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## “I'd failed to produce a baby and I'd failed to notice when the baby was in distress”: The social construction of bereaved motherhood

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# **“I’d failed to produce a baby and I’d failed to notice when the baby was in distress”: the social construction of bereaved motherhood**

## **Introduction**

The impact for women of stillbirth, which is defined in the UK as the death of a baby following 24 weeks’ gestation (NHS, 2018: online) cannot be understated. It is a traumatic and devastating experience for women and there is now a large body of research which demonstrates this. Such research has focused on documenting emotions such as shame and stigma (Cacciatore et al., 2013; Murphy, 2012; Brierley-Jones et al., 2014-2015), shock and numbness (Giles, 1970; DeFrain et al., 1986; Burden et al., 2016); denial (DeFrain et al., 1990-91); guilt (Peppers and Knapp, 1980; Downe et al, 2013; Burden et al., 2016); anger and bitterness (Seitz and Warrick, 1974); feelings of failure (Lewis and Page, 1978); and jealousy of other women’s pregnancies (Borg and Lasker, 1982). The impact of stillbirth on parental mental health following stillbirth has been another area of interest with mothers seen to more at risk of problems in this area than fathers (Armstrong et al., 2009; Murphy et al., 2014). Post-traumatic stress disorder has been suggested to be a particular issue for women and it has been linked to practice whereby women are encouraged to see their stillborn baby and have contact with him or her (Hughes et al., 2002). This was a matter of some controversy as the right for women to see and hold their stillborn baby had been long fought for. The research team received hundreds of letters from parents which accused them of ‘turning the clock back’ to the 1970s when the handling of a stillbirth In the UK was like a ‘rigger pass’<sup>1</sup>. It remains an area of debate although there is evidence to suggest that as long as the experience is handled well it is entirely appropriate to at least offer the mother the sight of the baby (Erlandsson et al., 2013). Much of the work outlined above lies within the

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<sup>1</sup> The ‘rigger pass’ was used to describe the practice of a stillborn baby being removed from the delivery room as quickly as possible following the birth. The mother would not be allowed to see it.

academic discipline of psychology concerned as it has been to document the range of emotions and mental health outcomes that women experience after losing a baby to stillbirth.

Stillbirth is, however, a social experience. Like birth or death – of which it encompasses both – stillbirth does not happen in a vacuum and, from the beginning of the experience to the end, a range of people are involved which include partners, family, friends, work colleagues and health professionals. Moreover, there are also particular societal ideas around pregnancy and motherhood that have the potential to impact upon the experience.

By drawing on the experiences of the 22 bereaved mothers and fathers that I interviewed as part of a doctoral research project I will set out how the experience of bereaved motherhood can be seen to be socially informed by considering how societal ideas about what it means to be a ‘good mother-to-be’, conspire to impact negatively on women bereaved by stillbirth.

While I use the term discourses to refer to societal ideas around motherhood and identity, this project was not undertaken as a discourse analysis. Rather I was interested to find out how women referred to wider ideas around pregnancy and mothering and how these ideas impacted upon their experience.

Before outlining the research findings, I will explore the sociological and anthropological research on pregnancy loss and then consider pertinent research around pregnancy and mothering. It is worth noting that while this article is concerned with stillbirth, the literature included here on pregnancy loss includes other forms of loss. The body of literature in this area tends to conflate various forms of pregnancy loss into one category. For example, stillbirth is often considered alongside neonatal death and miscarriage. This makes for a rather imprecise literature (Murphy and Cacciatore, 2017) which needs careful consideration.

## **The social side of pregnancy loss**

While there has been much psychological work on the experience of stillbirth, by comparison there has been less sociological and anthropological work in this area although this has begun to change over the last decade. In the United Kingdom, Alice Lovell was one of the first researchers to begin to interrogate this area. Lovell (1983) highlighted how the social location of the parent may have some impact on the experience of loss: the explanations given to parents about the pregnancy loss by medical staff were dependent both on class and cultural differences: women from ethnic minorities or lower social classes were given less information about their pregnancy loss than their contemporaries who were drawn from the middle classes. In interviews with both health professionals and bereaved mothers, Lovell (1983) also found that health workers would consider earlier pregnancy losses to be less traumatic than later ones. This ‘hierarchy of grief’ suggested that a miscarriage was not as bad as a stillbirth which, in turn, was not as bad as a neonatal death. Lovell’s (1983) interviews with bereaved mothers contradicted the views of the professionals: along with Peppers and Knapp (1980), she noted that a major determinant of grief was parental commitment to the pregnancy. This point was reiterated some ten years later by Letherby (1993) with reference to miscarriage.

Lovell (1983) also noted that the mother’s status in hospital with no baby to care for meant that her identity was ambiguous: without a baby, was she a patient or a mother? The denial of the woman’s motherhood and that of the personhood of her child was at odds with the ante-natal care the mother had received and “...her pregnancy, labour and postnatal experience were negated” (p. 760). The impact on identity extends beyond the hospital, however, with Murphy (2013) noting that for women who lost their first child, the identity of

‘bereaved parent’ gave rise to a conundrum: how could they be any sort of parent when they had not had a child who had lived outside of the womb? This was exacerbated by a lack of recognition of their parenthood by their social networks. Cacciatore et al. (2008) found similar ambiguities for parents who would how many children they had. They also noted that such ambiguity extended to the siblings of the stillborn as well.

Since Lovell’s work, the anthropologist Linda Layne has written extensively in this area. In a wide-ranging study of pregnancy loss support groups in the United States, Layne (1997) has argued that Foucault’s triple edict of modern Puritanism – ‘taboo, non-existence, and silence’ is applicable to pregnancy loss. Throughout the pregnancy loss literature, parents have recounted to researchers about how friends and family have refused to engage with them (see for example, Peppers and Knapp, 1980; Rajan and Oakley, 1993; Cacciatore et al., 2008; Cacciatore, 2010). This has led to some parents utilising the internet in order to do their griefwork online with people who have had similar bereavements (Davidson and Letherby, 2014).

This lack of social recognition has been explained in several ways: Layne (1997) herself has blamed an absence of ‘cultural scripts’ around pregnancy loss (see also Cecil, 1996): for example, there are no words that individuals can call on to sympathise with parents nor specific greeting cards to buy. Cote-Arsenault and Dombeck (2001) have cited social ignorance rather than a deliberate disregard for the feelings of the bereaved. But, noting the irony that at a point when women really need support, their social circle withdraws it, Rajan and Oakley (1993) point out that there appears to be a general cultural conception that the stillborn is readily replaced therefore there is less to grieve over.

The influence of medicine and its attendant technologies has been another of Layne's foci: she has pointed out that, due to ever earlier identification of pregnancy through the use of home pregnancy testing kits, parents have been able to bond earlier and earlier with the foetus than at any other point in history (Layne, 1997). This enables an earlier commitment to the pregnancy and, therefore, an earlier construction of the personhood of the foetus. In the light of the triple edict mentioned above, Layne (1992) has also noted that parents are able to utilize the technologies of science in order to counteract this. Parents who, in the absence of a baby, may feel the need to prove that there was a pregnancy are able to use artefacts such as the ultrasound scan photo in order to support the legitimacy of their grief. In a later article – 'He was a Real Baby with Real Baby Things' – Layne demonstrated how bereaved parents feel the need to retain material traces of the baby after its death. It is important for parents to ascribe a social identity for the baby, which is "...claimed via material items and practices which promise or evoke embodiment" (Hockey and Draper, 2005: 51).

While the experiences of women may be seen as an ideal focus for feminist research, Layne pointed out in 1997 that the issue of pregnancy loss was notably absent from feminist scholarship. She argued that this was likely to be because of the issue of abortion. She suggested this was because...

...anti-abortion activists base their argument on the presence of fetal and, even more importantly, embryonic personhood, feminists have studiously avoided anything that might imply such a presence. The fear in the context of pregnancy loss is that if one were to acknowledge that there was something of value lost, something worth grieving in a miscarriage, one would thereby automatically accede the inherent personhood of embryos/fetuses (1997: 305).

It may have been over 20 years ago since Layne noted this lack of engagement but it was as recently as 2018 that Catherine Kevin, writing in this journal, still felt the need to suggest that “[f]eminist responses to pregnancy loss require further interrogation and development” (p. 141).

While Layne’s suggestion of why there had, up until 1997 at least, been little feminist scholarship on the experience of stillbirth is probably an astute one, I wonder if there is another reason. If the personal is, indeed, political, then the initial consideration of pregnancy loss as a subject of feminist research was always likely to be initiated by women who had themselves gone through the experience. Layne, in all her work, is open about her experience of pregnancy loss, as are both Gayle Letherby (1993) and Deborah Davidson (2008) as well as Joanne Cacciatore – another academic who has also published extensively in this area.

It is perhaps timely to note that I am no different. I documented in my thesis (anonymised ref) how my second child died at 27 weeks’ gestation and, soon after giving birth, I overheard the midwives discussing my case: one of them said, “It’s more like a miscarriage really.” At that moment my overwhelming feeling was that they had devalued my experience. It was at that point that I became aware of the importance of language in the structuring of individual experience. The demarcation of stillbirth as an event that happens after 24 weeks’ gestation made stillbirth more important somehow than a miscarriage. Suggesting otherwise denigrated it and also made me feel somewhat of a fraud. It was some years later when I came across the work of David Armstrong that I began to understand why. He argued that the creation of the category of stillbirth changed the direction of ante-natal care. Care before the point at which stillbirth may occur is concerned with protecting a foetus, ante-natal provision following that point would be directed towards a baby, the attendant loss being a

stillbirth. For Armstrong (1986), medicine had "...mapped out the first year of [infant] life" (p. 216) beginning at 28 weeks' gestation and closing when the child turned one year old. While legally I had given birth to a baby, the midwives, by using miscarriage, had downgraded my loss to that of a foetus. On my return home from hospital and after the funeral, the event disappeared from my history until many years later when I decided to revisit it as the subject of an undergraduate dissertation altogether. As Layne would argue, I was subject to the Foucault's "...triple edict of modern puritanism – 'taboo, non-existence and silence'", (Foucault, in Layne, 1997: 291).

In considering the ways in which societal ideas around stillbirth might impact deleteriously upon women who experience such a loss, it is necessary to consider how pregnancy and mothering are framed in western industrialised society – a subject to which this article now turns.

### **Pregnancy and motherhood**

While ostensibly the concept of 'mother' may be seen one which is biological, it is social as well and, as Ruddick (1980) suggests, need not be attached to gender at all. Certainly the concept of 'mother' and its related concepts: motherhood and mothering are not neutral categories and feminism now has a long history where these terms have been deconstructed to demonstrate how the category has held particular meanings and significance across cultures and over time and how those structures are reproduced in order for children to become 'gendered members of society' (Chodorow, 1978). Certainly it can be seen that motherhood is something that needs to be controlled, for example, ideas around who should (or should not) mother in the UK abound and have often informed policy, for example, the rates of teenage mothers in the UK is deemed to be a social problem (Cook and Cameron,



2015) – so much so that Brady *et al.*'s (2006) study concerning teenage miscarriage is an apposite example: friends and family conceptualised the miscarriage as a solution to the problem of pregnancy at too young an age rather than envisaging the miscarriage as a personal tragedy for the young mother.

Both Chodorow (1978) and Westwood (1996) have both referred to the concept of the 'moral mother' which brings with it a certain amount of responsibility and that this is a concept that May (2008) exists today with an overriding ethic of the 'care of children'. If this is the case, it is no wonder then that women bereaved by stillbirth spend time trying to reclaim their 'moral identity' by revisiting their own behaviour and reassuring others that they did behave well in pregnancy (Murphy, 2012).

In her 1980 essay 'Maternal thinking', Ruddick considers how 'maternal thought' arises out of mothering. She argues that mothers are both powerless, either at the hands of the natural environment or the social one, as well as powerful: maternal power emerges from her ability to be able to use her body for childbearing. But this juxtaposition of powerfulness and powerlessness means that "...maternal practices [are] oppressive to mothers and children alike" (p. 343) even though these practices begin in a love which then compels women to "...protect and foster the growth of their children" (p.344). She argues that at the same time as maternal thinking, emerging also is a sense of 'maternal competence'.

Maternal competence as a concept is one which has been explored by Landsmann (2000) with regard to women who have given birth to children with disabilities. She argues that in order for 'real motherhood' to exist there then needs to be a 'real child': in a society where disability diminishes personhood, this may have implications for the woman who is mother to

a child with disabilities. Landsman (2000) found that a woman's maternal competence could be threatened if a woman gave birth to a child with disabilities. Her interviews with women revealed 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. Mothers of all classes represented in this study indicated that they were aware of experts' advice about how best to ensure the birth of a healthy baby. The vast majority of mothers' narratives include some statement of how the mother thought she had done everything right and therefore believed she should not have had a child with disabilities. (p. 173).

Indeed, Landsmann found that her participants would interrogate their behaviour during pregnancy to determine whether the disability could be construed as her own fault similar to the women in Murphy's (2012) study.

Indeed, for women there is much to consider when revisiting behaviour in pregnancy. At present medical advice given by the National Health Service in the United Kingdom suggests that pregnant women should not eat, for example, the following foods: soft cheese with white rinds; soft blue cheeses; raw or partially-cooked eggs; pate; liver; game; and some types of fish (NHS, 2017). Several years ago in the UK such a list would include nuts but they are no longer there – this is an apt demonstration of how 'science' is not a fixed concept but subject to variability. One wonders if there are some women whose baby died or had a disability that are still left wondering if the nuts were to blame when the theory has now been discounted. There are other areas where pregnant women are given advice too – around keeping well, drinking and drugs as well as exercise which all give women much to ponder on if the outcome of pregnancy is not one which is expected.

Indeed, in positing health in the terms of a ‘culture of meritocracy’, Layne (2000) has outlined how the language of individual responsibility informs popular understandings of health. This ethic of self-care, she argues, is prevalent when it comes to pregnancy and birth. Drawing in part on Emily Martin’s (1987) work which explored the experience of pregnancy in a capitalist society, she then likens pregnancy loss to an “...instance of failed production” (Layne, 2000, p. 170). Thus, she suggests that this results in pregnancy loss becoming a moral problem:

[i]t is not surprising, since the “successful production” of a baby may be credited as a moral achievement, the result of self-discipline and labor, that the inability to bear children is often attributed to a moral failing on the part of the woman (Layne, 2000, p. 171).

The other aspect to Landsmann’s work which is worth considering here is the consideration about a ‘real mother’ who can only be understood in opposition to a ‘real baby’. The title of Layne’s (2000) article, ‘He was a Real Baby’, is pertinent. To emphasise the realness of a dead baby is a way in which a mother might seek to emphasise her own identity as a real mother.

Such medical strictures co-exist with more ‘natural’ ideas around pregnancy. A popular notion has been the discourse of the ‘essentialized’ mother. Underpinned by medical discourses that have naturalised the maternal body, Harding (1998) notes that medical discourses have worked to naturalise the maternal body and Lupton and Barclay (1997) have argued that the condition of motherhood

...tends to be represented as having an instinctive core. While women are also encouraged to seek out information about pregnancy, childbirth and parenting,

motherhood is still commonly seen as more *essentially* a part of femininity, not a split from womanhood as fatherhood may sometimes be split from manhood. (Lupton and Barclay, 1997: 147).

‘Maternal instincts’, Lupton and Barclay argue, mean that women have a bodily/emotional sense of a child’s needs that men lack.

The actual existence or otherwise of the ‘maternal instinct’ is not important for this article.

What is important is how such an idea that one exists might serve to impact upon women who have had a baby die before birth. In order to consider this we can take, as an example, a recent international study on the presence of ‘gut instinct’ in stillbirth and pregnancy. This study was undertaken by medical professionals who are well respected in this area of investigation. They reported that women who had given birth to a stillborn baby were more likely to report a ‘gut instinct’ that something was wrong than were mothers of live born children (Warland et al., 2018). While the authors note that such ‘maternal intuition’ is reported in retrospect rather than at the time of the pregnancy itself, they contend that this might mean that there *is* such a thing as ‘maternal intuition’ that manifests itself during pregnancy. For this reason they suggest that medical professionals should listen seriously to concerns from mothers about the pregnancy. I cannot disagree with this suggestion. But I wonder how helpful it is to suggest on the basis of retrospective interviewing that ‘maternal intuition’ in pregnancy may be a thing. Given that the research was conducted by medical professionals it adds weight from what some may consider to be scientific point of view (even though I would argue that the research itself was not scientific) to the notion of an essentialised motherhood which may be seen to be oppressive to women and that could mean that those bereaved women who do not have a ‘gut instinct’ that something is wrong will have one more thing to feel guilty about. Back to my own experience here just briefly: my

daughter, Ann Rosemary, died a couple of weeks before the appointment where the midwife failed to find the heartbeat. I had not noticed that something was wrong – does that make me less of a woman? How do such ideas around behaviour in pregnancy and maternal intuition make other women feel? Before I consider this with regard to my findings, I will first outline the methods used when undertaking this research.

## **Methods**

The focus of this doctoral project was to unpack the experiences of both men and women who had experienced a stillbirth. It was exploratory research – at the time I undertook it there had been far less sociological and anthropological work in this area than there is now. While the focus of this article is on women's experiences, the interviews undertaken for the project were with both men and women. My inclusion criteria was for the stillbirth to have taken place since 1992 as this was the year that the legal definition of stillbirth in the United Kingdom changed from death after 28 weeks' gestation to death following 24 weeks' gestation. I excluded parents who had had a loss within the six months prior to interview. I aimed to interview couples jointly and then have follow-up interviews with each partner separately.

As my main aim was to gain a sociological understanding of the experience of stillbirth from the moment the pregnancy was planned and then through to the bereavement, I undertook qualitative in-depth interviews. The interviews began with a request that the interviewees told me the story of their stillbirth from the moment they decided to have a baby or had found out that they were pregnant. This was a deliberate tactic to try and lessen the emotional impact of being questioned around what is seen to be a sensitive topic. By telling me their story first, I felt like I was then able to explore areas in more depth as I would have 'hooks' to

use to facilitate my questioning – rather than just going in cold. As such I had a list of topics I would cover once I knew the story. These included exploring the following areas:

- GP/hospital care including interaction with the stillborn baby
- Social support from friends, family and work colleagues
- Accessing support through charities
- Funerals and memorialisation
- Grief and relationships
- Information-seeking post loss
- What positives can parents take from the experience?

I aimed to recruit participants through support group networks, pregnancy loss websites and personal contacts.

While my original aim was to interview couples, the reluctance of men to take part meant that I had to be flexible in my recruitment and, in the end, I spoke with ten couples and twelve mothers. I had intended to interview couples together and then separately but only five of the couples had follow-up individual interviews. This was mainly because as recruitment went on, more couples took part who lived a significantly long distance away from home: follow-up interviews became impractical. Of these five couples where I had both joint and individual interviews, there was one couple where the husband ‘did not feel comfortable’ taking part in an individual interview although I still spoke to his partner on her own. Joint interviews lasted between 45 minutes and four hours, while individual interviews with women ranged from 45 minutes to three and a half hours. With men the individual interviews ranged from 10 minutes to 45 minutes. The ethnicity of the participants was overwhelmingly white although two mothers hailed from south-east Asia. Many of the interviewees were from higher social classes with the exception of two fathers and two

mothers. This is more than likely a result of my recruitment methods as members of support groups tend to be white and middle-class (Allsop et al., 2004). However, both south-east Asian mothers were recruited via support groups.

The reticence of men to take part was disappointing but not wholly unexpected. As previous researchers have found, interviewing men around emotional experiences can prove to be difficult: McKee and O'Brien noted in 1983 that there seemed to be a generalised and relative disinclination among men to discuss their feelings and, writing fourteen years later, Puddifoot and Johnson (1997) found much the same with regard to pregnancy loss. This accorded with the reason I was given for that one male partner to not want to go ahead with his individual interview. Despite the preference for couples being made clear when I was recruiting participants, early on in the recruitment process women would volunteer to take part without their partners. When asked about this, mothers would generally say that their husbands or partners would not want to talk about it. The subtext was that the stillbirth remained for some men very much their partner's story rather than their own. This perhaps reflects the greater attention women get throughout the experience of stillbirth – both from the point of view of medical care but also from their social circle.

I analysed the data using Strauss and Corbin's (1990) version of grounded theory, an inductive analysis technique where theory is generated from the data. The process of analysis began early on in the project, during the interviews themselves, where initial concepts were generated. For example, my interview with couple number one included a consideration of how the child was remembered by the family over a period of time. This suggested that integration of the child into the continuing life of the parents and, indeed of a wider family,

might be an important aspect of the experience of stillbirth and this became a theme to ask about in subsequent interviews.

All interviews were coded line-by-line which gave rise to hundreds of concepts which were then grouped into categories. As an example of this, it became clear that all the parents routinely expected that the pregnancy would end with a live baby and therefore it became possible to isolate a category called 'expectations of success'. Once this category had been isolated, using the process of axial coding, subcategories were set up to explain why parents had this expectation. It emerged from the interviews that mothers had an expectation of success because of the following factors:

- the medicalisation of the pregnancy,
- the assumption that they had 'bodily integrity', that is, their body was fit and prepared to go through pregnancy and birth,
- 'maternal competency' and
- 'silence' which referred to the lack of information and talk among their social circle around pregnancy loss.

The research was granted ethical permission by the University of Surrey and my local National Health Service ethics committee. I assured participants that their names and any identifying information would be confidential and anonymous. They were also informed that they stop the interview if they so desired at any time and that they were able to refuse to answer questions. Fortunately, no participants (apart from the male partner early on) withdrew from the research and all questions were answered. As may be expected from a qualitative interview technique, the findings presented here represent a snapshot of the experience for bereaved parents and so cannot be generalised to bereaved parents as a whole.



### **‘Pregnancy taken-for-granted’**

Given the point noted in the literature review – that discourses around pregnancy and mothering that simultaneously see motherhood as something essential (Lupton and Barclay, 1997) but also as a subject to be learned with rules, given by the medical profession, to follow, the data presented here focuses on what women told me about their experience of pregnancy. The accounts collected suggested that, whether it was their sixth baby or their first, mothers did not expect that the outcome of the pregnancy would be anything but happy – what I termed ‘pregnancy taken for granted’. I identified four main reasons for this expectation: its medicalisation; the invisibility of stillbirth in their social circles and in books on pregnancy; maternal competence (of which there were two aspects) and mothers’ bodily integrity. For the purposes of this paper, my focus here is on *maternal competence*.

#### *Maternal competency and stillbirth*

In the literature review above I referred to the concept of ‘maternal competence’ which holds that women feel that they should be “...able to protect and foster the growth of their children” (Ruddick, 1980: 344) and that might serve to impact negatively on them if the pregnancy does not go as planned (Landsmann, 2000). Competency was not a word used explicitly in the accounts but was implicit in 14 of the mothers’ interviews. There were two aspects to such competence: ‘*rule-following*’ and ‘*knowingness*’ and these tasks were ‘lived’ by the women I interviewed: fostering the child during pregnancy had been a way of life and of parenting from the moment they realised they were pregnant.

#### *‘Rule-following’*

The first aspect was ‘rule-following’ and was informed by the pregnancy advice which is widely available to women in the UK. Mothers would, during the interviews, stress that they

had behaved well during their pregnancy: this mostly referred to refraining from smoking and drinking or they would merely tell me that they hadn't done anything 'wrong'. It seemed to be a way in which the mothers were trying to exonerate themselves from blame lest their behaviour be considered faulty:

*Penny:* We had a post-mortem but it 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.

Such behaviour modification assumed women to believe that they were able to assume some element of control over the outcome of the pregnancy. Health-care messages are powerful things and, at the same time as reassuring themselves that they had behaved well, such messages were used to highlight the unfairness of the stillbirth: participants would often contrast their own exemplary behaviour with the perceived actions of those whom they viewed as 'less-deserving' mothers due to their refusal or inability to obey the 'rules':

*Jane:* I begrudge people if I see them smoking [when] pregnant or [I think] "I bet you end up with a healthy baby out of it." And sometimes I think if I'd been a heroin addict or... whatever, crack addict I would have been monitored.

*James:* Just drank and smoked all the way through.

*Jane:* I'd have been monitored to the hilt and probably had a perfectly healthy baby. I feel like almost I've been punished for behaving properly.

These lay evaluations of unfairness tended to be reinforced by the parents' social circle and, in one case, by the medical profession when a consultant evoked the stereotype of the 'bad' mother:

*Grace:* He [the consultant] went on about prostitutes and drug addicts. “[They] have healthy babies, drink, smoke”, he said.

Well-intended recommendations from government agencies and health professionals, however, have unintended consequences: in a society where science might be expected to provide reasons for the loss, the unexplained stillbirth invites possible conjecture that the mother may be at fault. One mother explicitly mentioned recounting to others that she had ‘behaved well’. There was another case too where the mother rejected medicalized pregnancy and birth. This led to conflict for her afterwards – both in her own family who blamed her for the stillbirth – as well as from her social circle. She told me:

*Tanya:* I always felt odd [at coffee mornings] 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.”

It is worth noting here that all the other mothers interviewed had had a scan yet their babies still died. An understanding of the capabilities of the ultrasound scan in protecting an unborn baby, albeit an unrealistic expectation, has the potential to stigmatize the mother of the stillborn if she has acted outside of mainstream ideas. In the interviews with fathers –when interviewed with their partners and when alone, the men were also keen to emphasise their partners’ maternal competency. For example,

*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.

While maternal competency in terms of rule-following was firmly linked to discourses of medicine, the other aspect of maternal competency for the women I interviewed was clearly one that could be connected to an essentialized ideology of motherhood: ‘knowingness’.

*‘Knowingness’*

The mothers interviewed here assumed that they should have an ‘instinctual’ knowledge of what was happening within their womb as part of an ‘essentialized’ discourse of motherhood. In many instances, notions of a mother’s ‘instinct’ were referred to – if problems occurred they would ‘know’. For most of the mothers I spoke to they didn’t ‘know’ that something was wrong. This was especially the case for those women whose baby had been dead for a few days or more before they found out: they blamed themselves for not realising that something had gone wrong and this led them to question their competency. The following quote from Grace is an example of this:

*Grace:* I think I was sort of ashamed to tell other people that I hadn’t, um, I had failed, you see. I had, had failed again. I guess it’s that failure thing, I’d failed to produce a baby and I’d failed to notice when the baby was in distress...

Grace may be seen here to be taking firmly on board both the discourse of motherhood as a woman’s biological destiny as well as that of the essentialized mother. Such ideas may also be reinforced by the mothers’ social circle. Maggie, one of my south-Asian participants, told of how her mother helped to make her feel culpable in the death of her baby:

*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 tell me now that your tummy kept moving up and down and going hard.” And you know, for a long time I blamed myself.

Maggie’s mother was encumbering her daughter with maternal responsibility here, directly blaming her for the death in a physical way – ‘you killed him’ – but she is also doubting Maggie’s ability to learn from the books she read in echoes of the ‘rule-following’ mother as well as her failure not to have known that the baby was dying.

The idea of the importance of ‘maternal instinct’ also came from the medical profession and was reinforced by the midwives women encountered:

*Christina:* That’s why I don’t like that normal bit at hospital, because, um, it’s still got that horrible attitude that midwives have that your baby will be all right and your body knows. I can’t explain it to you but I don’t like it.

In naturalising pregnancy in such a way, the medical profession can actually compound the guilt that mothers who have suffered a stillbirth may feel. This guilt might also be reinforced for participants by listening to other bereaved mothers’ claims that they ‘knew’ that something was wrong with the baby:

*Grace:* Some of the other (bereaved) mothers you hear ... say they know when it happens, they can feel it, they know all those things. It makes me feel terrible sometimes, you know, thinking that I didn’t notice it.

While ostensibly these bereaved mothers were all in the same boat, such ideas can serve to delineate one bereaved mother from another and make one feel less competent of motherhood in the process.

Some of the women I interviewed did claim that they knew something was wrong – like the women Grace referred to and the women in Warland et al's (2018) research. Isobel, for example, refers to a 'knowingness' that the pregnancy would end unhappily, but she also somewhat contradictorily referred to the extensive testing that had assured them of their baby's health. Back to Tanya, who had rejected medicalisation:

*Tanya:* I just knew there was definitely something wrong, whether there was anything before that I can't really recall, but I definitely recall the movements in the morning and then I just recall the two o'clock lunch and nothing there so whether I'd had any suspicions before that I can't honestly say but I do know at two o'clock I just thought this isn't right and then I started all the pushing and all that and all that and just nothing happening. And just going within myself silently just went into myself. I went to yoga and everything, all through the class I, I remember I put myself in a corner away from everybody else. I just kind of like an animal instinct kind of thing.

Close examination of the above extract suggests however that the knowingness might actually be based on a conscious awareness of a lack of movement in the womb rather than on an instinctual knowledge that might be based in societal ideas around the maternal instinct.

A possible way in which mothers might try to recover some sense of maternal competency with respect to an instinctual awareness would be by attempting to pinpoint the precise moment of death:

*Fiona:* I went to have a bath and I was literally watching him move in the bath. And, um, how I remember it was that it was such an exaggerated move. He literally came right up on one side – really up and then just went down. And of course I never thought anything about it at the time but I, I believe now that that was actually when he went [died]. 'Cos he just really came up, so extreme, and then just went back down and that was it.

*Isobel:* Actually looking back we think we know now that was the actual weekend that she died but I'm *ashamed* to say I didn't notice her not moving.

The shame Isobel experienced – and that of Grace earlier – can be clearly linked here to the essentialized notions of motherhood that serve to stigmatise women bereaved by stillbirth.

While the men I spoke to occasionally considered their own competency (or lack of), paternal protection can only really begin after birth. It was mothers who have spent more time and energy in the pregnancy. The women I interviewed felt that they were in control of the outcome of the pregnancy and this fed into their guilt when the baby died. In contrast to all the other mothers interviewed here was Charlotte, though. Her comment throws into sharp relief the concerns and worries mentioned by the other mothers. Charlotte and Carl's son died during labour and the NHS trust admitted liability. 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, especially those whose loss was unexplained. Charlotte is recognising this and implicitly acknowledging that for other women, who have no one else to blame, may feel guilty.

The excerpts from the interviews above delineate how societal ideas around motherhood impact on bereaved mothers. The ‘moral mother’ (May, 2008) would have no need to feel ‘guilty’, or a ‘failure’ and or be ashamed’.

### **The social influences on bereavement**

It is probably worth, at this stage, returning to some of those words used to describe parental emotions that I highlighted at the beginning of this paper, particularly, failure, shame, guilt and stigma. If women are subjected to societal ideas of femininity that first of all suggests that motherhood is their primary destiny (Harding, 1998) then no wonder that stillbirth is an event – particularly for the first-time mother – that can instil within women a strong sense of failure. We live now in an age where fewer and fewer stillbirths occur and given that the women I interviewed felt that the medical care they received was one way in which a successful outcome of pregnancy was assured (see also, for example, Benson and Robinson-Walsh, 1996), so also was their own behaviour and it was this behaviour that they would spent time interrogating to try and explain to themselves why their baby had died.

This then leads on to guilt, shame and stigma as for the women their maternal competency – whether this was an ‘essentialized’ one or a ‘rule-following one, or, indeed, both – suddenly



became open to question. If we consider the mother bereaved by stillbirth as ‘stigmatised’ – and it seems that mothers themselves do (Brierley-Jones et al., 2014-2015) then, as Goffman (1963) has argued, it is their ‘abnormality’ that confirms the normalness of others. With stillbirth being a fairly unusual occurrence, certainly it was these mothers who confirmed the ‘normalness’ of those mothers around them.

Goffman (1963) has outlined how a stigma can be perceived as a gap between someone’s *virtual* social identity and their *actual* social identity. The interviews demonstrated clearly how ideas of the ‘good’ and ‘bad’ mother impact upon a mother’s experience of stillbirth. The ‘moral mother’ is competent enough to behave well and deliver a live baby as she has protected and fostered it throughout the pregnancy, the bad mother either chooses not to or is unable to exercise competency. For the women I interviewed their ‘actual social identity’ was ‘moral mother’; however, the stillbirth served to threaten them with the possibility that others might impose upon them a ‘virtual social identity’: of ‘immoral mother’. Certainly it seemed for at least some of the mothers that societal ideas about behaviour in pregnancy that is detrimental to a baby’s health, might mean that friends and family would suspect them as being in some way to blame for the stillbirth. This was certainly the case for Tanya who was blamed outright for her failure to have an ultrasound scan.

With these feelings brought to the forefront for women, I would argue then it is no wonder that mothers feel guilt, shame and stigma following a stillbirth and that they will be at more risk of mental health problems (Armstrong et al., 2009; Murphy et al., 2014). What might also compound these problems is the organisation of parenthood. In 1980 Oakley found that women who were at home looking after a new baby were lonely. For the mother of the stillborn, who remains entitled to maternity leave in the same way as a mother who has had a

live baby, this loneliness is compounded by the absence of a baby and all those tasks and activities which are associated with being a new parent. This is not to say that bereaved mothers should not have maternity leave but not going back to work for several months may serve to compound the loneliness. Moreover, anecdotal accounts from women in the literature have reported for years that they are often isolated by their social circle (see, for example, Cacciatore, 2010) and this phenomenon was also apparent in the interviews I conducted: people reporting that former friends crossed the road rather than talk to them or, once back at work, people would ignore them. Tanya's experience referred to earlier is also an example of this. Given that loneliness is a significant factor in depression (Erzen and Çikrikci, 2018), it may be the case that it may also be the loneliness of maternity leave following a stillbirth that may give rise to, or exacerbate women's mental health problems following bereavement.

## **Conclusion**

It has long been recognised that parenthood is socially constructed and that the concepts of how to mother is a fluid one which varies across cultures and between historical time periods. As such I would argue that so too is the category of bereaved mother. The contextual nature of the bereavement is paramount in explaining the ways in which men and women experience the event both on a personal level and within their social circles too. Just one aspect of this context relates to societal ideas around pregnancy and mothering. A greater understanding of how societal ideas and expectations of the pregnant woman can impact upon the mother of a stillborn child can go some way towards finding ways to ameliorate the experience for mothers. It is especially important for health care professionals to acknowledge this as argued by Murphy (2012).

While this was a qualitative research project, my findings cannot necessarily be generalised to a wider population. Indeed, most of the parents I spoke to were white and middle-class which is a feature of much of the literature around pregnancy loss (Murphy, 2015). As Murphy and Cacciatore (2017) have pointed out there is a need for far more research into the experience of stillbirth for other, more marginalised social groups. It would be also useful to consider how bereaved parenthood is socially constructed in a more systematic way – for men as well as women – in order to understand more ways in which parents bereaved by stillbirth may be supported.