experience of stillbirth, the allocation of blame (or the perception of how it might be allocated) emerged as a theme.

Claiming competency

Competency, in the form of rule-following, was referred to by the parents of 14 of the stillborn babies: in order to keep the baby safe, they recounted how they had taken certain steps to ensure their safety. Most often this was in respect of advice not to smoke or to drink. Indeed, the 'good' behaviour that the mothers exhibited during pregnancy was made clear to me early on in the interviews, giving a clear indication that this was a significant theme. It could be surmised that, in making such claims, mothers were exonerating themselves from any blame for the death. For example,

Penny: We had a post-mortem but it (cause of death) was unexplained. I hadn't drunk, hadn't smoked.

Barbara: I don't smoke, I don't drink and so it was none of those, I don't take drugs, all those eliminating factors.

The mention of the 'eliminating factors' clearly demonstrates the adherence to the idea that pregnancy, once established, is under the control of the pregnant woman through the modification of behaviour. However, the death of the baby brought with it the danger that others might think that she was, or they were, in some way to blame. Losing the veneer of maternal competency, then, is a risk following a stillbirth, especially in cases where the stillbirth was unexplained. Mothers did not only justify their behaviour to me; one mother explicitly mentioned recounting to others that she had 'behaved well'. Christina had come to the conclusion that there would be a chance others would then scrutinize her own behaviour and was keen to refute any allegations that could be made, as she explains:

Christina: But there *has* to be a reason. There doesn't have to be; but most people think there's *got* to be a reason for things to happen. So I wonder if people look at me and think "Well, why did her baby die? What happened?" If I'd see them out, if I had a drink in one hand and a fag in the other I'd say "I didn't drink or smoke when I were pregnant you know".... I wanted them to *know*. I didn't want them to think "God, she was like this when she were pregnant".

While Christina did not experience people blaming her directly for the loss, that was not the case for all mothers and the next section considers where women had explicit assaults on their competency.

Assaults on competency

Two mothers interviewed for this project recounted having been blamed for the death by members of their respective families. In her interview, Maggie, a south-Asian woman whose first-born son died at 28-weeks' gestation, recalled what her mother, the one person you might hope to turn to for sympathy in the face of loss, had told her:

Maggie: My Mum kept saying “You killed him, you killed him”. She kept saying “You didn’t know, you read all these books and you didn’t know what was happening”.... And you know, for a long time I blamed myself.

Tanya, too, was blamed by members of her family for what happened. She had rejected medicalised pregnancy and birth and had employed an independent midwife, intending to have a home birth. She had also decided not to have an ultrasound scan. The blame here was due to her ‘failure’ to utilize the technologies of medicine, specifically the scan. The very people who might be expected to be sympathetic – her family – were judgemental. Tanya claimed in her interview that it was not just her family who held her responsible for the stillbirth. In her account of her experience in hospital she referred to an incident with a midwife, which she claimed to be an assault committed upon her because:

Tanya: [t]hey like to punish you for daring to question their system.

Indeed, a lengthy complaint procedure was still ongoing at the time of the interview several years after the stillbirth. Tanya felt the reaction of other Sands mothers to her story was discriminatory, too, as at support groups

Tanya: [felt] odd. Because once I started to say that I was home birth [and] I didn't have any scans and I always got that feeling that there was this kind of, "Well that's why your baby died, because you didn't have a scan."

This happened to the extent that Tanya stopped attending the meetings. It is interesting to note that the power of the ultrasound scan as a tool for preventing stillbirth is perhaps overestimated by the population – all the other mothers I interviewed had taken a scan yet their babies still died. A misunderstanding of the capabilities of the ultrasound scan in protecting an unborn baby in this way has the potential to stigmatize the mother of the stillborn who has chosen not to avail herself of 'normal' antenatal care. But what of the father? In the accounts given by fathers a very different story was told.

Competent fathers?

Due to their lack of a physical connection to the baby, men did not refer to rule-following with regard to their own behaviour during their partner's pregnancy. Government advice recommending that men be in the best of health prior to conception was not referred to either: this advice, of course, presupposes that babies are being tried for; while all of the participants had

wanted their baby, not all of the pregnancies were planned. However, men reinforced the idea that their wives had been competent and had behaved in the way that they 'should'. This reinforcement would be sometimes explicit at the interview or implicit inasmuch as the men did not contradict their partners during the interview. Not, of course, that one would have expected them to, but even in the interviews with fathers where their wives were not present there was no criticism of their behaviour. For these men competency was a property of their partners:

Bob: You [to his wife] were also very careful. I mean *you* did absolutely everything by every book that we could read and knew about. *You* took all the right vitamins, avoided all the wrong foods. *You* did, you know, [you] changed your exercises at the gym.

They were keen to ensure that their partners were not blamed for the stillbirth. By extension it could be surmised that they too were concerned not to suffer any courtesy stigma via their association with their partner. However, one father did refer to himself as potentially stigmatised by drawing on the trope of genetic abnormality:

Ian: And it puts a slur on us as patients [sic] that obviously there's something wrong with our genes or we're inadequate in some way, 'cos children don't die. So I feel there's absolutely nothing wrong but outwardly my perception of how we're perceived is that we're second-rate parents for some reason. God help the first person who ever says that to us [laughs] perhaps more of what my perception of the reality is rather than what it is.

Similar to Christina's statement earlier, Ian's consideration of other people's perception demonstrates a high degree of reflexivity. On the whole, however, from the accounts collected, it seems from this research that it is mothers who are more at risk of having their competency questioned by themselves or others than are fathers.

Discussion

It is apparent that, in analysing parental accounts of stillbirth, the ideology of the 'expectant mother' is fundamental in framing women's experience of stillbirth. The well-intentioned medical advice given in pregnancy, which is well known to most members of contemporary western societies, required that women who experience a stillbirth need to undertake a certain amount of 'identity work' following the loss. This is necessary to distance themselves from the behaviour associated with the 'immoral mother', that is, the mother who does not have the best interests of her child at heart and indulges in transgressive behaviour accordingly.

Most of the women interviewed had unexplained stillbirths and, in a society where science might be expected to provide reasons for the loss, the lack of a reason holds the potential for conjecture that the mother herself may be at fault. It is not suggested here that, apart from the two exceptions, any of the mothers interviewed were explicitly blamed by members of their social circle for the death, but that does not necessarily mean that there was no suspicion of misbehaviour. As such, the bereaved mother of a stillborn is at risk of suffering from stigma. So it seems that Goffman's (1963) concept has some relevance here. Indeed, it is interesting to note at this point a comment made

by Charlotte whose son died during labour: the NHS trust admitted liability for the loss. As she said:

Charlotte: I'm lucky. I have nothing to feel guilty about.

The phrase 'nothing to feel guilty about' recognises the complex nature of discourses around pregnancy and motherhood and how these ideas may serve to affect those women who lose their baby to stillbirth.

The aim of the identity work performed during the interview and, according to one or two interviewees elsewhere, was a way in which mothers were able to reclaim their moral identity as the 'moral mother'. This was necessary as if they considered certain behaviours as being detrimental to a baby's health then, logically, other members of their social network might suspect them of indulging in the same behaviour and, as a result, blame them. While this might only be a perception, rather than the reality of their situation, in taking the role of others and expressing the opinions that others might hold which could potentially discredit them, these women were experiencing what Goffman (1963) referred to as 'felt stigma', that is, they were internalising the mores of a given society and judging themselves by them.

With pregnancy being embodied in the mother, fathers' experience of stigma is different. Fathers would take up this theme and reinforce it but would not be reinforcing their own competency: they did not perceive themselves as having had any rules to follow. While they may have been distancing themselves from a 'courtesy stigma', that is, a stigma where an individual is 'tainted' by association with the stigmatised individual (Goffman, 1963), there was no doubting of their actual social identity: their moral worth remained intact. Here lies the crux. While these men and women had lost their babies –

a tangible loss for them both – for the women interviewed there was also a threat to their self-identity of ‘moral mother’. The attempts to explain in the interview and to other people that they had done everything right might be seen as ways in which they could pre-empt other people from thinking less of them.

Equally important, though, in the understanding of how participants felt that they might be stigmatised, were the possible social identities that are attached to ‘bereaved parent’. In highlighting those women who might have a stillbirth – young mothers, smokers, drug addicts and women who drank to excess – the participants demonstrated how these social identities may be seen to be highly stigmatised: they are identities of the type of woman who might care not for her unborn child but only for herself. The fear for the women I interviewed was that some semblance of that ‘undeserving mother’ label might be attached to them and so the associated characteristics were ones from which they wished to distance themselves. Referring back to Goffman’s work once more, there was a possible ‘virtual social identity’ that required many of the mothers interviewed to reinforce the idea that their ‘actual social identity’ was ‘moral mother’, a competent woman who had behaved well but had unjustly lost her baby.

Conclusions

Medical science is assumed by many to provide explanations when things go wrong with our bodies, yet, two-thirds of stillbirths remain unexplained. This gap in medical knowledge is, arguably, a gap which enables women to feel

that others may blame them for the loss of the baby. The medical advice that exists around pregnancy is rich in its potential to provide ways in which the bereaved mother may blame herself for the loss or feel that her social circle may locate the blame in her. As such, following a stillbirth, the mother of the stillborn loses not only the baby and the attendant status of mother but also that of the 'moral mother', that is, the mother who is able to protect and nurture her baby. While it is important to recognise the needs of men following a stillbirth, this assault on the mother's identity also needs to be acknowledged; mothers need to be reassured that it is not they who are at fault, indeed, that it may be no one's fault.

The midwife who is dealing with bereaved parents needs to be aware of this propensity of the mother to blame herself. Strategies to prevent this may include encouraging the mother to have a post mortem and giving her and her partner the intellectual tools to understand that guidance in pregnancy is based on statistical likelihood, therefore, should not be used as a way in which she can blame herself for the death of the baby.

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